Phoenix Care Homes Limited

Deer Park Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 October and 20 October 2016. The visit was unannounced on 19 October 2016 and we informed the registered manager we would return on 20 October 2016.

Deer Park Care Home is a residential home which provides care to older people including people who have a diagnosed mental health illness. Deer Park Care Home is registered to provide care for up to 38 people. At the time of our inspection there were 36 people living at the home, however two people were in hospital. Accommodation is arranged over two floors and not all of the rooms had en-suite facilities. One part of the home supported people living with dementia and the main part of the home, supported people who had a diagnosed mental health condition.

This service was last inspected on 5 June 2014 when we found the provider was compliant with the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a lack of management oversight by the provider to check delegated duties had been carried out effectively. The quality monitoring systems included reviews of people's care plans, health and safety checks and checks on medicines management. These checks and systems were not regularly reviewed and completed so it was difficult for the provider to be confident people received a safe service. Accidents and incident analysis was completed but it did not provide an overall picture to prevent further incidents from happening.

There were not enough staff on duty to respond to people's health needs and to keep people safe and protected from risk. The registered manager could not be confident there were sufficient numbers of staff to keep people safe because there was no effective formula that calculated what safe staffing levels should be. The registered manager and deputy manager regularly supported staff on shift which meant some quality checks and improvement actions were not always identified and resolved. This affected the quality of service people received.

Risks to people's health and welfare were identified but not always effectively managed. Where people were at risk of harm, actions had not always been taken to keep people safe. Care plans provided information for staff that identified people's support needs and associated risks.

People said staff provided the care they needed. Care was planned to meet people's individual needs and abilities. Care plans were reviewed although some information about people's mental capacity required updating to ensure staff had the necessary information to support people as their needs changed. Some

people's physical and mental stimulation was limited because they were not proactively supported to pursue their own hobbies and interests because staffing levels did not always allow time for this.

The registered manager and staff had limited knowledge of their responsibilities in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, staff's knowledge and people's records did not always ensure people received consistent support when they were involved in making more complex decisions, such as decisions around medical procedures, finances or where they wanted to live.

Before providing care, staff sought consent from people and gave them time to respond. They respected people as individuals and supported them to make their own choices as far as possible.

Staff were trained and knew how to keep people safe from the risk of abuse although staffing levels made it difficult to prevent people becoming agitated with one another and staff. People told us they felt safe living at Deer Park because they had support 24 hours a day, seven days a week.

People felt cared for by staff who had the skills and experience to care for them. Staff understood people's needs and abilities and received updated information at shift handovers. Staff training was completed and there was an effective system to identify which staff required training updates.

People were offered meals that were suitable for their individual dietary needs and preferences. People were supported to eat and drink according to their needs, which minimised risks of malnutrition and dehydration.

Staff ensured people obtained advice and support from other health professionals to maintain and their health and wellbeing.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Following the inspection the provider took action to address the fire safety and other issues, We will follow this up at the next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to keep people safe and protected. Staff supported people who had been identified as being at risk, however staffing levels did not support people safely and sufficient measures were not taken to keep people safe. Staff understood their responsibility to report any observed or suspected abuse. People received their medicines when required but we saw some unsafe practice in how medicines were administered and kept safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider trained staff to equip them with the right skills and knowledge to support people in their care. However, staff did not always know which people lacked capacity and there was a lack of consistency in supporting some people in line with the principles of the Mental Capacity Act 2005. Staff respected people's privacy and dignity and supported people in a respectful way. People received support from and had access to other healthcare services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff provided care in a kind and sensitive manner, however there were periods of time when staff were not available or attentive to meet people's needs. People told us when staff spent time with them, staff were patient, caring and understanding.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff understood people's preferences, likes and dislikes and how they wanted to spend their time but there was minimal physical and mental stimulation for people, which did not always

meet their needs. The staffing levels restricted staff's ability to respond to people's needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some systems required better organisation to ensure improvements that had been identified, resulted in positive actions being taken. The provider's risk assessments of the premises had not identified potential risks to people. This meant that a number of shortfalls continued in relation to the service people received. People and staff felt supported by the registered manager and each other.

