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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Beechcroft provides accommodation for up to 43 people who need help with nursing or personal care. At the time of the inspection 31 people lived in the home. The majority of the people living in the home required nursing care and most people lived with dementia.

People's experience of using this service
At this inspection, we identified serious concerns with the management of risk, care planning and delivery, the management of medicines, the implementation of the Mental Capacity Act 2005, dignity and respect and governance.

People's risks were not always properly assessed or managed. Staff lacked clear and sufficient information on people's needs and risks. Guidance on the support people needed to keep them safe and well was not always provided for care staff to follow, which placed people at risk of inappropriate or unsafe care.

It was difficult to assess what clinical care (nursing care) people needed as these needs had not always been assessed, care planned or monitored by nursing staff. Nursing notes were often difficult to read as record keeping was so poor. It was not possible therefore to tell if people experienced good outcomes or whether such outcomes were promoted in the delivery of care.

Medication was not always stored or managed safely. Staff lacked sufficient guidance on how to administer high risk medicines such as Warfarin and as and when required medicines such as painkillers or anxiety medicines. Medicines to thicken people's drinks to a consistency safe from them to drink were not stored, recorded or managed appropriately which placed people at increased risk of choking.

The provider failed to provide people with the support to have maximum choice and control of their lives. This was because managerial and nursing staff failed to ensure the Mental Capacity Act 2005 was always followed to ensure legal consent was obtained from people in relation to decisions about their care. This was found at the last inspection, but little action had been taken to address this.

There was an over reliance on agency staff to fill gaps in the staff rota. This meant there were not always enough staff on duty with sufficient knowledge of the needs and risk of people living in the home. Staff told us the lack of consistent staffing was stressful and impacted on their ability to provide people with the care they needed, as the extra burden of supporting unfamiliar agency staff stretched them to their limits.

People and relatives told us that staff were kind and caring and our observations during the inspection confirmed this. People's right to be treated with dignity and respect, was however not always promoted in the day to day management of the service. This was a concern at the last inspection but little improvement had been made.

The systems in place to monitor quality and safety were satisfactory but the action taken to improve the service was ineffective and lax. A culture of continuous improvement and learning was not embedded and despite the provider, manager and staff team having knowledge of the improvements that were needed over a period of several months, they had not been made.

After the inspection, CQC asked the provider to submit an urgent and immediate action plan for improvement. The provider and manager responded swiftly, and a programme of improvements was commenced without delay. However, it should not have taken a CQC inspection to identify and act on these risks.

People were referred to and received support from a range of other health and social care professionals in respect of their needs. People's views on the support provided had been sought via a survey in December 2020.

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 November 2019). At the last comprehensive inspection in October 2019, breaches of regulations 10 (Dignity and Respect), 11 (Consent) and 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. The provider submitted an action plan to advise of the improvements they intended to make to ensure regulations were met.

You can read the report from our last inspection, by selecting the 'all reports' link for 'Beechcroft' on our website at www.cqc.org.uk.

At this inspection, we found that improvements had not been made and the service continued to be in breach of the above regulations. An additional breach of regulation 18 (Staffing) was also found.

Why we inspected
We conducted a focused inspection to follow up the breaches identified at the last inspection. The inspection was in part prompted by a monitoring call completed with the manager which raised concerns that improvements to the service had not been made. As a result, we undertook a focused inspection to review the key questions of safe, effective, caring and well-led only.

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 COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified within the domain of 'responsive'. We therefore did not inspect this domain. Ratings from previous comprehensive inspections for this key question were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

For more details, please see the full report which is on the CQC 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.

Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will work with the local authority to monitor progress.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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 well-led? The service was not well led. Details are in our Well Led findings below.	**Inadequate**

Beechcroft

Detailed findings

Background to this inspection

The inspection
We carried out this focused 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 under the domains of safe and well-led, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was undertaken by 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 service.

