Phoenix Care Homes Limited

Deer Park Care Centre

Inspection report

Detling Avenue
Broadstairs
Kent
CT10 1SR

Tel: 01843868666

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Deer Park Care Centre is a residential care home providing accommodation and personal care to up to 38 people. The service provides support to older people with mental health support needs. Some people also had a learning disability. At the time of our inspection there were 31 people using the service. Care was provided to people in one two story building. There was a lift and accessible garden for people. People also had access to kitchen and laundry facilities where they were able to access these independently.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support:
Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome.

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; the policies and systems in the service supported this practice. Staff supported people to make decisions following best practice in decision-making. Staff communicated with people in ways that met their needs.

There were mechanisms for people to feedback their views on the service. People's views were listened to and action was taken as a result. Staff felt supported in their role.

Right Care:
People's care, treatment and support plans didn't always reflect their range of needs. Some risk assessments were not in place prior to the inspection. However, the service had enough appropriately skilled staff who knew how to meet people's needs and keep them safe.

Staff understood how to protect people from poor care and abuse. The service worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. People were protected from the risk of infection by infection control procedures.

Right Culture:
Quality checks at the service continued to need improvement. Checks had failed to identify concerns such as care plans which required updating. Some checks had not identified actions were needed, such as

supporting people to access dental care. Recruitment processes had not always followed safe practices.

Incidents were reported and action taken to minimise risks to people. However, the analysis of some incidents needed to be improved to reduce the risk of re-occurrence. CQC had not always been notified of reportable incidents.

The management of environmental risks had improved since the last inspection.

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 requires improvement (published 09 August 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last eight consecutive rated inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part by a notification of a specific incident. Following which a person using the service died. This incident is subject to ongoing investigation. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk to people's health and well-being. This inspection examined those risks. As a result, we undertook a focused inspection to review the key questions of Safe 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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. The overall rating for the service has remained requires improvement.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to good governance and failure to notify CQC of a serious injury at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Deer Park Care Centre

Detailed findings

Background to this inspection

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

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
The inspection was carried out by two inspectors.

Service and service type
Deer Park Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Deer Park Care Centre is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was no registered manager in post. The registered manager had de-registered shortly before the inspection. However, they were still managing the service at the time of the inspection but were due to leave shortly. Therefore, they are referred to as the manager throughout the report.

Notice of inspection

This 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who lived at the service. We spoke with two relatives about their experience of the care provided. We spoke with eight members of staff including the manager, senior care, care staff and kitchen staff. We reviewed a range of records. This included five people's care records and medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- Staff recruitment had not been consistently safe. Full employment histories had not been consistently obtained. Some application forms noted only years of employment and not months. This meant the provider could not be assured they knew the person's full employment history to ensure they were skilled, knowledgeable and experienced to carry out the role. During the inspection the manager updated the application form to prompt applicants to use months and years.
- Gaps in previous employment had not been explored or explained. When references had been received, the dates of employment were not checked against the application form. There were discrepancies in three of the six references we reviewed. This was addressed during the inspection by the manager.
- Disclosure and Barring Service (DBS) checks were completed before new staff began working at the service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
- There were enough staff to support people. We observed people received support from staff when they needed or wanted it. There was a dependency tool in place and people's support needs were individually assessed to calculate staffing levels. A second activities co-ordinator had also been recruited to support people to go out more and undertake more activities. One relative said, "There always seems to be enough staff. They are friendly enough."

Assessing risk, safety monitoring and management

- Some care plans needed more information to provide guidance to staff on how to keep people safe. Where people were at risk of choking there was a lack of guidance for staff. We raised this with the manager. They put care plans in place, immediately after the inspection, to guide staff on how to reduce the risk of the person choking but these still lacked information on what to do if the person did choke. However, staff were providing appropriate support to people and knew how to support people safely in the event of an incident of choking occurring.
- At the last inspection plans to support people with constipation needed to be updated to include information on what support people needed. At this inspection we found they had improved.
- People told us they felt well supported. One person said, "This is definitely one of the better places. The staff are good. I feel safe living here."
- Environmental risks were managed. For example, regular hot water temperature checks were completed to reduce the risks of scalding. Equipment such as hoists, the passenger lift, gas and electrical appliances had been inspected and serviced and were in good working order. Information about what action to take in the event of a fire was available and there was clear signage throughout the service. At the last inspection we raised concerns about a rotting window on the first floor, this had been replaced.

Learning lessons when things go wrong

● At the last inspection we identified the analysis of incidents needed more detail to support staff to identify areas of concern and to put in place actions to mitigate the future risk. For example, analysing what time incidents took place to identify any patterns. At this inspection the analysis of some incidents such as falls had improved. However, where incidents of emotional based behaviour occurred, the analysis would benefit from further improvement to assist staff to identify the root cause.

