Phoenix Care Homes Limited

Deer Park Care Centre

Inspection report

Detling Avenue
Broadstairs
Kent
CT10 1SR

Tel: 01843868666

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Deer Park Care Centre is a residential care home providing personal care to people living with complex and enduring mental health conditions. In addition to this some people were living with a range of physical health conditions. At the time of our inspection 26 people were living at the service. The service accommodates up to 38 people in one adapted building.

People's experience of using this service and what we found
People told us they liked living at Deer Park Care Centre, their comments included, "I think its very good here" and "The staff are marvellous. There is always something to do".

The provider did not have the required oversite of the service. They had not taken action to ensure people always received a good quality service that kept them safe and well. A system was in operation to check the quality of the service. This had not been effective and shortfalls we found had not been identified. When checks had identified shortfalls, and these had been addressed.

There were not enough staff on duty at night to ensure people's needs were met and their safety was maintained. The manager increased the number of staff on duty each night shortly after our inspection. There were enough staff on duty during the day. Staff had been recruited safely.

The service was not clean. The manager arranged for a deep clean to be completed to address this. Government guidance was not consistently followed to reduce the risks to people from COVID-19.

Care had not always been planned to mitigate risks to people. No one had come to any harm and the management team put guidance in place following our inspection. Risks relating to the building were managed safely. Accidents and incidents were analysed, and action was taken to make sure they did not happen again.

People were protected from the risks of abuse. Their medicines were managed safely and staff worked with other professionals to ensure people's needs were met and processes were up to date.

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 requires improvement (published 23 August 2019).

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We carried out an unannounced comprehensive inspection of this service on 16 July 2019. The provider had

complied with warning notices from the previous inspection in relation to medicines management, the management of risks and building safety but we needed to be assured the improvements they had made were sustained.

We undertook this focused inspection to check the action the provider had taken to improve the service had been sustained. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Deer Park Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, staffing levels, hygiene and checks and audits at this inspection.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Deer Park Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by two inspectors.

Service and service type
Deer Park 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.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was to check if any one had suspected or confirmed COVID 19 and arrange for information to be sent to us.

What we did before the inspection
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. We took this into account when we inspected the service and made the judgements in this report.

We analysed information we had received about the service and gathered feedback from the local authority commissioning team, health care professionals and the local fire and rescue service. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with nine staff, including the manager, deputy manager and care staff.

We reviewed five people's care records, records relating to building safety, checks and audits and three staff files in relation to recruitment and induction.

After the inspection
We looked at a variety of records relating to the management of the service, including policies and procedures, staff rotas, and training and cleaning records.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● Risks to people were not managed as well as they could be. For example, guidance had not been included in care plans to ensure staff knew catheters were working properly and what action to take if there were any issues. A urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag. However, staff we spoke with knew what to do and district nurses visited daily to check the catheter was working effectively. A care plan was put in place after our inspection.

● There was a risk some people may not drink enough to remain as healthy as possible and they were at risk of becoming dehydrated. The amount they drank required daily monitoring to make sure they were drinking enough. The daily intake was not added up the majority of the time, to check the goal had been achieved. We would expect staff to check the person had achieved their goal each day and act if they had not.

● Some people were at risk of becoming constipated and were prescribed medicines to help manage the condition. One person did not have a constipation care plan or risk assessment to inform staff about the support they needed and when to seek medical advice. Following our inspection, the management team put care plans and risk assessments in place covering all risks to people. We will review these at our next inspection to make sure they have been effective.

We found no evidence that people had been harmed however, the provider had failed to assess and mitigate all risks to service users. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks to people were managed safely. For example, diabetes, asthma, and changes in people's mental health. Staff had a good understanding of how to manage risks to people's safety. They described how they supported people with complex needs to protect them from harm.

● Action had been taken to manage risks relating to fire. Since our last inspection there had been a fire in the building started by a discarded cigarette, smoking is not permitted in the building. Individual fire risk assessments had been completed and were followed to reduce the risks to everyone. Evacuations plans were in place and included clear guidance about the support each person required to remain safe in an emergency. Staff had practiced evacuation procedures.

● Risks relating to the building had been assessed. Regular checks were completed to ensure action taken to mitigate risks remained effective. Water temperatures were tested monthly and were within a safe range.

Staffing and recruitment

● There were not always enough staff to support people when they needed. The provider did not have a process in operation to decide how many staff were required to meet people's needs. Six or seven care staff

supported people during the day. However, this reduced to two at night. Following our inspection, the provider told us they had reviewed the process they used to assess staffing levels. We will check this has been effective at our next inspection.

● Some people required the assistance of two staff at night. This meant at times there were no staff available to complete important tasks, such as safety checks. In a recent survey one staff member had commented that more staff were required at night to support people. Following our inspection, the manager increased the number of staff on duty at night.

