Flightcare Limited

Beechcroft

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Beechcroft is a care home that provides accommodation for up to 43 people who need help with their personal care or nursing care. At the time of the inspection 40 people lived in the home. There are three communal lounges for people to share and a pleasant back garden for people to enjoy.

People's experience of using this service: The overall rating for this service is 'inadequate' so therefore the service is in special measures by CQC.

There were no adequate or effective systems and processes in place to monitor the quality and safety of the service. This resulted in people being exposed to ongoing risks with regards to their care.

The provider's fire safety arrangements were unsafe. There was no evidence that staff had practiced how to evacuate people from the home in an emergency for a significant period of time. People who lived in the home did not have adequate personal emergency evacuation plans in place and there was a lack of evacuation equipment in place to assist an evacuation.

People's needs and risks were not properly supported or managed and people's support was inconsistent and in some instances unsafe. Some people sustained accidental injuries during the delivery of support due to poor moving and handling practice. Some people had fallen due to being left unsupervised or unsecure in a wheelchair or recliner chair. This did not show that people were well treated or looked after.

People who required support at their end of their lives did not have support plans in place to advise staff how to provide appropriate and responsive support to meet their needs.

Some people had unexplained injuries. Some had been reported to the local authority but some had not. A significant number of these unexplained injuries had not been reported to CQC as required. Some people sustained similar injuries for a significant period of time but no consideration had been given to whether this indicated potential abuse.

The number of staff on duty was insufficient to meet people's needs. People's call bells rang for significant periods of time before being answered. When call bells rang staff did not always respond with any sense of urgency. Some people told us they waited a long time for help. One person said that they could wait for hours during the night for someone to help them.

Where the manager had concerns about staff conduct they had not always ensured that appropriate action was taken when they left the provider's employment. This meant they had failed to demonstrate a duty of care.

During our inspection, we observed that staff interacted with people in a kind and caring way. They were respectful towards people and patient.

People had access to a range of activities either group based or one to one in support of their social and recreational needs.

Rating at last inspection: At the last inspection in 2017 the service was rated good. After this inspection, the registered manager in post left the home.

Why we inspected: This was an urgent and responsive inspection planned in response to information of concern reported to CQC via the 'Share your experience' link on CQC's website.

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

Follow up: The home has been placed in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Beechcroft

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two adult social care inspectors, one inspection manager and a medicines inspector.

Service and service type: Beechcroft is a care home. People in care homes receive accommodation and personal care. 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 they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did: We reviewed information we had received about the service since the service was last inspected. Prior to this inspection, we received information of concern about the running of the home and the safety of the people living in it and we looked into these issues during the inspection.

During the inspection we spoke with eight people who lived in the home and four relatives to ask about their experience of the care provided. We spoke with two members of care staff, three nurses, the cook, the maintenance person, the care quality manager and the registered manager.

We reviewed a range of records. This included five people's care records and people's medicine records. We also looked at three staff files for staff who had been recently been recruited. Various records in relation to training and supervision of staff, records relating to the management of the home and a variety of policies implemented by the provider.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse
● There was a system in place to identify and respond to incidents of potential abuse. Records showed however that this system was not always followed appropriately.
● For example, one person had made an allegation of potential abuse that had not been appropriately acted upon by the manager or referred to the local safeguarding team and CQC for further investigation.
● Some people had unexplained bruises that had not been reported to the local authority safeguarding team. Some people had sustained similar injuries over a significant period of time yet no consideration had been given to whether this indicated a pattern of potential abuse.
● There was a significant number of safeguarding incidents that were not reported to CQC in accordance with the provider's legal responsibility to do so.

This lack of appropriate action meant people were not protected from the risk of abuse. This demonstrates a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● We had considerable concerns about the safety of the people who lived in the home in the event of a fire. There were inadequate staffing arrangements in place to meet people's needs safely in the event of an emergency.
● Personal emergency evacuation plans (PEEPS) were incomplete for several people and the PEEPS in people's care records were not the same as the PEEPS in the home's emergency 'grab' file.
● There was a lack of adequate evacuation equipment in place to enable people who had difficulty walking to evacuate safely.
● Risks with regards to mobility, falls, nutrition, personal care and pressure sores were assessed. Other risks such as those associated with the risk of choking or health conditions such as diabetes were not. This meant staff had no information on the level of risk posed to people's health and welfare.
● Some of the risk management guidance given to staff to follow was generic and unclear. For example, some people required support to change position in order to prevent pressure sores but staff had no guidance on how often they required this support. One person lived with a health condition but staff had no guidance on how to manage this condition or the signs or symptoms to spot in the event of ill-health.

This lack of adequate safety arrangements and adequate risk management guidance placed people at risk of harm. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There was little evidence that the service used information relating to accidents and incidents to learn from things when they went wrong.
● For example, accidents had occurred when people were being supported by staff. There was no evidence that information about how these accidents had occurred was used by the manager or staff to prevent similar accidents occurring in the future.