Deer Park Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 19 October 2016 by one inspector which was unannounced. We told the registered manager we would return on 20 October 2016. On the second day, three inspectors visited the home.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Deer Park Care Home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we spoke with five people so we could gain people's own experiences of living at Deer Park Care Home. We completed observations during both days to help assess whether people's needs were appropriately met and identify if they experienced good standards of care.

We spoke with the registered manager, a business manager, a senior care staff member. four care staff, an activity co-ordinator and a cook. During our inspection visit, we spoke with a visiting community health worker who made frequent visits to the home to support people and provide advice and support to the registered manager and staff team.

We looked at three people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, risk assessments and care plans. We also looked at quality audits, records of complaints, incidents and accidents at the home and health and safety records.

Inadequate

Is the service safe?

Our findings

Most of the people living at Deer Park Care Home had limited ability to communicate and were unable to tell us in detail, if they felt safe living at the home. Those people we did speak with said they felt safe living there. One person said they felt safe because, "I can get support 24/7, there is always someone here to help me."

The registered manager and staff said people could become anxious, distressed and agitated on an individual basis and would benefit from staff spending more time with them to provide emotional support to prevent behaviours escalating. We were told staff did not have time to do that. People were living as a group and negative behaviours impacted on others and caused their behaviours to escalate. Staff did not have the time to monitor those interactions which increased risks to people in the home.

We spoke with staff and asked them whether people were protected from risk and if they did all they could to keep people safe. Staff told us it was not always possible to observe people throughout the day, especially when people became verbally and/or physically challenging with each other. Since January 2016 the provider had sent us notifications relating to five safeguarding incidents. All five incidents took place outside in the designated smoking shelter and resulted in people being physically assaulted.

The registered manager told us a high number of people smoked at the home. To reduce risks, they were only allowed to smoke outside in the designated shelter. The registered manager explained that in response to the assaults, the smoking shelter had been made bigger, and there had not been any further incidents. They also told us people who used the smoking shelter were always observed by staff to keep them safe and to monitor their interactions with each other. However, on both days of our inspection, there were times when no staff were seen to observe people while they were in the smoking shelter. On several occasions we spent 15 minutes in the smoking shelter with two or more people, but there was no staff presence. On one occasion, a person talking with us did not realise their cigarette had burned low which increased their risk of being burned. We observed another person with two large cigarette burns to their t-shirt. A staff member told us that when smoking, the person would leave their cigarette in their mouth and the ash would drop down onto their clothes. We asked how staff managed this risk. They told us during the morning the laundry and domestic staff monitored people who smoked and in the afternoon, care staff monitored them. Our observations confirmed that supervision was not being maintained and staff were not monitoring people in the smoking area.

Equipment to reduce the risk of a fire spreading in the home was not always used appropriately. A fire door separated the corridor from the external smoking area. A towel was wrapped around the hinge which prevented the door from closing and sealing in an emergency. The registered manager knew this was being done and said it was to stop the door from making a noise which affected people in adjacent rooms. The registered manager was aware this was not in line with fire safety procedures. There had previously been three separate incidents involving a fire in the home.

Risks to people's safety and welfare were not always identified, so action to minimise risk was not planned appropriately. For example, care plans identified some risks to those people who smoked, however other

risks related to smoking were not identified. None of the care plans we saw included actions to minimise the risks if a person accidentally dropped a lit cigarette on their clothes, such as making a fire retardant clothing cover available, or having equipment to hand to extinguish a fire. People's risk assessments required staff to stay with them while they smoked, but we saw people were left unsupervised. None of the care plans required people to sit at a distance from the external doors and windows, which meant other people who did not smoke were exposed to cigarette smoke while sitting in their own or communal rooms. There were no written plans to protect staff, who chose not to smoke, from the risks associated from passive smoking.

