Holsworthy Health Care Limited

Deer Park Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Deer Park Care Home is a residential care home providing personal care to people aged 55 and over at the time of the inspection. On the first day of inspection there were 35 people living at the home. The service can support up to 56 people in a purpose-built building which has two floors. People living with dementia mainly live on the upper floor, which can be accessed by a lift.

People's experience of using this service and what we found
People were positive about how staff treated them. Some people had their social needs met and enjoyed the company and friendliness of the home. However, for people living with dementia their environment was less stimulating while their social activities and access to outside space were restricted.

Relatives had been supported to visit during the pandemic but said at times communication was disjointed and they did not always know who to speak with when they rang.

Records of care tasks were not always completed. We found gaps in the recording of repositioning people. Fluid intake was poorly monitored putting people at risk of dehydration. Care plans did not consistently have the required information to support staff in understanding a person's individual needs. Comprehensive assessments were not in place for everybody living at the home.

There had been multiple changes in managers running the home and this had impacted on staff confidence and morale. However, the appointment of a new manager who had immediately begun to address issues of concern was reassuring.

Medicine management had improved. Staff were recruited safely. However, staff training and induction was not effectively managed. Supervisions took place but observations of staff practice had mainly focussed on medicine administration.

Some people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. But for people living with dementia improvements were needed to ensure they had equal choices.

Systems and processes were not effective in ensuring the safety of people or the environment.
Systems in place to monitor and review the quality of care had not been effective in improving standards, and ensure the service was meeting people's needs safely and effectively.

During the inspection, we raised individual safeguarding concerns for some people living at the home. This was to ensure risks to their health and well-being were assessed and reviewed by health and social care professionals.

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 March 2021) and there were five breaches of regulation. At this inspection enough improvement had not been made, and the provider was still in breach of regulations.

After the last rated inspection, the provider sent monthly reports to show what they would do and by when to improve.

Why we inspected
This was a planned inspection based on the previous rating. It was carried out to follow up on action we told the provider to take at the last inspection.

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.

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 five breaches in relation to this inspection.

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 meet with the provider and request an updated action plan to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 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 always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was caring.

Details are in our effective findings below.

Good

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Deer Park Care Home

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. 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
One inspector visited the home on the first day. On the second day of the inspection two inspectors and an assistant inspector visited the home. On the third day, verbal feedback was given to the provider and new manager. During the inspection, two Expert by Experience spoke with people visiting and living at the home via Zoom and phone calls to gain their views. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Deer Park Care Home 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.

Notice of inspection
The inspection was unannounced.

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 professionals who work with the service.

During the inspection
We met with the provider, the consultancy company and the new manager. The provider is also the

Nominated Individual, this means they are responsible for supervising the management of the service. We spoke with 17 staff members, eight people living at the home and eight relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not comment directly on their experiences.

We reviewed a range of records. This included six people's care records, including fluid and pressure relieving charts, activities, and a selection of medication records. We looked at three staff files in relation to recruitment. We reviewed accident and incident records, minutes from meetings, staff rotas, information on staff training and supervision. We looked at records relating to the management of the service, including the hot weather policy and action plans.

After the inspection
We continued to seek clarification from the provider to validate evidence found and establish what action had been taken place to keep people safe. We looked at training data and quality assurance records. During a multi-disciplinary meeting, we gathered feedback from health and social care professionals who had contact with the service.

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 rated inspection this key question was rated as Inadequate. 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

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were at risk of pressure sores. We found people who required repositioning at prescribed times did not have this need met. For example, records for three people who required repositioning at set times to support with risks of pressure damage, showed there had been delays in their care putting them at increased risk of harm.
● Equipment to reduce the risk of pressure damage was not set correctly and therefore potentially increased the risk of pressure sores. Staff lacked awareness of the impact this had on increasing the risk of harm.
● Some people required their fluids to be monitored to reduce the risk of dehydration. Goals and actions by staff were not based on the individual. For example, one person asked for company when they drank but this was not provided. Their fluid intake was low. No actions had been recorded when people did not meet the required fluid target. This put people at risk of dehydration.
● There was a hot weather policy, but it was not followed, despite the high temperature on the day of the inspection.
● The bathroom used by people living with dementia had a keypad on the door; staff said this was to keep people safe and prevent them using the bathroom, including the bath, without supervision. The door was left open on two days of our inspection.
● In the lounge used by people living with dementia an aerosol spray was left in easy reach of people, which put them at risk of injury.
Learning lessons when things go wrong
● On two previous inspections, a cupboard containing a boiler and pipework was not locked; we were told on both inspections this would be addressed to keep people safe from burns. On this inspection, we found the cupboard was still not locked and accessible to people living at the home.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback during the inspection, the new manager quickly put in systems to improve fluid intake

and they reviewed how pressure care was managed and monitored.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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 somewhat assured that the provider was using PPE effectively and safely. We fed back to the new manager that two staff did not follow PPE guidance regarding the use of gloves so this could be addressed. The majority of staff adopted good PPE practice. There were plentiful supplies of personal protective equipment (PPE) in place around the home.