This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff recruitment was satisfactory with sufficient and appropriate pre-employment checks undertaken prior to employment.
●The manager told us when they first came into post they had experienced difficulties with some staff members but that these staff members no longer worked at the home. We asked to see the records maintained in relation to these difficulties to ascertain whether the provider's recruitment and staff management procedures had been followed. The manager was unable to produce any documentation to show that they had. This was not good practice.
● We looked at the provider's dependency tool which indicated the required staffing levels that the home needed to function safely. We looked at the three previous weeks rotas and saw that staffing levels were consistently below these levels.
● We observed several occasions when people were asking for support and did not receive it in an acceptable time. One person waited over 30 minutes to go to the toilet.
● One person told us that they regularly had to wait when they needed support.

Insufficient staffing levels places people at risk from harm as their needs cannot safely be met. This demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
●Records relating to the receipt of medicines were not always up to date and accurate. This meant that not all medicines could be accounted for properly and the records did not always show that medicines had been administered as prescribed.
●Medicines were not always administered according to the prescription instructions or at the right time for example some medicines needed to be given before or after food.
● Some people's medicines were out of stock for example one person's painkillers had run out and had not been re-ordered. This meant they were not available to the person to manage their pain and ensure their comfort.
● Some emergency medicines were not available for people who may need them in a crisis. This meant that should an emergency occur; this person's health and welfare would have been placed at significant risk.

Unsafe management of medicines places people at risk from serious harm. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We looked around the home and saw that it was clean and fresh.
● Gloves and aprons were available in all the bathrooms and toilets for when they were required.

Inadequate

Is the service effective?

Our findings

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

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

Supporting people to eat and drink enough to maintain a balanced diet
● Some people had lost weight and were at risk of malnutrition. Despite this, no adequate action had been taken to ensure that people received sufficient nutrition and hydration to meet their needs.
● For example, some people had eating and drinking charts in place that recorded what they had to eat and drink. These records showed that people's fluid intake was consistently poor and that people rarely received anything to eat or drink after tea-time until breakfast time the next day.
● One person told us they usually had their tea at 5.30pm and were hungry by 9pm. They said to get anything else to eat or drink you had to ask.

This meant that there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the nutrition and hydration needs of people were not always met.

● Some people told us that the meals they received were satisfactory. One person said the food was good. Another said the food was "Alright" and a third person told us the food was not hot enough when it was served.

Staff support: induction, training, skills and experience
● We looked at the frequency of staff supervision sessions and appraisals and saw that this was inconsistent and infrequent.
● Some staff had never been supervised or had appraisal of their skills and abilities despite working at the home for several years. This included nursing staff who should have received regular supervision with regards to their clinical practice.
● Staff training was inconsistent and staff did not always receive the training when it was required.

This meant that staff had not received appropriate support to ensure people received safe and effective support. This demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found the implementation of the MCA required improvement in order to ensure people's right to consent was properly respected.

● We looked at capacity assessments for people whose ability to make certain decisions about their care and welfare was in question.
● We saw that people's capacity to make a range of different decisions about their care had been assessed at the same time on the same day. This did not evidence that the service recognised that people's capacity could fluctuate at different times.
● Conducting multiple capacity assessments on the same day at the same time does not show that the manager or provider has fully understood the principles of the Mental Capacity Act or, that they considered that having multiple assessments at same time was confusing and tiring for people to participate in which may in turn have impacted on their ability and motivation to respond.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Some but not all of people's needs and choices were assessed and people's support was not always provided in accordance with standards or best practice guidance.
● For example, people's nutritional support and the way in which people's medicines were managed was not in accordance with best practice guidelines specified by the National Institute for Health and Care Excellence (NICE) guidelines.
● People's capacity was assessed but the way in which the assessment process was undertaken was not in accordance with best practice advice stipulated in the Mental Capacity Act 2005.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to adequately assess, monitor and improve the quality and safety of the service in accordance with recognised standards.

Adapting service, design, decoration to meet people's needs
● The home was designed to accommodate the people living there. However, one of the communal bathrooms on the ground floor was out of use due to the bath hoist being broken. Some of the radiator covers in the home were loose and not secured to the wall and sufficient emergency evacuation equipment was not available to assist in an emergency.
● The home had a pleasant garden for people to enjoy with seating areas for people to sit out. The garden however was not secure and was accessible to unauthorised persons.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had received support from speech and language therapy, dieticians, GP's, and other health and social care professionals when required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
● We saw a variety of very personal information on display in the home that could be accessed by anyone. This meant that people's right to confidentiality was not respected.
● People's care records were not always securely stored as we found an unlocked area of the home containing people's care records. This meant that this information was accessible to visitors to the home. This was a breach of Regulations 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's privacy and dignity was compromised as their private information was not kept secure or confidential.