This was a breach of Regulation 12 (1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff told us they had concerns about the staffing levels within the home. There were 36 people living in the home at the time of our visit. Six people lived in the unit for people with a diagnosis of dementia and were supported by two staff, and 32 people lived in the main unit, supported by four staff. From 2pm, staffing levels dropped to three staff in the main unit, and then from 3pm, one of those staff went into the kitchen to prepare meals and drinks for supper. This left only two staff to support 32 people until 6.00pm. Two staff continued to support the people in the dementia unit.

The registered manager told us they assessed people as high risk, medium risk and low risk. We asked how this information calculated the number of staff hours required to keep people safe and meet their needs effectively. The registered manager said it did not, and they were not confident there were enough staff, saying, "Our staffing levels are not safe because people are more dependent." They recognised the layout of the home provided challenges and said they needed 'eyes and ears' to safely supervise people, but it was not always possible. Staff said a high number of people needed continence care, and as many of them needed two staff to support or transfer them safely, this reduced the numbers of staff on the floor. The senior care staff's role was to supervise the shift and we asked how they dealt with these situations. They said it was not easy, especially over the last six months, "You have to prioritise." They explained some people became anxious and worried and benefitted from staff spending time with them. They said, "You have to assess each situation, and go to who needs you the most." They said, on occasions some people had to be left because staff were busy helping others. The registered manager told us people benefitted from time with staff, being supervised and spoken with, but it was not always achievable. They said, "We do our best." They told us, "I want more staff on the floor, basic needs are met but emotional support, well….it goes out the window."

All the staff said it was a challenge to support people, especially at certain times of the day. Some staff said mornings could be especially difficult. Staff said two care staff helped 15 or more people with personal care, or to transfer safely. Staff said because mornings were busy, it was difficult to spend time chatting with people and observing them to ensure they remained safe. Some staff told us they provided 'task based' care because they went from supporting one person to another, or helping another staff member when a person required support from two care staff. We asked how they managed to monitor the interactions between people in communal areas. They responded, "That is only done while staff are walking around. It is just monitoring as you are walking through (communal areas)." This was confirmed by our observations on both days when we sat in the communal lounges. There was no staff presence except when they walked through as they went about their care duties. We saw numerous examples where people were not supervised whilst smoking with others. Incidents or accidents could have happened and staff would not have been on hand to provide support in a timely way. The layout of the home meant it was difficult for staff to see where people were. Staff said it was okay in the communal areas but the corridors, outside area and first floor meant they could not respond quickly or knew, if people needed support or if incidents took place.

The business manager completed staff rotas. We asked how they planned staffing numbers. They told us this was based on feedback from the registered manager and a senior care staff member. They confirmed they did not know people's dependencies or use a dependency tool to calculate safe staffing levels, so could not be certain current staffing levels met people's needs. We asked them if staffing levels on duty were enough to support people. They told us, "I don't think it is enough, we should have six staff in the afternoon," but they were unable to explain why there were only five staff on the rota. We told them what the management team had said to us regarding their staffing concerns. The business manager said they were not aware, but if there were concerns, staffing would be increased. We saw minutes of a 'General support workers meeting' dated 28 July 2016. The business manager, registered manager and senior care staff member were present, as well as care staff. The minutes recorded the senior care staff member made frequent requests to the registered manager and business manager to increase staffing levels, saying 'I worry about the workload and the heavy work, it's nonstop'. The registered manager and senior staff member told us staffing levels had not increased following this meeting although could not give us an explanation or reason.