● 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. The home was clean with no longstanding unpleasant odours; there were systems to ensure dirty and clean laundry was kept separate to prevent cross infection.

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

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Checks were in place to monitor people's temperature and regular Covid-19 tests were carried out on people working, visiting and living at the home.

Using medicines safely
At our last inspection the provider had failed to safely manage medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of this element of regulation 12.
On this inspection, we found staff were knowledgeable and effective changes had been made. This meant the previous Warning Notice had been met. Following the inspection, concerns were raised about the timeliness of ordering medicines and this is currently being followed up as part of a safeguarding process to look at how medicines are supplied to the home.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to safeguard people. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● At the last rated inspection, there was a breach in safeguarding, because appropriate alerts had not been made by the provider and a number of staff had not completed safeguarding training. Training was now

being addressed.

● Since the inspection, the new manager has raised appropriate safeguarding alerts and engaged with CQC and other agencies to update them on actions taken to keep people safe. Staff were knowledgeable about their duty to report concerns or abuse; whistle-blowers have contacted the Care Quality Commission, which showed staff know their responsibilities to raise concerns over practice within the home.

● People told us they felt safe and had access to call bells. For example, one person told us "I'm very safe, they're very particular in every way, they try to do it properly, I'm very comfortable here, the staff really try their best."

Staffing and recruitment

● Staffing levels met people's care needs. Some staff said there were not enough care staff on each shift but said tasks were still completed to keep people safe. There had been shifts where some care staff had worked additional hours to cover short notice staff sickness or because agency staff had not turned up.

● However, other staff, such as well-being, activities and housekeeping staff, provided additional support. A staff member commented, "Some days we have been a bit short…but there are days when there are too many staff…I don't think staffing levels have impacted on residents as we have all helped each other."

● People living at the home said call bells were responded to in a timely way. Staffing levels, apart from activities, did not impact on people's day to day routine. For example, people confirmed they could have baths and showers at a time which suited them and on a regular basis.

● The new manager is currently reviewing the staffing structure to promote improved team working across departments to benefit the people living at the home. For example, care staff assisting with providing drinks so they could informally assess people's health and well-being.

● Safe recruitment practices were in place and the provider used references and the Disclosure and Barring service (DBS) to ensure staff were suitable to provide support for the people living at the service.

Requires Improvement

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 a previous inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider had failed to ensure the premises were suitable for the purpose for which they are being used. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

Adapting service, design, decoration to meet people's needs

- The layout of the home did not benefit everyone living there. People living with dementia mainly lived in one area of the home, which included a lounge/dining room. Staff called it the unit and a keypad on the main door was used to enter or leave it. There was no direct or easy access to the garden as the unit was upstairs. A staff member said, "They have just one corridor to walk up and down – in dementia (care) it's meant to be somewhere they can walk around."
- The main corridor was not adapted to meet the needs of people living with dementia. There was a lack of contrasting use of colour and the corridor looked clinical and unappealing. In the lounge, some of the chairs were stained; a board used to orientate people to the day and weather was inaccurate on both days of our inspection. A staff member said, "My honest opinion of the unit - it needs improvement. It needs more stimulation and the hallway needs to look less like a hospital…"
- Pressure mattress controls were kept on the floor which increased the risk of the setting being knocked and the mattress being set incorrectly and therefore potentially causing harm. This risk had been highlighted on a previous inspection in October 2020. It had been addressed at the time, but good practice had not been sustained.
- Due to an uneven surface, staff raised concerns about the safety of the outside space for people living at the home. They also said more could be done to make it an attractive space to spend time in. A person living at the home said," What bugs me is the garden outside, everything is grown over."