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 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 announced this inspection from the car park on the day of the inspection. We returned to the service the following day for the purposes of continuing a focused inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and

improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with the manager, the regional manager, a nurse, three permanent care assistants and an agency member of staff. We reviewed a range of records. This included six people's care records, a sample of medication records, five permanent staff files and two files pertaining to agency staff and records relating to the management of the service.

We contacted people using the service and their relatives by telephone to seek feedback about their experiences of the care provided prior to the inspection.

After the inspection visit.
We continued to seek clarification from the provider to validate evidence. We continued to review evidence in relation to people's care, health and safety and maintenance records. We also liaised with the Local Authority to share information about the service and our inspection. We made safeguarding referrals for three people living in the home as we had specific concerns pertaining to their care.

We concluded the inspection on 10 September 2021.

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 requires improvement. At this inspection, this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff did not have adequate information or guidance on people's needs, risks or the care they required. This placed them at significant risk of receiving inappropriate and unsafe care.
- People's nursing needs and the clinical care they needed for specific medical conditions had not been properly assessed and there was little evidence that they were adequately monitored or supported to mitigate risks to people's health.
- Records did not show that people always received the right support in respect of nutrition, skin integrity, wound or catheter care. For example, wound care is a basic nursing requirement, yet despite this, records showed that some people had not had their wounds assessed, reviewed or re-dressed appropriately.
- The use of bed rails had not been risk assessed to ensure they were safe to use. For example, some people had limited mobility or uncontrolled body movements which placed them at specific risk of entrapment. This is where a person's limbs or head becomes trapped in the bed rail. Entrapment can cause serious injury and even death. Despite this, no risk assessment or management plan had been put in place to mitigate this risk.
- Some people did not have personal emergency evacuation plans in place to provide staff and emergency personnel with important information about their needs in an emergency situation.

The provider had not ensured risks to people's health, safety and welfare were adequately assessed and mitigated to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was asked to submit an urgent action plan for improvement with regards to risk management and the delivery of care. An action plan was submitted, and urgent improvements commenced immediately.

Using medicines safely

- Important information about people's diabetes for example, safe blood sugar ranges, was not available to enable nursing staff to assess whether people's diabetes was managed and treated safely.
- Two people had tubs of thickening medication left in their bedroom. This is not safe practice. Thickening agents are usually in the form of a powder that when mixed in a person's drink make the drink a certain consistency to help them swallow safely. However, if swallowed accidentally they pose a serious choking risk. Such medicines should therefore be stored safely in a locked facility out of people's reach.
- Both tubs of thickening medication were unlabelled. This meant it was impossible to tell if they were prescribed for the people whose bedroom they had been left in. There were also no dispensing instructions

on either tub of medication to advise staff on how much thickening agent to add to each person's drink. Records in relation to their administration had also not been maintained. This meant it was impossible to tell if people's drinks had been thickened safely.

● Specific care plans and written guidance was not in place for high risk medicines such as Warfarin (blood thinner). This meant staff lacked critical information about how to manage these medicines safely.

● Written guidance for staff to follow when administering people's prescribed 'as and when required' medicines such as painkillers or anxiety medication was not always available.

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

Preventing and controlling infection

● Appropriate Infection prevention control policies and procedures (IPC) for COVID-19 were in place.

● There were safe procedures in place for the admission of new people to the home and for visiting.

● Staff and people living in the home were involved in the COVID-19 vaccination programme

● Personal Protective Equipment (PPE) was in use and worn appropriately.

Staffing and recruitment

● There were not enough suitably qualified, competent and experienced staff on duty to meet people's needs.

● A person living in the home told us, "I'm not sure there are enough staff on duty. You can tell by the manner they go about things. You can tell when they go past your door and ignore you, you can tell something is wrong. When you ask they tell you they are short staffed".

● A relative told us their loved one had to wait 25 minutes for assistance after pressing their call bell. They told us when staff came, they said they were very busy and short staffed.

● We found there was an over reliance on the use of agency staff to fill gaps in the staff rota. The manager confirmed this. This meant people were often cared for by staff they were not familiar with. Staff told us about the added stress and pressure of having to support agency staff who did not know the people they were caring for, at a time when they were already short staffed.