Our observations throughout the inspection, showed staffing levels were not sufficient and the high number of incidents and accidents recorded in the home showed this impacted on the safe care people received. We looked at the incident records which showed between January 2016 to the date of our inspection visit, 59 incidents. We saw periods of time where people were left unobserved in communal areas of the home for at least 20 minutes. Other people spent time in other rooms and were not supervised. People in the smoking area identified as requiring supervision, were not supervised and prior to the smoking shelter becoming larger, people's behaviours had challenged others. The registered manager told us they and the senior care staff member frequently provided support to the staff to ensure people received the level of care they required to keep them safe. The registered manager told us staffing levels at times impacted on them directly as it prevented them completing timely management checks, incident analysis and to oversee the home to the quality they wanted. We asked if they could get additional staff to help keep people safe. They said, "It's what we have always staffed to" and could not explain why staffing levels were not increased when they had shared their concerns.

We were concerned that staff levels and the dependency needs of the people impacted on the levels of care and support people received. Staff did not always have the time to support people in a way they needed to help keep them safe and protected from risks.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

All staff had a clear understanding of the different kinds of potential abuse, and told us they had received training on how to protect people from abuse or harm. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had happened within the home. One staff member said, "I would call outside agencies like the safeguarding team and raise an alert and report to managers." All of the staff we spoke with said they had not seen anything that required reporting or gave them cause for concern that we were not already made aware of. The registered manager told us what action they would take if they suspected abuse. They told us they would refer any incidents of abuse to the provider, CQC and the local authority and, if necessary, the police.

People told us they received their medicines when required, however we saw some unsafe practice. We observed senior staff administering medication at lunch time on the second day of our visit. The senior brought the medication trolley into the dining room, unlocked it and took the blister packed medicines out and put them on top. The senior dispensed medicines into a pot and took them to a person sitting in a

lounge off the dining room, which was out of sight of the medicines trolley. The senior did not put the blister packs away or lock the trolley while they were in the other room. In the same area, we saw a person being given their medicines in a pot which was left beside their meal. The senior left without actually seeing the person take them. Because of people's assessed fragile mental health, this had potential to place people at risk.

Regularly prescribed medicines were delivered by the pharmacist with an accompanying medicines administration record (MAR). Each person's MAR included their photograph, the name of each medicine and the frequency and time of day it should be taken, to minimise the risks of errors. MARs were signed by staff to confirm people had taken their medicines, although from our observations, we could not be certain people had always taken them prior to the MAR being signed.

Some people required medicines to be administered on an "as required" (PRN) basis, for example, pain relief medicines or medicines to manage complex and challenging behaviours. There were no detailed protocols in place for the administration of these types of medicines, to make sure they were given safely and consistently by staff. For example, information was not provided to staff about each person's needs and how staff should assess people's pain levels, or levels of behaviour, if they were unable to communicate verbally. This put people at risk of not receiving medicine when they required it or being given medicines before other methods of reducing behaviours had been attempted.

One staff member explained staff knew people well and could assess people's pain levels, saying, "We can see when they are in pain, they show facial expressions and make noises to indicate this." This member of staff described the use of medicine to control aggression and challenging behaviours saying, "We give this when [Name] becomes aggressive and starts to throw things." There was no indication however whether this medicine was given in a timely way, and could have prevented the person from becoming anxious and aggressive if administered earlier.

We asked staff and the registered manager whether there were always enough trained staff on at night to give people their medicines, if they became anxious or were in pain. Staff told us, and the registered manager confirmed there were not always trained staff on duty at night to give people medicines. The registered manager said it was not something they had considered as it had not been an issue. We could not be sure that people who required PRN medicines at night were given them as prescribed.

Some people required topical cream to be applied to their skin as part of their regularly prescribed medicine. This was for a range of medical conditions including dry skin, and to treat skin ulcers. Where creams were administered to people, a separate cream chart was used to record when they were applied. However, instructions about how to administer creams were not always followed. For example, one person had been prescribed cream that needed to be applied twice a day. The cream charts showed the cream was only given on five days during the month of October 2016, and only in the morning. We asked a member of staff about the administration of the cream. They said, "This is only given if we think they need it." We noted there were no instructions in the person's records to explain to staff when the cream needed to be applied. This meant the person was not receiving their prescribed medicine in line with GP and pharmacist advice.