The provider had failed to ensure the premises were suitable for the purpose for which they are being used. This was a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the pandemic, some areas of the home had been re-carpeted and decorated; staff said the provider was aware of their concerns to the appearance of the home. The new manager was reviewing how areas of the home were used and whether people living with dementia benefited from their rooms being

upstairs.
● Some people living with dementia used the downstairs lounge on an individual basis but were not able to access this area without staff accompanying them.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were suitably qualified, competent, skilled and experienced. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff did not always have the required skills or training to support people living at Deer Park Care Home. For example, training records evidenced, staff had not complete recent fire training. One staff member expressed concern they had been told to assist a person with their meal, they had no experience or training to carry out this role.
● A number of staff said they would benefit from dementia awareness training or a higher level of dementia training. Several said they did not have the skills to meet the needs of some people living with dementia whose behaviour they viewed as particularly complex. Other staff also said training in understanding people's diagnosed mental health needs would be beneficial.
● Recently recruited staff had not benefited from a formal induction programme; there was a lack of clarity over the oversight of induction paperwork. For example, a staff member said, "I will give it out on their first day and then I chase it up… I don't get a lot of it back. I guess it is me who needs to chase it but how much can you chase?"
● Competency checks on staff practice were mainly focussed on medicines, not other areas of care. We observed some practice which showed some staff would benefit from further training and oversight. For example, staff did not ensure that people living with dementia had company when they served them drinks to ensure they could be prompted and to make the task a social occasion. On another occasion, a staff member spoke about a person who was end of life whilst in their room, which we addressed at the time.

The provider had failed to ensure staff were suitably qualified, competent, skilled and experienced. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the new manager began to address gaps in staff training for example, fire training from an external trainer. They also observed staff members' practice to help identify further areas for development.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional needs were met. The new manager had met with the kitchen staff to discuss people's dietary needs to ensure people's individual needs were met. People were positive about the standard of food, for example, "Pretty good. There are two choices each lunchtime...if there is something you don't like they find you something else."
● Minutes from residents' meetings showed feedback was sought on the range and quality of the meals provided; people were encouraged to make suggestions regarding the menu.
● People said they had a regular supply of drinks throughout the day, as well as access to a jug of water or squash in their rooms.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The new manager had been in contact with other agencies to ensure people's care needs were met. They were responsive to feedback during the inspection about how pressure care was being managed in the home. For example, working with the district nurse team to review how often people needed to be moved to prevent pressure sores developing.

● People were confident in the skills of staff to recognise changes in their health, with one person describing them as being "on the ball." Staff handover records highlighted changes and how staff should monitor people. Staff reported new concerns to a senior member of staff; records showed GPs and community nurses were requested in a timely way. A chiropodist regularly visited the service.

● Relatives reported a mixed picture about being informed of changes to people's health. They said this was not helped by finding it difficult to speak to a staff member for updates as they were not always sure who to ask for. Other relatives had a more positive experience saying "I have no problems at all. They give me a ring even if it's a minor problem."

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).

We checked 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.

● Information was in place to ensure decisions were only made by relatives who had the legal power to do so.

● Appropriate deprivation of liberties applications had been made, apart for one person, which we told would be addressed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People told us they were happy with the care provided and staff knew how to support them. The previous consultants had worked on the care plans to improve them following previous feedback, but some care plans still lacked detail and were therefore not person centred in some areas of care. For example, end of life decisions and wishes.

Good

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 a previous inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care

● Meetings were held to gain people's views on the service and as a place to update on changes, such as the appointment of new staff. A core group of people attended, and they told us they could make suggestions, such as to activities or meals. The majority of people living at the home did not attend so further work was needed to capture their views and feedback.

Ensuring people are well treated and supported; respecting equality and diversity

● Despite staff sharing tensions within the staff group, people said staff got on well with each other, for example one person said, "I think they get on alright you hear them laughing in the corridors, which is lovely." People described staff as "very good" and "Nine out of ten are just brilliant…we've never been anywhere else, so we don't know anything different."

Respecting and promoting people's privacy, dignity and independence

● People were positive about the way their dignity and privacy were supported, for example, "That's fine, no problems they are very good, they knock on the door before they come in the room."

● We saw staff interactions, which were caring and compassionate, for example one staff member carefully explained to a person how their catheter worked when they became anxious about it. They used an analogy which the person responded to showing they understood; the staff member ensured the conversation was discrete and the person relaxed.

● The new manager recognised there was a balance of choice and staff encouragement to help people have more fulfilling lives. A number of people living with dementia were cared for in bed or chose to stay in bed; this was being reviewed as to whether this was in people's best interest.

Requires Improvement

Is the service responsive?

