Holsworthy Health Care Limited

Deer Park Care Home

Inspection report

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Date of inspection visit:
29 October 2020
12 November 2020
18 November 2020

Date of publication:
09 March 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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 47 people living at the home. The service can support up to 56 people in a purpose-built building which has two floors. On the upper floor, there is a unit to provide care for people living with dementia.

People's experience of using this service and what we found
Risks to people's health were not well managed. Steps to reduce these risks were not followed. For example, people were not moved at specific times to reduce the risk of pressure ulcers. Health professionals raised concerns that changes to people's health and well-being were not always identified in a timely way. Some equipment was broken or there had been delays in accessing additional items or replacements. There were a number of fire safety concerns and infection control was poorly managed which put people and staff's health at risk. Medicine administration and storage was not safe. There was poor management of staff training, induction and supervision. Staff turnover was high and morale was low. Staff did not feel valued by the provider.

The service was not well-led. The provider had not recognised the quality of the service had significantly deteriorated and had therefore put people at risk of unsafe care. There were inadequate systems in place to monitor and review the quality of care, 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.

There was no registered manager in post. An application to register a new manager was being processed by CQC at the time of the inspection but the person chose to withdraw their application. During the inspection, the provider arranged for a manager from another of their services to oversee Deer Park Care Home as a temporary acting manager. In the acting manager's first week, they began to address poor infection control, gaps in staff training and began to improve practice. Two people's care needs were re-assessed, and as it was identified the care home was not suitable for their needs.

After our inspection, the acting manager sent us an action plan to address immediate risks. This showed they took the concerns raised seriously and took quick action to start improving the quality of the service and the safety of people living there.

Following the inspection, a whole service safeguarding enquiry was started by the local authority. Two local authorities put a block on funding new admissions, and the provider agreed to a voluntary suspension of new private admissions. CQC informed the fire service of our concerns and contacted another regulator

regarding personal protective equipment.

Despite the above concerns, people living at the service praised the kindness of staff and their caring attitude. Their comments included, "The staff are kind and willing and will do anything you want", "They are very kind and yes if I had a sad day, they would talk to me. They are all very nice" and "They are very caring and if I felt down in the mouth, I would find a carer for a chat."

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

Rating at last inspection
The last rating for this service was Good (published July 2019).

Why we inspected
CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We undertook this targeted inspection to follow up on specific concerns about infection control and lack of support from the provider. A decision was made for us to inspect and examine those risks.

We inspected and found there were concerns with other areas such as medicines, the running and safety of the service, quality assurance, identifying and addressing risks for individual people. So we widened the scope of the inspection to become a focused inspection which included all areas covered by the key questions of safe and well-led.

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 coronavirus and other infection outbreaks effectively.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Deer Park Care Home 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 have identified breaches in relation to safe care and treatment, safeguarding service user from abuse and improper treatment, premises and equipment, staffing and good governance at this inspection.

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

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

Follow up
We will request an action plan for the provider 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 meet with the provider.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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?

Inadequate

The service was not 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 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 and second day of the inspection and met with staff. In between the first and second day of inspection, an Expert by Experience spoke with people living at the home via Zoom 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. An assistant inspector and a second inspector also contacted a group of staff to hear their experiences of working at the home. This was done by e-mail and phone. On the third day a specialist pharmacist visited the 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
On the first day of the inspection, we gave short notice of our arrival so they could instruct us on their infection control measures. The second and third day of inspection were 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. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
On the first day, people living at the home invited the inspector to join a residents' meeting; this was attended by 17 people. An Expert by Experience also spoke with 15 people individually. We spoke with or received e-mails from 15 members of staff during the inspection.

We toured areas of the building with the acting manager, including service areas, such as the laundry. We also visited the basement to check where personal protective equipment was stored.

We reviewed a range of records. This included four people's care records, including fluid and pressure relieving charts and a selection of medication records. We looked at one staff file in relation to recruitment. We reviewed a summary of falls, complaints, staff rotas, information on staff leaving and joining the service and staff supervision. We looked at records relating to the management of the service, including policies and the statement of purpose.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. During a safeguarding meeting, we gathered feedback from health and social professionals who had contacted 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 inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Some people had been assessed as being at risk of dehydration. However, we saw their fluid intake was poorly monitored. There were no individual goals for people with fluid charts in place. This meant there was not consistent guidance to ensure individuals were drinking enough fluid daily. The amounts drunk each day were not always totalled. When this did take place and the daily total showed people had drunk little, no action was recorded.