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

Requires Improvement

Is the service effective?

Our findings

People living at Deer Park Care Home told us staff knew what to do, and how to support them to do the things they wanted to do. Those people who spoke with us felt staff involved them in their care decisions and any care provided, was with their agreement. People said staff asked them for their consent, before any care was provided and if they refused, staff respected their wishes. One person told us, "I have a good relationship with staff…they are great."

Staff told us seeking consent from people was important when they delivered care to people. Staff told us how they sought people's permission. One staff member said if people seemed reluctant, "I explain, give them time…don't rush them." They went on to tell us if a further attempt to provide support was not successful, they got another staff member to help which was usually successful. Staff said if people refused, 'that was their choice' and this was respected.

People who could understand and make decisions were involved in day to day choices, such as what they wanted to eat and drink, where they wanted to sit and what they wanted to do. We asked staff how they supported people who had a cognitive impairment and whether they supported people in line with the Mental Capacity Act. Talking with staff, we found staff knowledge and understanding of mental capacity and what it meant for people, varied. We were given inconsistent information from staff about which people lacked capacity and for those people who did what specific decisions they could not make for themselves.

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.

We checked whether the provider was working within the principles of the MCA. We found mental capacity assessments were not always documented for people who lacked capacity to make certain decisions. The provider did not record people's decision making abilities to determine whether people could make decisions for themselves or if they needed others to make decisions in their best interest. For example; a decision which had a significant impact on one person had been made by external health professionals, but it was recorded the person had capacity to make their own decisions. Months later, this person required treatment in hospital. A best interests meeting was held between the registered manager, senior staff member, surgeon, staff nurse and psychiatrist to seek approval for surgery to go ahead. There was no assessment made as to whether the person lacked the mental capacity to make their own decision to have to the surgery or not, and the person was not involved.

This person had returned to the home in October 2016 and was now refusing personal care and spent long periods of time in bed, without mobilising. We asked the registered manager and staff if this person lacked capacity, but received different opinions. This person had a known history of self-neglect and staff

acknowledged this person's health and wellbeing was declining, but had not assessed their mental capacity around personal care. It is a requirement to record best interest meetings and mental capacity assessments. We asked a visiting mental health support worker about this person because they completed regular reviews with them. They told us, "[Person] doesn't have capacity, it's quite clear." This person and others, were not effectively supported in line with the MCA which put them at risk of receiving care and support which maybe against their personal wishes.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, two applications had been approved and 25 had been sent to the local authority to make sure people's freedoms were not unnecessarily restricted. The registered manager told us most of the applications were to restrict people from leaving the home, without staff supervision. We checked examples of these people's care records and there were no mental capacity assessments that had assessed whether they had the capacity to leave the home unsupervised or not.

The provider was not working to the principles of the MCA, and meant they were in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we spoke with a visiting mental health team support worker. They were complimentary about the staff team and the support people received. They told us they had confidence staff followed advice and guidance and if there were any improvements or recommendations, the registered manager and staff would implement them. However, they could not explain why mental capacity assessments had not been completed for those people they regularly checked on, but agreed to provide any support and training required to ensure people's lack of capacity was assessed and decision specific.

People received care from staff who had the skills and knowledge to meet their needs effectively. Staff told us they attended training in subjects that were relevant to people's needs, such as moving and handling and how to care for people with mental health needs. During our inspection, staff attended a training session in managing challenging behaviours. Staff told us this training gave them confidence when dealing with challenging situations such as what to say and how to react.

