Holsworthy Health Care Limited

Deer Park Care Home

Inspection report

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Date of inspection visit:
11 December 2020

Date of publication:
09 March 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

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.

When we inspected on 11 December 2020, we were not assured that this service met good infection prevention and control guidelines and we will inspect the service again. Improvements were needed regarding staff practice, guidance, laundry management and infection control.

Following the inspection, we shared our concerns with the provider. We shared this information with commissioners and health colleagues. Deer Park Care Home did not have a registered manager in place, although interviews were taking place. A consultancy company was overseeing the management of the home on behalf of the provider and were addressing the breaches of regulation highlighted at the last CQC inspection which began on 29 October 2020.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection (and update)
The last rating for this service was Inadequate (published 17 December 2020) and there were multiple breaches of regulation.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Inadequate

CQC has introduced targeted inspections to follow up on Warning Notices or 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.

Enforcement
We have identified a continued breach in relation to infection prevention and control at this inspection.

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

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme.

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 of 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?

Inspected but not rated

Inspected but not rated.

Deer Park Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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
An inspector completed the inspection.

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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We met with the provider and the consultancy company. We sought feedback from the local authority and professionals who work with the service. We participated in multi-agency safeguarding meetings. We used this information to plan our inspection.

During the inspection
At the time of the inspection, there was a Covid 19 outbreak at the home. The majority of people were being cared for in their rooms as an infection control measure. We spoke briefly with two people and staff. We completed a tour of the building with the consultancy team. We reviewed records.

After the inspection
The consultancy team provided a service improvement plan, which included infection prevention and control. This was discussed as part of a multi-agency meeting on 18 December 2020.

Inspected but not rated

Is the service safe?

Our findings

We inspected Deer Park Care Home on Friday 11 December to follow up on a warning notice, which was served on 4 December 2020. The compliance date for the warning notice was 8 December 2020. We found there were still concerns surrounding infection control procedures in the home. The service has had two outbreaks of Covid 19 in 2020.

The management team explained how people were being isolated in their rooms, because of the current outbreak. And the communal areas on the lower floor were closed. One person said they were fed up as due to the second outbreak the downstairs lounge and dining room were closed. Upstairs, there was only one person who had tested as Covid 19 positive and they were being cared for in their own room. Other people living with dementia were eating together, the atmosphere was calm, and one person shared with us how much they had enjoyed their meal.

We reviewed the Coronavirus (Covid 19) management for Care Homes Policy dated 1 October 2020 which was in place at Deer Park Care Home and saw from training records the commitment to ensure all staff would be trained in the safe use of PPE had not been met.

We were told the provider had removed visors from the service despite these being a key item of personal protective equipment for staff caring for people with Covid 19. This was despite a Covid 19 outbreak at the care home. The provider assured us they had returned the visors when requested by staff. They did not provide a reason for removing them.

In contrast, there were large amounts of Covid 19 tests in stock, staff assured us regular weekly staff tests took place. The management team said they would now oversee testing of staff and residents, as well as the ordering of PPE stock.

On the day of our inspection, a staff bike shed funded by an infection control grant was full of discarded equipment making it unusable for its original purpose. Following our inspection, we contacted the provider and they told us the equipment had been removed and the bike shed was available for staff. Staff had been encouraged by the former manager not to share cars and instead cycle into work to reduce the risk of cross infection.

We completed a tour of the building with the consultancy team. Laundry procedures needed to be improved further to ensure effective infection prevention and control practice as processes were still unclear. 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 for soiled and unsoiled clothing was not clear. Staff practice in other areas of the home showed they needed further training and guidance to ensure their use of PPE was effective. Further training was being organised from an external source.

We saw the furnishings and carpeting in the downstairs lounge were stained and flooring in the communal toilets unclean. The consultancy team said hygiene practices in the home needed to be improved further.

They said they had highlighted the quality of furnishings and carpeting as areas to be addressed by the provider. Since our last inspection, a specialist chair had been placed in one person's room; staff confirmed it did not belong to the individual and were not sure why it had been moved in there as the person was cared for in bed. The covering was significantly ripped in several places and posed an infection control risk. A member of the consultancy team ensured it was removed immediately from the room and requested it was discarded because of its poor state of repair.

Due to some people living at the home testing positive for Covid 19, the provider had temporarily stopped visits from family and friends, apart from in exceptional circumstances, such as end of life care. The management team identified improvements were needed to visiting arrangements in the future, for example social distancing in the conservatory. At the time of the inspection, the provider had agreed not to accept new admissions as part of the whole home safeguarding process.

We saw PPE was available around the building, including outside people's individual rooms. Apart from visors, we saw there was a good supply of PPE for staff to use, which was now stored in an area which all staff could access.

People's temperatures were taken twice daily to help monitor for signs of Covid 19. There was a separate area for staff to change in and out of their uniforms, which was good practice. On this inspection some improvements had been made, a hand gel dispenser in a key area of the home was full and an ear thermometer to take people's temperature was used correctly to ensure it was clean each time it was used. Clean clothes were no longer stored in a corridor regularly used by staff.

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 The provider failed to assess the risk of and prevent and control the spread of infection.

The enforcement action we took:

We issued a Warning Notice to improve infection control.