● People's weights were infrequently monitored, despite records showing they were losing significant amounts of weight. For example, there was a gap of four months for one individual's weight records. They had lost a significant amount of weight in this period. One person's family contacted the local authority to raise concerns about the altered appearance of their relative due to significant weight loss. This is being investigated through an individual safeguarding process.

● Three people had pressure ulcers and were mainly being cared for in bed. Charts were in place to guide staff as to how often people should be moved to prevent further damage to their skin. For example, for one person, this was every two hours. Charts showed they were regularly left in the same position for over three hours and on several occasions for over five hours.

● In September 2020, a health professional had raised concerns with the service regarding the competency of staff when preparing drinks for people with swallowing difficulties.

● Some people's distress had become normalised. One person loudly expressed their emotions by crying, shouting and swearing. On one occasion, staff members went in briefly to see them but then left. Another member of staff said "Is (X) still going?" A staff member said they thought this behaviour no longer had an impact on others living at the home.

● Health professionals raised concerns staff did not always recognise changes in people's health needs and therefore did not request support and advice from outside agencies in a timely way. A person with a pressure ulcer was calling out and sounded in distress. The acting manager had to ask staff to go to them to reassure them. Staff said the person regularly called out and they thought it might be linked to pain. The acting manager told them to call a GP immediately to request a review of the person's pain management.

● During our inspection, we contacted the fire service with safety concerns, which included fire safety equipment checks, fire training and storage arrangements in the basement, which posed a potential fire risk.

These examples are a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we shared our concerns with health and social care professionals about how

risks to people's safety and well-being were being managed in the home. We raised a safeguarding concern for several people due to unplanned weight loss so their care could be reviewed. Reviews of people's care needs by external health and social care professionals had begun to ensure they were at not at risk of harm and to review pain relief. Staff said regular meetings on each shift enabled them to keep up to date with people's care needs.

● Following our feedback, the basement was cleared, and the acting manager and provider liaised with the fire service to update them on the recent actions they had taken to improve fire safety.

● The acting manager said poor record keeping would be addressed by training staff to use the electronic care system more effectively and reduce the use of paper records. Formal training had taken place three years ago, but this was not available to new staff who made up the majority of the staff group.

● The acting manager had identified a potential risk of people being prepared food that was unsafe for them due to a risk of choking. A risk system was set up by them to show kitchen staff which people had swallowing difficulties and how their food should be prepared.

● The acting manager was addressing unsafe staff practice linked to the use of prescribed thickeners in drinks. Equipment arrived during our inspection to help improve.

Using medicines safely

● The service uses an electronic medicines records system which appeared well completed and doses administered in accordance with the prescription. However, the electronic records for topical administrations did not always correspond with the records made on the paper charts or in the daily care log.

● Some parts of the medicines care plans were generic and did not contain the detailed information held by the staff. However, staff could clearly describe how people were supported to take their medicines.

● There were systems in place to report any medicines errors or incidents. Regular medicines audits were completed, we saw not all issues were identified, and some of the information recorded was not complete.

● The service did not have systems in place to store medicines safely. The medicines refrigerator was not monitored to ensure correct temperatures were maintained. This meant medicines may not be as effective as expected

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

Staffing and recruitment

● People told us staff were busy, "The staff are very caring but too busy to chat as they have a lot to do."

● Staff generally worked 12-hour shifts. Staff said they regularly missed or had delayed breaks because of the amount of work and being short staffed. There was the potential for mistakes to be made because of the number of hours some staff worked each week.

● Staff turnover was high. There were 51 care staff in post, 31 have been working at the home for 12 months or under. Approximately half of this group had worked at the home six months or under.

● We were told the turnover of staff put additional pressure on existing staff because of their need to orientate and support new staff. New staff raised concerns regarding the quality of their induction; for some staff no induction was recorded.

● During our inspection, staff resigned. Exit interviews did not routinely take place so the service was not collecting feedback to understand why staff left.

● Staff said shifts sometimes ran below the assessed number of staff needed because of staff sickness and agency staff not being available. There were a high number of people living at the home who needed two members of staff to assist them to move. One person had been assessed as needing one to one support from a staff member because they were at high risk of falls. They were often restless and unsettled. Staff said

dedicating one staff member to work with the person impacted on their availability to meet other people's needs.

● Shifts were run and worked by a number of staff who had not received training in key areas of care. Records showed significant gaps in their training included dementia care, end of life care, Mental Capacity Act awareness and safeguarding. This meant the provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff working at the home.