Our findings

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

At a previous inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Care records did not routinely show how people had been involved in them, particularly for newly admitted people. A number of people said they did not know the content of their care plan: monthly reviews were not holistic and did not show the views of the individual.
- For those people who had been admitted for end of life care, care plans were basic and were missing information about how they like to be supported, how they wanted to spend their time, what comforted them and their spiritual or religious needs.
- People were receiving end of life care at the time of our inspection; we raised safeguarding concerns about how their admission to the home had been assessed, the quality of the records linked to their care and a lack of person-centred care. The local authority carried out reviews of their care and the new manager took immediate action to address our concerns, including writing a care plan with one individual and their family.
- End of life care training had been completed by many care staff earlier in the year but recommendations have been made by other agencies for this aspect of care to be revisited.
- Prior to the new manager's appointment, admissions had been delegated to a staff member who not previously had this responsibility. People who had recently moved to the home had not had their care needs adequately assessed which put them at risk of harm.

The provider had failed to ensure the care and treatment of people met their needs and reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- We saw people responded well to the staff member who oversaw activities. The staff member was engaging, and person centred in their approach ensuring each person felt valued. However, they were open that they could not meet everybody's needs. They recognised people living with dementia were not stimulated by their environment. People living with dementia were removed from the general life of the home because of living upstairs and therefore were not stimulated or involved.
- During the inspection, a staff member with no dementia awareness training or activities training spent time with a person who could become unhappy and angry with staff. The staff member had been inappropriately allocated to work with them. The person's reaction showed they were not engaged with the task of colouring.
- The records of people living with dementia or people being cared for in bed showed their social needs

were not always met. A relative of a person living with dementia said, "We are concerned she is not being stimulated enough…I don't know who she mixes with. I don't know what they do upstairs." A staff member said. "People in their rooms with dementia do suffer – the people downstairs in the lounge have a great time but people in their rooms do not have it as good and it is just unfair."

The provider had failed to ensure the care and treatment of people met their needs and reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who used the main downstairs lounge were positive about the range of social events they could participate in, including art classes, bus trips and pamper sessions. One person said, "There is something every day, if there's not an activity there is a sing song, they cover it well" and another person said, "We always have entertainment if you want it." One person particularly valued the greenhouse and had grown vegetables in it. Visitors were not always sure how people passed their time but said their relative had access to the radio and or a television.
● Relatives were positive about being able to visit and the arrangements to undertake visits during the pandemic.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Staff demonstrated an awareness of people's individual communication needs, although staff said it was sometimes difficult for people living with dementia to engage with them due to staff wearing face masks. Staff took time to ensure people could hear them and gave people eye contact; staff checked with them to ensure they understood information.
● Where people had sensory loss, staff ensured they were included by explaining what was happening around them and assisting them to participate in group conversations. However, one family said they had repeatedly asked for their relative to have a hearing test but this request had not been actioned or responded to.

Improving care quality in response to complaints or concerns
● There was a system for complaints; people visiting or living at the home did not raise any concerns, apart from one person who said they were still without a heater in their en-suite. We asked the provider to address this.
● CQC have received several complaints in the last year, one of which was a longstanding one linked to the belongings of a person who had died, which was resolved after CQC's intervention. Others included poor infection control practice, although subsequent infection control inspections did not find a breach of regulation.
● Minutes from recent residents' meetings showed missing laundry was still an ongoing complaint that had not been effectively resolved. This was raised as a concern at a previous inspection in 2020. However, feedback from people who contributed to the inspection was mainly positive and a new staff member who worked in the laundry said they were not aware of any current issues with lost clothing.

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. 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.

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

At our last inspection the provider had failed to establish systems or processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service had not been well-led. We have identified five breaches of regulation linked to good governance, managing risk, person centred care, staffing, premises and equipment. Four of these were continued breaches. On this occasion, the previous safeguarding breach was met but there was a new breach in relation to person centred care.
● Since October 2020, CQC have inspected this service six times to address different concerns and taken enforcement action to drive improvement in the service.
● The service had been without a registered manager for over two and a half years. Managers have been appointed but some chose not to take up the post or resigned shortly after starting or were dismissed.
● Following a previous inspection in October 2020, the provider had appointed a consultancy company in response to feedback from external agencies. During this inspection, they finished their contract with the consultants and appointed a new manager who plans to register with the Care Quality Commission.
● Monthly reports were submitted to CQC to show what actions the provider had taken to make the service safe but this inspection showed the service was still unsafe.
● The provider told us there were reviewing their own role as Nominated Individual as they were hoping in the future to appoint an experienced person to fulfil this position.
● Staff said the changes of management and the subsequent different ways of working had at times led to contradictory advice and unprofessional behaviour from some members of management. Some tasks had been delegated to staff who lacked training and experience to fulfil them, for example assessing new admissions.
● There remained confusion over roles both within care, management and human resources; rotas were poorly completed and inaccurate.
● Several staff had made complaints to a member of staff who was not currently working at the home rather

than using the providers complaints system. This created difficulties in addressing their concerns about staffing and the running of the home.