● One person's care plan indicated a trigger to emotional based behaviours was being supported by female staff. We saw female staff provide support to the person. The manager explained that the person got on well with some females. They had not explored if there were patterns and trends around female staffing. There was also limited information about what was going on in the environment, for example the temperature or noise levels in the service or if the person had been out that day.

● Staff knew how to report incidents when they occurred. Where incidents had occurred, some actions had been taken. For example, after one fall the person was referred to the GP to identify if there was an underlying medical cause.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

● Staff understood that people had the right to make unwise decisions where they had the capacity to do so. People were supported to maintain their independence and to make choices. People also told us staff advocated for them when they needed support to express their choices. For example, staff were supporting one person who wanted to move to live independently.

● People's capacity was assessed where appropriate. Where people needed support to make decisions, these were made in their best interests and recorded.

Using medicines safely

● People received their medicine safely, on time and as prescribed. People's support needs for medicine had been assessed to ensure people were supported to maintain their independence, where appropriate. One person said, "I take quite a few medicines. Staff make sure I have it when I need to."

● Bottles and creams were dated when they were opened. This was because some creams and liquids are not as effective after they have been opened for a certain length of time. Medicine was ordered, stored and disposed of safely.

● Where people had a medicine which was applied through a patch on the skin, the placement of this medicine was rotated, to reduce the risk of irritation to the skin.

● Where people had 'as and when' (PRN) medicine such as pain relief there was information for staff such as how often the medicines could be taken and when it may be needed. During the inspection we identified one PRN protocol was missing. This was put in place by the manager and no harm to the person was identified as a result of this not being in place.

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 supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

● People received visitors, in line with government guidance.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. There were systems in place to ensure allegations of abuse where recorded and investigated. Where there were concerns these had been reported to the manager.
● Staff knew how to identify concerns and were confident these would be acted upon.
● People told us they felt safe living at the service.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

Continuous learning and improving care
At our last inspection the provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. This placed people at risk of harm. This was a continued breach of regulation 17 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 provider has consistently failed to make and sustain sufficient improvement to the service. This is the eight consecutive rated inspection where the provider has failed to achieve a rating of good. The service has been rated requires improvement for seven consecutive inspections prior to this inspection. This is the third consecutive breach of regulation 17.
● At the last inspection the provider's quality assurance systems continued to fail to identify and address the issues found at the inspection. At this inspection we identified the same concern and sufficient improvement had not been made. For example, the provider had failed to identify risk assessments for choking were not in place. Whilst existing staff knew how to support people safely there was a potential risk that new staff would not know about the person's support needs. Quality systems failed to recognise safe recruitment practices had not always been followed.
● Checks on care plans had not identified where actions were needed or care plans needed to be updated. For example, one person's oral care plan was reviewed monthly. Their assessment had identified in January 2022 they needed to see a dentist. This had not been arranged with the person despite the person's oral assessment being reviewed each month. Another person's care plan stated they had a grade 3 pressure sore which was no longer the case.
● At this inspection the manager and provider had improved the analysis of some incidents. However, incidents of behaviour lacked detail and more improvement was needed to support staff to identify if there were specific triggers which led to people becoming upset and reduce the likelihood of incidents re-occurring.

The provider had failed to operate an effective system to assess, monitor and improve the quality and safety of the service. The provider had failed to ensure people's records were accurate and complete. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The manager and provider had failed to ensure notifications were always sent to CQC when they were required to do so. One person's care notes stated the person had a grade 3 pressure sore. The manager confirmed this was the case. Services are required to notify CQC of the development after admission of a pressure sore of grade 3 or above.

● Other notifications had been submitted to CQC as required. Services are required to display the rating by law. The rating for the service was on display.

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

● The manager understood their responsibilities in relation to duty of candour. A duty of candour incident is where an unintended or unexpected incident occurs which resulted in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

● Where incidents had occurred, relatives told us they were kept informed. One relative said, "I think they are very good at keeping me informed."

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

● People had opportunities to express their views about the service and to raise issues. There were surveys for people to complete to feedback their views. There were also residents' meetings where people could raise issues directly with staff. These gave people the opportunity to be introduced to new staff and discuss areas such as the environment, activities and ideas for the menu. We observed people were also happy to approach the manager throughout the day when they wanted or needed to.

● The service kept people updated on what actions they had taken following issues people had raised. The service produced 'you said, we did' reports so people could see what had been done in response to any issues they had raised. For example, people wanted improvements to the appearance of the outside of the building. Window's had been replaced and new flowers planted in the garden areas.

● Staff were also asked for their view of the service. Staff had raised they wanted the path at the back to be improved to make it easier to support people in wheelchairs. This was being undertaken at the time of the inspection. Staff told us they felt listened to and supported in their roles.

Working in partnership with others

● Staff worked closely with partners where appropriate. For example, mental health teams, community psychiatric nurses and district nurses to provide support to people.

● Staff had access to healthcare professional's advice and understood how this fit in to the support they needed to provide for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. The provider had failed to ensure people's records were accurate and complete.