● The provider had not ensured staff were suitably trained in the use of the electronic care system, which would have made accurate and timely recording easier. Instead, staff said they struggled with a mix of paper and electronic records.

● Staff were promoted within the service but expressed concern about the quality of their induction and training to prepare them for their new role. For example, one senior had completed minimal training. Training listed as mandatory, which they had not completed, included safeguarding, end of life care, infection control, Mental Capacity Act awareness and fire safety.

● Rotas showed night shifts were mainly worked by staff who had been in post less than 10 months. This included the senior and the team leader. A staff member said recruitment for night care staff had been difficult. The service was heavily reliant on agency staff to cover nights, including running the shift and to administer medicine.

● In response to a safeguarding concern in November 2020, the previous manager had met with night staff to remind them of the procedure when a person fell. An audit of falls in September 2020 showed they mainly occurred at night.

● Staff gave a mixed response as to whether they felt under pressure to work additional hours to cover staff sickness. They said although rotas showed agreed staffing levels, sickness levels impacted on the actual staff numbers for each shift.

● Records showed high levels of staff sickness for some staff, others had to isolate due to Covid 19. Staff told us there was not a system to ensure all staff were offered an interview on their return to ensure they were fit for work. Some staff said they were frustrated when staff repeatedly rang in sick as they felt this was not addressed effectively and put undue pressure on remaining staff.

These examples are a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite some staff feeling under pressure, people commented on their kindness. For example, "Yes I am well protected and cared for. All the staff are different, but I am happy with them all."

● There was a heavy reliance on agency staff, who worked on every shift, for example four agency staff on dayshifts. However, the agency staff only worked at Deer Park Care Home, which reduced the risk of cross infection, and meant they knew the people living there. A permanent staff member said the agency staff "were a good bunch."

● Recruitment practice ensured references and police checks were in place before staff started work at the home.

Systems and processes to safeguard people from the risk of abuse

● There was not an established system to ensure staff received training to help them identify different types of abuse. The training matrix showed 37 out of 55 care staff had not completed training in this area of care. According to the training matrix, staff inductions should have included safeguarding awareness, but this had rarely happened in 2020. And therefore, there was the potential for some staff not to recognise all forms of abuse.

● Following the inspection, CQC raised safeguarding concerns linked to six individuals' care as we were concerned risks to their health and well-being were not being safely managed. When we began the

inspection, five other people's care experiences were already being investigated. These safeguarding concerns had not been raised by the provider.

This is 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.

● However, people living at Deer Park Care Home told us they felt safe. For example, "I feel safe because all the staff are nice here." Other people said they knew the staff well and this added to their feelings of security.
● During the inspection, staff told us they understood their responsibility to report abuse. Safeguarding information was clearly displayed with contacts for external agencies.

Preventing and controlling infection
● CQC received concerns linked to poor quality and ineffective personal protective equipment (PPE). The provider told us boxes of gloves which expired in 2015 were not to be used by staff and were just being stored at the home. However, the gloves were stored with the PPE stock. There were no signs to tell staff not to use them.
● Staff told us the provider had not addressed their concerns regarding the face masks provided to them. For example, the smell of one type of face mask gave some staff headaches.
● At the beginning of the pandemic staff said they were issued with two cotton masks each; one to wash and one to wear. A staff member said "…we have used them all up, there are none left." The use of these mask went against guidelines stating this type of mask was not suitable for care home settings. Initial hand gel provided to staff by the provider caused irritation to their skin; some staff said the provider did not take their concerns seriously and they had to continue using the gel until it was finally replaced.
● On the second day of our inspection, we completed a tour of the ground floor with the acting manager. We saw numerous examples of poor infection control practice, which the acting manager began to address as we saw them. For example, an ear thermometer left on a trolley in the corridor with ear wax on it. This piece of equipment was used daily to measure the temperature of all the people living at the home. This issue was addressed immediately.
● At the time of our inspection, the training matrix showed only one person out of a team of eight housekeeping staff had completed infection control training. Seven kitchen staff out of a team of 13 had not completed infection control training.
● The layout of the laundry did not allow for there to be separate areas for soiled and clean washing entering and leaving the area. Information on washing temperatures lacked clarity. Clean clothes were stored on a clothes rail by a fire exit in an area continually used by staff, which could lead to cross infection.