Staff told us they had opportunities to discuss their practice, training requirements and any concerns at one-to-one meetings with their manager. Staff felt supported by the provider to learn and complete training relevant to their job roles. We spoke with a newly employed staff member who praised their induction. They said their induction was over a two week period and part of their induction was to shadow an experienced staff member. They said, "It is helpful, you get to know how to deal with people in a good way." This staff member said staff and the registered manager were approachable and helped them settle in and supported them on their shift.

People had a choice of meals and chose where they wanted to eat. During our inspection visit we heard people say to staff they enjoyed their meal. One person said, "That was a nice meal [staff name]. I haven't eaten so well in my life." Menu boards told people what choices were on offer and people were supported to eat and drink throughout the day. At lunchtime, there was a choice of two different hot meals and desserts. We were told if people did not want either of the choices, alternatives could be provided and prepared in line with people's dietary needs.

People told us they had access to, and used the services of other healthcare professionals. Senior care staff and the registered manager arranged healthcare appointments if people's health conditions or behaviours

caused them concern, or if people requested it. Records confirmed people received care and treatment from their GP, psychiatrists, mental health teams and other health care professionals involved in monitoring people under sections of the MCA.

Requires Improvement

Is the service caring?

Our findings

People that spoke with us praised the staff who provided their care and support. People felt staff treated them well and had their interests at heart. One person explained to us the problems they had faced over a long period of time and how these challenges had affected them. They said moving to Deer Park and being looked after by the staff team was, "Heaven sent." They said, "It's like living with friends." They told us about the support they received that showed to them, staff cared. They said staff helped them take pride in themselves and lose weight. We were talking with this person and the registered manager walked past. The person pointed at the registered manager and said, "[Registered manager] is great, she helped me buy new clothes... they are great." They explained the support they had received had given them confidence and pride in what they had achieved since they moved to the home.

The registered manager told us they were proud of their team and knew they were caring. They told us they regularly observed staff practice and saw how staff cared for people. They said, "I pride myself in the staff, I know good care…they get it." A senior staff member equally said staff worked hard and cared about the people they supported. They said they could tell this because every time they had a one to one with a staff member, they, "Always talked about people living at the home, not themselves." A senior staff member told us they cared about people. They had worked at the home for a long time and had seen changes in the people they supported. They said it was hard to see people's health decline but knew they were doing their best. We asked what kept them motivated to care. They said, "I'm not going to be a millionaire being a carer. I do it because I am a born carer. I work late if I have to but that's not a problem." They said working with families and other health care professionals gave them a sense of achievement when people responded well.

However, we found there was an inconsistent caring approach by the provider in how people were supported, despite the caring efforts of staff. Because of the impact of staffing levels and staff deployment, we did not see staff talking with people and the registered manager felt this was a missed opportunity for people and staff to exchange conversation. Some people's mental health caused them anxieties and concerns and their individual care plans recorded that staff should spend one to one time with them. Staff told us, staffing levels could not always ensure this happened. We spoke with a senior staff member who said, "You get your good days and bad days. If it is a good day it runs smoothly but you don't always get that time for a one to one." They said, "Some days it only takes one person to start everybody else off."

Availability of staff meant staff could not always respect people's dignity. For example, a senior staff member told us that on more challenging days, people may not get their showers, which was important to maintain people's dignity and respect. The senior staff member said, "If one of the residents is uptight it can affect the whole shift."

During our inspection visit we saw people's dignity around personal care compromised. On the second day we saw two people with large wet patches to the back of their clothing. We told the senior staff member about one person who said this person had been referred to the doctor due to their incontinence. However, it took us to identify this to staff which showed us staff had not seen this. Once it was pointed out, the senior

staff member encouraged the person to get changed and later, we saw them in clean clothes. Another person with wet clothing sat in chairs in the communal areas. The senior staff member acknowledged that there was a potential cross infection risk. The registered manager told us managing people's continence needs was challenging because of the number of people who had incontinence. Staffing levels meant staff did not always have the time or opportunity to support people to maintain their dignity.