This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider had voluntarily agreed to restrict admissions so the focus could be on improving the service.
●The new manager had engaged with external agencies, including CQC, commissioners and the local authority safeguarding team. They have been open in their assessment of the service and the current barriers to improvement. They were working hard to identify key staff members to lead by example and had encouraged staff to develop their skills through training and working alongside them.
● Staff spoke positively about the new manager's appointment, and how they had met with them, but some were still sceptical the promised improvements would not happen. Other staff were keen to embrace the changes the new manager was implementing.
● People living at the home knew there was a new manager and spoke favourably about their first impressions. For example, "She's polite, walking around seeing residents. She's very good." Since the inspection, the new manager said people living at the home visit her to have a chat or raise concerns. She had also met with some families to discuss their relatives' care and offer reassurance.

Continuous learning and improving care; Working in partnership with others

At our last inspection the provider had failed to establish systems or processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Systems within the home were not effective. Information was duplicated which potentially hindered effective monitoring of care. There was poor oversight of fire safety practice and drills. Quality assurance processes had failed to identify people did not have ownership over their care plans. Paperwork for the five-year electrical inspection certificate could not be found. Equipment was not regularly cleaned.
●There was poor oversight of inductions for recent staff with a lack of clarity as to who ensured induction paperwork was returned and reviewed. Gaps in staff training had not been effectively addressed; the training matrix was unclear as some topics were duplicated. Poor infection control practice by established staff had not been addressed effectively.
● Systems and processes were inadequate to monitor the environment. Environmental checks failed to identify a bolt on the outside of a bedroom door, and the boiler cupboard and pipework being accessible to people living at the service. A bathroom door was not kept closed despite a keypad on it which should have made it inaccessible to people living with dementia.
● Despite hot weather, the home's hot weather policy was not implemented.
● The home's complaints process had not been effective in addressing an on-going issue of missing laundry.
● Systems had not identified care plans for new admissions were not person centred and lacked effective assessments. Other care plans still had information missing despite work having begun in January 2021 to make care plans more person centred.
● Quality assurance processes had not addressed that social events in the home did not meet everyone's needs, particularly those cared for in bed or living with dementia.
● Poor record keeping had not been addressed, for example fluid charts, and monitoring arrangements for

pressure mattress settings had left people at risk of harm.

This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The bolt on the bedroom door was removed during the inspection and a keypad was fitted to the boiler cupboard. And following our feedback, the new manager quickly arranged fire training for staff, as well as training in other areas of care. They are committed to improving the running of the home and have worked closely with CQC and other agencies to provide updates on progress as well as highlighting barriers, such as problems with the supply of medicines. Some staff expressed frustration that the service was not adequately supported by the older people's mental health team.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

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Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There was not always a positive respectful culture within the staff group which impacted on creating a compassionate service where equality and diversity was respected. The staff group had very mixed views as to how well they worked as a team; some said they worked hard not to let staff friction impact on people living at the home.
● Steps had been taken to address disrespectful behaviour towards colleagues, but comments made by some staff showed there was still distrust and a focus on their own experiences rather than those living at the home. One person who lived at the home said, "Sometimes they are talking about things that are outside here and you feel a bit left out…it doesn't happen very often."
● Lack of action to address poor practice showed staff had not considered the impact on the individual and their own responsibility to address issues rather than seeing it as another staff member's job.
● Some staff were resistant to change and making improvements to the service. This had been identified on a previous inspection; subsequent managers had not successfully addressed this divisive group, which undermined other staff.
● Relatives gave mixed feedback as to whether they would recommend the care home to others. They acknowledged Covid-19 and the subsequent visiting restrictions had caused them additional anxiety as they did not always feel reassured due to inconsistent communication and not knowing who to ask for when they rang. However, several other visitors said their relatives had settled well in Deer Park when this had not been the case in previous care homes.
● People living in the main part of the building looked relaxed and at ease in their surroundings, but this positive atmosphere was less apparent in the area used by people living with dementia.

This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Activities) Regulations 2014.

● People living at the home said they felt confident to speak to particular staff members if they had any

concerns or worries. People said good things about the service included "the company", "the friendliness, the meal service" and "I feel safe and you are warm and well fed."