● Some staff had not completed basic training the provider required. Seven staff had not completed infection control refresher training. Only 13 staff had completed the COVID-19 workbooks the manager used to test staffs understanding of the virus and infection control measures. The manager had prompted staff regularly and explained the risks of not completing the required training.

We found no evidence that people had been harmed however, the provider had failed to deploy sufficient numbers of suitably skilled staff to meet service users needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Checks on staff's character and previous employment, including dates of employment and reasons for any gaps in employment, had been obtained. Criminal record checks with the Disclosure and Barring Service (DBS) had been completed. There were vacancies in the staff team, and these had been advertised. Vacancies were covered by agency staff. Some had been working at the service for several years and knew people well. In a recent survey people's relatives had complimented the staff saying, 'Staff are wonderful, very kind and caring and understanding' and 'Staff are excellent'.

Preventing and controlling infection

● People were not consistently protected from the risk of infection and areas of the service were dirty. Cleaning schedules were in operation however these were not effective. For example, the edges of floors had a build-up of dirt. Taps, sinks and baths were heavily stained with limescale. Limescale gives germs a place to multiply. Some equipment such as toilet frames and showers chairs were rusty, making them difficult to clean. Following our inspection, the manager arranged for the service to be deep cleaned and for day to day cleaning to be more effective. We will check the action taken has improved hygiene at the service at our next inspection.

● The manager knew about the government guidance around COVID-19 and had shared this with staff. A supply of personal protective equipment was available to staff. However, we observed this was not always used correctly. For example, we observed some staff wearing face masks incorrectly, with their nose uncovered. This was against government guidance and the providers policy.

The provider had failed to ensure all areas of the service were clean and people were protected from the risk of infection spreading. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other action had been taken to protect people from the risk of COVID-19 . People's temperature was monitored twice daily and staff observed for the signs of COVID-19 . Plans were in place to isolate any new people for 14 days. People and staff had taken COVID-19 tests. The manager was aware of guidance around testing and was waiting to receive a stock of test kits. Plans were in place to manage an outbreak of COVID-19 and reduce the risk of it spreading. This included isolating people with COVID-19 away from other people.

Learning lessons when things go wrong

● Accidents and incidents involving people were recorded. The registered manager reviewed accidents and incidents so the care people received could be changed or advice sought to reduce any risks.
● A monthly analysis was completed of falls, accidents and incidents to look for patterns and trends. None had been found.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe at Deer Park, they were not restricted and were free to move around the house and grounds are they wished. Staff supported some people to go out and about, others went out alone. One person went out during our inspection and told us on they had enjoyed their outing.
● The manager had discussed any concerns about people's safety with the local authority safeguarding team. When necessary, action had been taken to prevent incidents occurring again.□

Using medicines safely
● People's medicines were managed safely. People received their medicine as prescribed. Medicines were ordered, stored and disposed of safely. Medicines administration records (MAR) were complete with no gaps or errors. Staff received training in the safe management of medicines, and this was refreshed every 12 months.
● Some people were prescribed medicines 'as and when necessary', such as pain relief or when they were anxious. Information was available for staff about how to administer the medicines safely and consistently. The guidance included, why the medicine was prescribed, when the person may need to take it and maximum number to be taken in a 24-hour period.
● Community psychiatric nurses visited regularly to make sure people were receiving the medicines they need to keep their condition stable. People were also supported to attend appointments at the local mental health centre so their medicines could be reviewed.
● Medicines audits were completed regularly to check they had been given correctly. When errors were identified action was taken by the manager to prevent a re-occurrence. Staff checked the stock levels each time they administered medicines to check they were correct.

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 requires improvement. At this inspection this key question has 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.

Continuous learning and improving care

- The provider did not have oversite of the service and had not taken action to improve and maintain the quality of the service at a good level. The service has been rated requires improvement at each of the six inspections completed since October 2016. The provider met with the manager monthly and discussed some operational issues. They did not complete checks to assure themselves the service was operating at a good standard. Shortfalls at the service identified by an external consultant in March 2020, continued not to be addressed in July 2020.
- They had failed to establish and operate an effective quality assurance process over a number of years. Shortfalls found during our inspections had not been identified and addressed and this left people at on going risk of harm. The provider had not learnt from breaches of regulation or acted to ensure these did not happen again. For example, at four inspections between 2016 and 2020 we found risks to people were not managed. In 2016 we found the provider did not have an effective process to ensure there were always enough staff on duty to support people. At this inspection we found this had not been addressed after four years.
- We took enforcement action against the provider in 2019 and served them with two warning notices requiring action be taken to address shortfalls within a short timescale. Action had been taken to address these shortfalls and maintain improvements, however, other areas of the service had deteriorated.
- At this inspection we found the provider's audit system did not ensure all shortfalls were identified, so action could be taken to address them. The manager completed regular audits the provider required. Checks the manager completed were not reviewed to ensure they were accurate. The shortfalls we found in care planning and risk assessments had not been identified as areas for improvement. Infection control audits had not identified cleaning was not effective.

The provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some checks the manager completed had led to improvements. For example, medicines audits had found staff did not have access to an up to date list of medicines information. The manager had added a link to the list to computers accessible to staff so they always had access to current information. Staff told us, "The manager does a lot more checking. They check staff are competent and take action if there are any shortfalls".
- One staff member told us, "It feels like a fresh start with the new manager. There are lots of new ideas".

The manager had developed an improvement plan which they kept under review. Some actions to reduce risk, such as staff training to use fire evacuation equipment, had been completed. Other actions were on going such as repairs to the building. Improvements had begun on the environment, including extending and redecorating the TV lounge.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had failed to make sure the management team fully understood their responsibilities and fulfilled their role. The manager had been employed as the deputy in November 2019 and promoted to manager in June 2020. There was no evidence of a robust recruitment process based on skills and experience to improve a failing service for people with mental health needs. They manager and deputy did not have a background in working with people with long standing mental health conditions and had not completed an induction relevant to their role. The manager and deputy manager completed training in relation to mental health following our inspection.
- The manager was not fully aware of risks related to Covid-19 and had not assessed risks to black and minority ethnic staff from COVID-19. Plans were in place to protect staff at increased risk, including how they would be protected in the event of an outbreak at the service. This placed some staff at an increased risk of harm.
- The manager had reminded staff of their responsibilities and were held accountable. For example, staff had asked if they could stop wearing face masks during very hot weather. The manager had told them they could not and had shared government guidance with them about personal protective equipment for care workers working in care homes during the COVID-19 pandemic.
- The provider met with the management team monthly to look at how plans to improve the service were progressing. They had offered development opportunities and reminded the management team they were available to support them. However, the provider had a history of not challenging and supporting managers to improve the services they owned. This had led to people receiving very poor quality services which did not protect them from harm. Learning from inspections of the provider's other service were discussed along with the managers registration application.
- The provider had conspicuously displayed the Care Quality Commission quality rating in the service and on their website, so people, visitors and those seeking information about the service were informed of our judgments.
- The manager understood the duty of candour requirements. They knew when they were required to notify CQC of events that had happened at the service.

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

- People, their relatives and staff had been asked for their views of the service in March 2020 and their feedback had been positive. However, the questions in the survey were not related to the pattern of shortfalls at the service. Many people had lived at the service for a long time and there was a risk they had become accepting of poor quality care. Action had not been taken to support people to understand what a good quality service looked like and to understand the standards of support they should expect from the provider.
- The manager has asked people to complete a further survey in June 2020 but only one person had completed one. Resident meetings had been held in January and February 2020, these were not attended by everyone and some basic requests had been fulfilled. However, action had not been taken to ensure everyone was supported to share their views. People had not been told how other suggestions had been

responded to. At the time of the inspection people were choosing which colour they wanted the new lounge painted.

● Staff followed government guidance to support people to receive visitors. At the time of our inspection the weather was fine, and people were able to see their friends and family at a social distance in the garden. Plans were being made to support people to safely see visitors in bad weather. The room being considered had step free access and was accessible to all.

● There was a positive culture at the service and people were treated with respect. One staff member told us, "People get what they need here. We make sure that they are doing what they want and like. Everyone is treated as an individual and can choose every day what they want to do". Staff knew people well and we observed people being supported to live their life in the way they wanted.

● People and staff told us there had been changes in the leadership style since the new manager had come into post. They told us the manager was supportive and approachable. One person said, "The new manager has made a difference. I can talk to them when I want to".

● The new management team were working to develop an inclusive atmosphere where everyone felt comfortable to join in.

Working in partnership with others

● The manager worked with other professionals to support people to stay as safe and well as possible. For example, they had been unable to order a stock of COVID-19 test kits, so they could test staff and people regularly. They had discussed this with a support nurse, and this was being raised through the local clinical commissioning group (CCG).

● When people's needs changed and could no longer be met at the service, staff worked with health and social care professionals. Two people had been served notice and staff followed professional's guidance to keep the people as safe as possible until they moved.

● People were referred to advocacy services when they needed to make important decisions about their lives.

● The manager was part of a local registered managers COVID-19 communication group which they used to gather information around best practice. They also kept up to date on local challenges and ways to over come them. They knew who they could contact for support with issues or concerns, including CCG staff and the local authority safeguarding team.

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 We found no evidence that people had been harmed however, the provider had failed to assess and mitigate all risks to service users. This placed people at risk of harm. 12(1)(2)(a)(b)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure all areas of the service were clean and people were protected from the risk of infection spreading. This placed people at risk of harm. 15(1)(a)(2)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate an effective system to assess, monitor and improve the quality and safety of all areas of the service. This placed people at risk of harm. 17(1)(2)(a)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found no evidence that people had been harmed however, the provider had failed to deploy sufficient numbers of suitably skilled staff to meet service users needs. This placed people at risk of harm. 18(1)(2)(a)

The enforcement action we took:

We imposed a condition on the provider's registration.