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

●There were systems in place when people visited the home, including taking their temperature, and asking people to fill out a form to confirm they were not experiencing symptoms linked to Covid 19. However, we were told outside contractors did not routinely adhere to these measures.
● Following the inspection, some of the above risks were reduced because the acting manager said all PPE which had not been obtained from a known source had been disposed of. They were reviewing how the housekeeping team were managed and supervised, and their working hours. On the second day of our inspection, housekeeping staff were completing key training.
● Action was being taken to ensure laundry was washed at correct temperatures, and once clean was stored appropriately.
● New admissions were tested for Covid 19 before they moved in and stayed in a separate area of the home

for 14 days to try and reduce the risk of cross infection. People shared their experiences of this arrangement and understood why it was needed.

Premises and Equipment
● We saw examples of poor practice in relation to hazardous substances, including handmade labels on spray bottles left on trolleys in the corridors.
● There was broken equipment which impacted on infection control, including a trolley for moving soiled laundry.
● The controls for pressure mattresses were on the floor, which was unsafe. Staff said they had highlighted this as a concern, but it had not been addressed.
●In a residents' meeting in November 2020, people said the response times to call bells could be variable. Staff identified an issue with not being able to hear call bells in some areas of the building. We were told there were not enough pagers to alert all staff on each shift when assistance was needed. One person told us, "I pressed the bell in the night, and it took the carer half an hour to come…" The person said the staff member said they would return but did not.

This is a breach of regulation 15 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our second day of inspection, the acting manager monitored housekeeping staff practice and instructed them to remove identified risks and explained what best practice looked like.
● After the inspection, we were told the controls for pressure mattresses were now stored off the floor. The provider said they had previously been bought in the past and could not understand why they were not in use.
● During our inspection, more pagers and more tablets were delivered, and additional static computer screens ordered to be installed around the home for easier staff access.
● Changes were being made to how spare equipment was stored to make it accessible to staff on all shifts. This included equipment related to pressure mattresses.

Learning lessons when things go wrong
● The inspection history for the service shows the key question of safe was rated as inadequate in 2017 and was rated as requires improvement in 2018 and 2019. The current rating for this question from this inspection shows a marked deterioration in this area of care. The provider had not ensured people and staff working practices at the home were safe.
● Issues covered in previous enforcement action by CQC in 2017, for example the safe care and treatment of people, are still of serious concern following this current inspection.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider was also the nominated individual. The nominated individual is responsible for supervising the management of the service. The provider had not sent requested information and audits to CQC to show how they monitored the quality of the care and the safety of people living at the home.
- The service was unsafe and was not well-led as shown by five breaches of regulation linked to good governance, managing risk, staffing, safeguarding, premises and equipment.
- The provider had not recognised the quality of the service had significantly deteriorated. They did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs safely and effectively. They had therefore put people at risk of unsafe care.
- The provider had not identified staff were not suitably trained.
- The provider had not identified medicine audits were not effective and medicine stored at incorrect temperatures.
- The provider failed to ensure infection control was well managed in the home. For example, they had not ensured there were cleaning schedules and adequate equipment in place, for example enough specialist moving and handling sheets to prevent cross infection.
- Systems to reduce risks to people's health were not followed, for example pressure care guidance, and audits of these charts were not completed.
- Delays in addressing the quality and the amount of equipment, such as tablet computers, had negatively impacted on the quality of records and audits, and potentially put people at risk from missing information. For example, we were told problems with tablet computers had led to one-night shift's records being lost.
- There was no registered manager in post. An application to register a new manager was being processed by CQC at the time of the inspection but the person chose to withdraw their application.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Decisions made by the provider had left staff feeling the service was unsafe. This included the quality of PPE and the provider's decision to move two people from the home during the first Covid 19 outbreak to be cared for separately to protect them.
- Poor communication by staff left some people concerned they were not getting an accurate picture of

their relative's health and well-being. This caused them distress.
● Despite changes within the management of the home and staff leaving, exit interviews were not routinely carried out. This meant the provider was not able to use the information about why staff were leaving to improve the quality of care.