Staff said there was a good team that knew people's needs and they all helped each other. All the staff said they enjoyed working at the home and got on well with people they supported.

Requires Improvement

Is the service responsive?

Our findings

We observed staff interactions with people. We found staffing levels at times, impacted on the time staff spent with people, which meant staff were not always responsive to meet people's individual needs. Most of the staff said it was difficult to meet people's needs. They told us extra staff were needed because some people were at risk and they were unable to check all the time to make sure people were being supported in line with their care needs.

A senior staff member told us a number of people became anxious and had been aggressive to people and staff. They said, "People need time to sit and chat…this helps manage their behaviours." A staff member told us in the afternoon staff had to work in the kitchen preparing drinks and meals. They said losing one staff member meant if someone needed help to transfer safely with another staff member, it left no one to supervise other people. They said, "If someone becomes aggressive, it's tricky, you need to leave them to go and find help." The registered manager said it was difficult to be responsive to people's needs because most of the care provided by staff was reactive, rather than spending time with people to prevent situations from happening.

On the second day of our inspection visit in the dementia unit, at lunchtime we saw a person was agitated and started banging the table. This resulted in another person raising their voice at them to stop. This went on for a few minutes. There was only one staff member in the dementia unit as the second staff member had gone to support people in the main unit. We asked the staff member if they were okay because they had told us it was their first day working in the dementia unit, post their induction period. This staff member dealt with the situation well, but the addition of a second staff member to respond, may have reduced other people's behaviours from escalating.

We asked staff if they read people's care plans and if they knew people's needs. Some staff said they did not always have the time, although from speaking with staff we found they were aware of people's needs. Staff said they received a handover between each shift which provided them with useful and up to date information about people's health needs. We looked at three care plans. People's care records contained information that enabled staff to provide the support people required, for example spending time with people who were anxious on a one to one basis. However, staff on occasions did not always ensure this was followed. Care records were reviewed and if there had been changes in people's health or support needs, these were reflected. The registered manager agreed with us that care records needed to include where people lacked capacity regarding specific decisions so staff provided consistent support.

Some people said there was little stimulation or staff involvement to keep them entertained, or to pursue their interests. The registered manager said this had previously been an issue because staff did not always have the time, to sit with people or help people with activities, particularly on an individual basis. The registered manager said an activity co-ordinator had recently been appointed which had made a positive difference to people. People spoke positively about the support they received to pursue their interests and personal goals. One person told us they were supported to lose weight and had been successful. They said, "[Staff] help me," and they said the involvement from staff had given them a sense of personal achievement.

The staff said the recent employment of an activities co-ordinator had been positive. The registered manager said they had time to provide a person centred approach to what people needed. They said they supported people with improving life skills and independence which they said before, was missed.

The activities co-ordinator told us they had been in post since May 2016. They said, "I encourage what people want." They said they had taken people to the cinema, for walks, and had taken one person to a vintage car rally. They told us they were planning to take some people swimming. They said taking people shopping helped them to be as independent as possible and increased their social skills with others outside the home. They said they read people's care plans to get an understanding of the person they supported. They felt supported by the provider and registered manager in their role and felt able to shape their role around people's personal interests and goals.

People said they knew how to make a complaint, but had not because they were pleased with the support they had received. A typical comment was, "I would tell staff or the manager." The registered manager told us they had received one formal complaint in the last 12 months. This had been resolved to the complainant's satisfaction. They told us they 'had an open door' where people, family or staff could discuss any issues or concerns. They said their openness and availability meant, "Things were headed off before they became a formal complaint."

Requires Improvement

Is the service well-led?

Our findings

People we spoke with made positive comments about the home and staff. People said the staff and management were very approachable. One person said the support they received from the registered manager and staff, "helped me get my life back" and living at Deer Park was, "Great because I have friends."