● One staff member said, "We spend a lot of time supporting agency staff as well. The provider has changed what agency they use and we get a lot of ones who have never been here so it takes a lot of time and it's so hard".

There were not enough staff on duty who were suitably qualified, competent and familiar with people's needs and care to support them safely. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Appropriate pre-employment checks were carried out to ensure staff employed were safe to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse

● During the inspection, the CQC inspection team made safeguarding referrals for three people whose care we had concerns about.

● Safeguarding procedures were in place and had been followed where potential safeguarding incidents had occurred.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

At our inspection in 2019 we identified that the service was in breach of Regulation 11 (Need for Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the service remained in breach of this regulation.

We checked again to see whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found they were not.

- Where there were concerns about a person's capacity to consent to a particular decision, the MCA was not always followed. In some cases, statements made in relation to people's capacity were not accurate, or where contradictory.
- Some people had 'do not resuscitate' records in their care file in place with no evidence that the person had the capacity to consent to this or that it was in their best interests.
- A deprivation of liberty safeguard application had been submitted to the Local Authority for some people living in the home to deprive them of their liberty without a mental capacity assessment and best interest process being conducted to determine if this was necessary.
- Some people had bed rails in place on their bed. Bed rails are used to prevent people accidentally falling, or slipping, out of bed but require formal consent for use, as they are considered a form or restraint. Despite this there was no evidence that some people's capacity to consent to bed rails had been explored.

People's legal right to consent to their care was not always protected in accordance with the Mental Capacity Act 2005. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs, risks and choices were not always assessed or care planned appropriately on admission to the home. This meant staff lacked vital information about new people in their care. This placed them at risk of avoidable harm.
● People's needs and choices were not always reflected in their care plans in accordance with best practice standards.
● Records in relation to people's day to day care were poor. Records made by nursing staff were often impossible to read due to the quality of the handwriting. This meant it was not easy to identify important clinical information or changes in people's care that needed to be acted on. This increased the risk of people not receiving the care they needed.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional needs were not always assessed or care planned adequately which meant staff lacked important information on how to support them to eat and drink enough.
● Records in relation to how much people had ate and drank were not always completed properly. There was little evidence that nursing staff or the manager reviewed these records to ensure people's intake was sufficient.

People's needs, risks and choices were not properly assessed, care planned or adequately monitored in accordance with standards, the law and best practice. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Records showed that staff received appropriate training and supervision to do their job role. A staff survey in December 2020 confirmed this.
● On the day of the inspection however, staff told us that although they felt the manager was supportive, they had not had supervision with the manager or their supervisor for some time. One staff member said, "I can't remember when I had a supervision". Another said, "I don't know, not sure I have had one for a long time".
●Staff told us that morale was low and the environment in which they worked stressful. Comments included, "Stressed. Everyone is stressed and under pressure" and "Not good at the moment (staff morale). We are struggling and stretched and we have to work hard for the residents".

We recommend that the provider reviews the staffing arrangements in the home to ensure the home is sufficiently staffed with permanent staff who are properly supported, supervised and enabled to do their jobs.

Supporting people to live healthier lives, access healthcare services and support
● People received support from a range of other health and social care professionals as and when needed. However records made by nursing staff in relation to professional visits was often impossible to read due to the quality of the handwriting, which made it difficult to understand and know if professional advice was always followed.

Adapting service, design, decoration to meet people's needs
● The home accommodated people over four floors. The top floor at the time of our visit was empty.
● The home was clean and adapted to meet people's needs. The home had decent sized communal

lounge/dining room with a small additional lounge adjacent to it for people to use. On the day of our inspection, only one or two people used the communal lounge, with the majority staying in their bedroom for most of the day.

● The home had a number of communal bathrooms with adapted bath and shower facilities for people to use. One of these bathrooms on the day of our visit contained an armchair which made it difficult for staff to access the bath. It was also unhygienic.