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Since the beginning of the Covid 19 pandemic, the provider had not ensured people visiting, working or living at the home were updated or reassured regarding the running of the service. Feedback from staff included, "It can sometimes feel as though more and more workload is being added but extra provisions to provide the right level of care aren't always alongside it, … staff are very stressed at the moment and physically exhausted… It can sometimes just get a bit overwhelming."
● Information about visiting arrangements was not consistent; some relatives felt they were not encouraged to visit, which they said contrasted with people who visited regularly.
● Relatives and visiting professionals said there was poor communication between the staff group leading to delays and misinformation.
● Staff had a mixed experience of how often they had one to one supervisions. This meant there was not a consistent approach to support staff members' well-being, training and competency.
● During a residents' meeting people were engaged and shared their ideas for change and improvements. However, discussions at the meeting showed improvements had been delayed as the provider needed to agree the funding. Staff said these delays blocked improvement to the service.
● Low response rates to both relatives' surveys and staff surveys in 2020 showed a lack of engagement. Complaints information, residents' meeting minutes, our contact with people and survey responses in 2020 showed people's clothes were regularly lost; this was a long-standing problem. A relative said, "My (spouse) was dressed in other people's clothes – very distressing." The provider had failed to take appropriate action to resolve this as issues around missing clothing was longstanding.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
● Staff said they felt the provider did not value them or their work during outbreaks of Covid 19 at the home. Staff talked about their experiences during the pandemic and the pressure to stay strong for other staff and their families to reassure them. For some staff the emotional toll of Covid 19 outbreaks in the home had impacted on their emotional well-being. For example, "Since Covid, morale has gone down a lot and it has been very difficult … It has been scary for all of us."
● The provider's manner was described as "intimidating" by some staff; they said they would not go to the provider with a problem. This did not demonstrate a positive culture which was open and inclusive.
● The provider had not promoted a positive culture between their services; staff spoke of rivalry between services, which did not foster joint working and learning or a positive atmosphere.
● Despite the previous concerns, most people living at the home, said it was well-run, although feedback from the residents' meeting showed there were issues, they wanted addressing, such as the laundry service being improved. They recognised the commitment of staff and the previous manager. For example, "The manager is approachable, and we are good friends."

● Staff recognised and praised support from the previous manager and the deputy manager. The previous manager was described by a staff member as "absolutely brilliant" and the deputy manager was praised by staff for their approachability and their support. Staff recognised they had both been under "immense pressure." They said handovers and daily meetings helped keep them up to date, but they found it hard to keep up with the continual changes within the home.
● Staff said they remained in post because of their love for their job and their relationship with other staff members and people living at the home. For example, "It's nice, it's got a good atmosphere. Most of the floor staff are very friendly and I think they are really good with the residents."
● Written feedback from relatives included comments such as "You are all special people and deserve a lot more praise than you get."
● People were pleased with the improvements to the menu and the quality of the food. Before the previous manager left, people had been involved in choosing colours for flooring and décor for the lounge and the dining room. The lounge carpet was badly stained, and people were enthusiastic about their communal surroundings being re-decorated.
● The first day of the temporary acting manager was 9 November 2020. In their first week, they began addressing poor infection control practice and staff training. Two people's care needs were re-assessed, and it was identified the care home was not suitable for their needs.
● The acting manager's approach to introducing change in the way the home was run and care provided had upset some staff. Some said they had not been informed of the acting manager's role and had not been introduced to them. Relatives said they were not informed of significant events, such as a change in manager.
● After our inspection, the temporary acting manager sent us an action plan to address immediate risks. This showed they took the concerns raised seriously and took quick action to start improving the quality of the service and the safety of people living there.
● The provider said since the pandemic they had thanked staff when they saw them in the home and bought biscuits to show their appreciation. During the inspection, some staff members' pay was being reviewed.

Working in partnership with others
● Following our inspection, a whole service safeguarding enquiry was started by the local authority. Two local authorities had put a block on funding new admissions, and the provider had agreed to a voluntary suspension of new private admissions.
● The provider was engaging with the local authority safeguarding team and quality assurance and improvement team (QAIT) to improve the management of the service.
● Following the resignation of the previous manager, the provider arranged for a manager from another of their services to oversee Deer Park Care Home. The provider was committed to employing a new manager and was working with the local authority to make interim arrangements to improve the running of the home.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to safeguard service users from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There was a failure to ensure equipment is suitable and appropriate for use.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure staff received appropriate support and training.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to effectively mitigate risks to people which placed them at risk of harm.

The enforcement action we took:

We imposed a condition for the registered provider to designate a competent person to undertake audits of all care records for service users receiving care, and to send a monthly report to the Commission about the outcome of the audits to include all areas of concern, including pressure care, hydration, and nutrition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure the governance of the service was effective.

The enforcement action we took:

We imposed a condition for the registered provider to designate a competent person to undertake audits of all care records for service users receiving care, and to send a monthly report to the Commission about the outcome of the audits to include all areas of concern, including pressure care, hydration, and nutrition.