The registered manager knew their strengths and areas for improvement. We asked the registered manager what they felt the service was getting right and what could be improved. They responded, "I have a great caring team, I pride myself on that but it's the paperwork that needs improving." The registered manager said, "I spend time on the floor helping, then this stops me doing other things." They agreed this was sometimes at the cost of the necessary day to day overview of the service, management and checks, but said their priority was to keep people safe.

We looked at the management checks and audits that monitored whether the service was safe. We looked at examples of completed audits such as health and safety, water quality checks and fire safety. Regular monitoring made sure people received support in an environment that kept people safe and protected.

The registered manager completed an audit of accidents and incidents for each person and analysed the results for patterns or emerging trends. We were told action had been taken for people at risk and actions were monitored to ensure they had minimised further incidents. For example, alarm mats were used that alerted staff when people who were mobile may need support. Although individual analysis was completed, there was no overall analysis which made it difficult to establish any emerging trends amongst the 59 incidents recorded between January 2016 up to the date of our inspection visit. The registered manager understood what analysis was required and agreed to improve their audit. This meant they would have a complete picture of incidents within the home and could take prompt action to make sure people continued to be safe and protected.

Some actions were completed, however, the audit system required further improvement because they had not identified some of the concerns we identified. The issues we raised regarding a lack of mental capacity assessments should have been identified, particularly where approved DoLS where in place. Medicine audits were completed but these had not identified the concerns we found regarding staff administering and storing medicines safely whilst undertaking a medicines round. PRN protocols were not considered and there were no trained staff at night to offer pain relief medication to people. We saw cream charts were not completed in line with pharmacist instructions and incomplete records and staff knowledge, meant we could not be sure people received their prescribed creams as required. Systems to identify people's dependencies to staff to those needs were not completed. This meant the provider could not be assured safe staffing levels provided the care and support people required. Where management and staff raised their concerns, we were told actions had not been taken.

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

People had opportunities to talk about the service and share ideas. The provider held meetings for people to attend which provided them with opportunities to raise any concerns or provide feedback. We looked at minutes from a meeting held in March 2016. People discussed trips out, menu options and if people felt supported by staff. The registered manager said actions were taken but there was no evidence to support this.

Staff felt supported and respected by the registered manager. One staff member said the registered manager was, "Really nice, approachable and warm." They said it helped knowing they could approach them with any concerns or issues and knew they would be listened to. Staff said the provider equipped them with the knowledge to support people by providing training and learning opportunities. Staff said they worked well as a team and said the management supported them by covering the floor when required. The registered manager was very complimentary about their staff team. They said they had the right staff with the right skills and attitudes to care for people. Staff told us staff meetings were held regularly and that they were inclusive and productive, although they were sometimes left frustrated when their concerns were not acted upon, for example with staffing. All the staff said they received one to one supervision from managers that helped them to reflect on their training and achievements.

People's personal and sensitive information was managed appropriately and kept confidential. Records were kept securely in the staff office on each floor so that only those staff who needed to, could access those records. Staff updated people's records every day, to make sure that all staff knew when people's needs changed although some required further improvement to ensure they remained accurate so people continued to receive the right levels of support.

The registered manager understood their legal responsibility for submitting statutory notifications to the CQC, such as incidents that affected the service or people who used the service.

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 11 HSCA RA Regulations 2014 Need for consent Suitable arrangements were not in place to obtain and act in accordance with people's consent to their care and treatment. The provider had not followed the requirements of the Mental Capacity Act 2005. Assessments had not been undertaken to ensure that decisions were made in people's best interests. Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way because risks were not managed and action was not taken to minimise the risks to people's health and wellbeing. Regulation 12 (1)(2)(b). The provider had failed to operate safe medicines management processes in relation to the storage of medicines, the recording of the application of prescribed creams and regularly checking staff's practice remained safe. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	Systems or processes were not robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17 (1)(2)(a)(b)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there was sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs. Regulation 18 (1).