● There was a lovely garden area for people to use and on the days we visited, we saw a couple of people enjoy sitting out in the garden for part of the day.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

At the last two previous inspections, the service has been in breach of Regulation 10 (Dignity and Respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the service remained in breach of Regulation 10.

● People's bedroom doors were left open, sometimes with them in a state of un-dress. This practice did not underpin the principles of privacy and dignity.
● People's private continence products were left in communal corridors or their bedrooms where they could be seen from the communal corridor. For example, one person's new continence pad was left on an armchair that was propping open their bedroom door. Another person's catheter bag was clearly visible to anyone walking passed their bedroom door.

People's right to privacy and dignity were not always promoted in the delivery of their care. This was a continued breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, a staff presence was not always visible in communal areas such as corridor areas or lounges. Of those interactions we did see we observed staff being kind, caring and patient when supporting people. People and the relatives we spoke with confirmed this. Their comments included, "The staff are very nice. They are friendly. We are treated very good. The office staff are very good to you as well" and "They are all very nice and they are nice to residents."

Supporting people to express their views and be involved in making decisions about their care
● People's views on the support they received were sought via a provider survey in December 2020.
● 16 people living in the home participated in the survey, with 14 people (88%) confirming they felt they had a say in their care and thought staff were caring.
● Compliments and complaints had been recorded and responded to appropriately by the manager.

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 requires improvement. At this inspection, this key question has deteriorated to inadequate. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last two inspection, the service has been in breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and they remained in breach of this regulation.

- In February 2021, a new manager of the service was appointed, the organisation 'Flightcare Limited' and the home was also purchased by a new provider. At the time of this inspection, both the manager, the regional manager and provider were fairly new to the service.
- At this inspection, serious concerns with the management of the service and the safe delivery of care were found. As a result, the service failed to meet its regulatory requirements and failed to ensure risks to people's health, safety and welfare were mitigated.
- The governance systems in place to monitor the quality and safety of the service were satisfactory. These systems had identified some of the same concerns we found during our inspection. For example, concerns had been identified with assessment and care planning, wound management, record keeping and staffing over a period of several months prior to our inspection. The action taken to address these concerns was ineffective and lax, which meant little improvement was made.
- The service failed to promote good outcomes for people as people's care was not always planned or delivered appropriately and it was difficult to tell if people received the support they needed.
- During the inspection and as a result of the serious concerns identified, the provider was asked to submit an urgent action plan for improvement to CQC. The provider and manager responded quickly with a programme of immediate and necessary improvements was commenced. However, it should not have taken a CQC inspection to ensure such action was taken.

The governance arrangements in place were not robust, managerial oversight was poor and risks to people's health and welfare were not managed sufficiently to protect them from harm. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 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; Continuous learning and improving care

- Despite improvement plans being put in place to improve the service in October 2020, and staff being

provided with opportunities to learn and improve their practice, improvements had not been made. This did not indicate a culture of continuous learning and improvement was embedded in the service.
● The manager had reported notifiable incidents to CQC as required. For example, safeguarding events and accident and incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People were referred to and received support from other health and social care professionals. For example, the Speech and Language Therapy Team, physiotherapists, local GP's and mental health services, as and when required.

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 10 HSCA RA Regulations 2014 Dignity and respect People's right to privacy and dignity were not always promoted in the delivery of their care. This was a continued breach of Regulation 10.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's legal right to consent to their care were not always protected in accordance with the Mental Capacity Act 2005. This was a continued breach of Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks to people's health, safety and welfare were adequately assessed and mitigated to prevent avoidable harm. People's needs, risks and choices were not properly assessed, care planned or adequately monitored in accordance with standards, the law and best practice. The management of medication was unsafe.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

There were not enough staff on duty who were suitably qualified, competent and familiar with people's needs and care to support them safely.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The governance arrangements in place were not robust, improvements not been made were needed and risks to people's health and welfare were not managed sufficiently to protect them from harm.

The enforcement action we took:

We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.