Ensuring people are well treated and supported; respecting equality and diversity
● Staff supporting people were observed to be kind, caring and respectful in all of their interventions with people. However some people sustained accidental injuries during the delivery of support which indicated staff did not always ensure due care was taken when people's support was provided.
● People who lived in the home gave mixed comments about the quality of support they received most of the people we spoke with said staff were kind.
●One person said "The staff are marvellous. They are very helpful". Another person said the staff "Are lovely" and a third person told us "Staff are very nice, very helpful. There is one that is not very pleasant. Doesn't speak to you".

Supporting people to express their views and be involved in making decisions about their care
● A survey had been undertaken with people who lived at the home in 2019, the results of which were mixed with regards to the quality of the support they received.
● There was no other forum such as a resident meeting for people to attend at the home to enable them to be involved in the running of the home and express their views.
● A relatives group had been set up called 'Friends of Beechcroft' but at the time of our inspection, a relatives meeting had not taken place for over 7 months.
● There was therefore little evidence that people were supported to express their views in any consistent or meaningful way.

Inadequate ●

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- People who were in receipt of end of life care did not have care plans in place to guide staff on how to provide people with safe and responsive care that met their needs, wishes and preferences. This meant there was a risk that people's end of life care would not be suitable for them.
- We found that people's day to day support was not always provided in a person centred way. For example, people did not always receive the support they needed with regards to repositioning and nutrition and hydration. People's medication was not always given to meet their individual needs.
- People's care plans had been reviewed but the reviews were meaningless. They did not show that staff had fully considered people's needs and any potential changes in order to ensure the support they received remained responsive and appropriate.
- Some people's call bells rang for significant periods of time during the inspection but staff did not respond with any sense of urgency. We observed that some people waited over 20 minutes for staff to provide support and one person told us they could wait for hours for someone to come to aid during the night. This did not show that staff were responsive to people's needs.

This evidence demonstrates a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care files contained some information about their likes and dislikes, their preferred daily routines and information about their personal background. This helped staff gain an understanding of the people they were caring for.
- People had access to a range of activities provided by the activities co-ordinator. This included both group and one to one activities for people who were nursed in bed.

Improving care quality in response to complaints or concerns

- There was a complaints policy in place.
- When asked the manager was unclear as to what complaints had been received.
- When we asked for the records relating to complaints and compliments, they gave us a large pile of paperwork. We were unable to make much sense of most of it.
- After reviewing all of the documentation, we managed to find evidence the manager had respond appropriately to at least one relative who had raised concerns about a person's care.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● We have numerous discussions with the manager during our inspection about the concerns we had identified. The manager was not able explain why there were so many issues of concern in the home or give a satisfactory explanation as to why they had not been dealt with, other than to say that they would improve things.
● The care quality manager was present when we provided feedback to the manager on days two and three of the inspection. They did not provide any explanation as to why such significant concerns had been found during the inspection or provide any explanation as to why the issues identified had not been picked up and addressed.
● From these discussions it was clear they did not have an adequate knowledge and understanding of the health and social care regulations that they were legally responsible for complying with.
● Statutory notifications relating to allegations or incidents of potential abuse were not made to CQC in accordance with the manager's and provider's legal responsibility to do so. This was a breach of Regulation 18 of Care Quality Commission(Registration) Regulations 2009.

● During the first day of the inspection, we checked the management of medication by the nursing team. We found that the attitude and demeanour of some of the nursing staff during these checks was defensive and intimidating. We spoke with the manager about this. It did not demonstrate an open and transparent culture or the expected professional standards of practice and behaviour expected of nursing staff. We also raised concerns with the provider that the manager and staff did not understand the remit of CQC.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving
There were no effective systems in place to monitor the quality and safety of the service in order to ensure person centred high quality care. This meant that the manager and provider failed to identify and manage risks to people's health, safety and welfare. This placed people at significant risk of harm.
●For example, there was a lack of adequate fire safety arrangements.
● The delivery of care was not safe or up to appropriate standards
● People's nutritional and hydration needs were not always met.
● Staffing levels and support were insufficient
● Incidences of poor staff conduct had not been responded to appropriately.
● Safe safeguarding procedures and reporting requirements had not always been adhered to.

- Medication management was inadequate and people had not always received the medication they needed.
- People's private information was not always kept confidential.
- There was no evidence that the manager and provider used information in the day to day delivery of the service such as care plan reviews, safeguarding incidents, accident and incident data to learn from and improve the care provided to people.
- At the previous inspection of the home in 2017, the home had achieved accreditation for their end of life care. At this inspection, the home was no longer accredited and standards of end of life care had declined. Despite this, the manager had not removed reference to this accreditation from the home's noticeboards.

The above issues demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not well managed or well led.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
- There was limited engagement with people using the service.
- People had access to a range of other health and social care professionals such as dentists, opticians, doctors and social workers who visited and supported people at the home.