Holsworthy Health Care Limited

Deer Park Nursing Home

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

This inspection was a comprehensive inspection and took place on 20 and 21 June and 5 July 2017. At the last comprehensive inspection, completed in April 2016, we rated the service as overall requires improvement. We issued two requirements in relation to regulation 11, the need to consent and regulation 18 - staff did not receive appropriate supervision and support to be able to identify and plan of future professional development. The service sent us an action plan to show how they intended to meet these requirements by June 2016 or earlier.

At this inspection completed in June 2017 we found that although some improvements had been made in respect of supervision and support to staff, further improvements were still needed in relation to how consent to care was recorded. This related to the lack of records in relation to best interest decisions where restrictive practices had been used to keep people safe. This included the use of bedrails and pressure mats which alerted staff when people might be at risk of falls. We also found other areas where the service was not meeting the regulations.

Before this inspection we received some information of concern about staffing levels from an anonymous source. We also received some information from visiting professionals about the lack of a proactive approach in meeting people's needs and in particular about end of life care. At this inspection we found there were adequate staff but their deployment was not always ensuring people's safety and comfort. For example no staff presence in lounge areas for periods of up to half an hour. We also found some of the care planning around end of life care and the skills of some nursing staff in ensuring effective and safe pain relief, required some improvements.

The local authority quality assurance team (QAIT) had been offering support and guidance to this service in developing an improvement plan and reviewing the care plans to ensure they were more personalised. This work had been halted at the services' request as they had decided they needed to remodel their service and were working with Devon County Councils business relationship manager to implement this. The remodelling involved reducing the nursing staff by one per shift and skilling senior care staff to take on some of the medicines and care planning processes. At the time of our inspection this had not been implemented.

Deer Park nursing home is registered to provide personal and nursing care for up to 56 people. They provide care and support for frail older people and those people living with dementia. On the day of the inspection there were 46 people living at the home, including one person who was having a short break there.

There was a registered manager who has been in post for just under 12 months. 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.

People were not fully protected against the risks of unsafe medicine management. Medicines were not given on time and nurse practices and competencies had not been checked. The treatment room was disorganised and this made it difficult for nurses to have enough space to prepare medicines and to find the right equipment. By the third day of our inspection the medicines and treatment room had been de-cluttered and the registered manager had checked nursing staff competencies. They had also changed the start of the daily routine so that nursing staff received a short written handover report which freed their time to start the medicines for the morning at an earlier time. It was reported this was working to good effect and that the morning medicines were completed in a more timely way than when we had inspected.

Risks had not always been fully assessed and monitored which placed people at risk of receiving unsafe care and support. This related to the way one person was supported to eat and their risk of choking. We also found one person who was at risk of poor nutritional intake whose daily records did not assure us they were getting sufficient amounts to maintain good health. Records in relation to wound care were not clear as to how often dressings were needed or if they had been changed. It was difficult to assess if improvements to wounds were being fully monitored. By the third day of our inspection, these areas of concern had been addressed.

Although there were sufficient staff working at the home, they were not always deployed to ensure people's safety and comfort. For example, on the first day of the inspection there was a period of over one hour where people sitting in the lounge had very little staff interaction. Following feedback the registered manager and provider were taking actions to address this. This included changes to the routines of staff roles and advertising for another full time activities coordinator.

Healthcare needs were not always responded to in a timely way. We received feedback from healthcare professionals who gave examples of needing to direct the staff to seek medical assistance for specific conditions. This included checking for basic common health issues such as a urinary infection. In some instances nursing staff did not have a proactive approach to referring to other healthcare professionals.

The service had achieved a national beacon status for end of life care. However, improvements were needed in some of the nurses' skills for managing with complex pain relief. Records in relation to end of life care were not personalised.

People were at risk of receiving inconsistent or inappropriate care. This was because not everyone had a care plan in place to guide staff about how best to plan and deliver care and support. Care plans were not person centred and did not reflect people's needs, preferences, interests, hobbies or past lives. This meant staff would have limited knowledge about people and events that were important to them, and would limit what staff could talk to people about. The registered manager had created some basic care plans for those who did not have them in place by the end of the second day of our visit. They had also organised some additional training and support for improving their care plans.

Audits and systems for checking the quality of care and support delivered had not identified the number of issues we found, including three people having no care plan, MCA information not being well documented in terms of best interest decisions and the skills and competencies of staff not being reviewed and monitored.

People were positive about living at Deer Park and were complimentary about the caring nature of staff, the cleanliness of the home and the quality of food they were offered. Comments included; "I am very happy with the staff. They treat me well…they are good, helpful people" and "Most staff are kind and very willing. I know some of the local girls working here, which is nice."; "Yes, I feel I am always treated with respect and that my dignity is preserved." Similarly, relatives were positive about the care their family member received.

One said "I do believe they offer the right care. I can sleep at night knowing they are well cared for."

The home was kept clean to a high standard and infection control procedures were followed to ensure people were protected from the risk of cross infection.

People were protected from the potential of unsuitable staff working at the service. This was because staff were only recruited once they had all the checks in place to ensure they were suitable to work with vulnerable people. Staff understood what may constitute abuse and how and to whom they should report any concerns.

Staff felt valued and believed their opinions and views were listened to. People and staff felt confident any concerns they raised would be dealt with appropriately by the management team. Staff spoke about the increased use of supervision and training being useful to help them understand their role and develop their skills.

There were surveys, meetings and one to one discussions with people to ensure their views were gathered in relation to feedback about the service and how to improve for the future.

In light of the findings of this inspection the management team have decided to voluntarily suspend any new placements to the service for a four to six week period. They want to spend some time consolidating their training, care plans and other actions taken to mitigate risks we identified. They have also provided CQC with actions about addressing staff training, records and audits.

We found six breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report.

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

Many aspects of this service were not safe.

Medicines were not always well managed and this resulted in people receiving their medicines much later than prescribed. Poor medicine practice potentially put people at risk of harm.

Deployment of staff required some improvements to ensure people were kept safe and their care needs met in a timely way.

Risk assessments and review of what actions to take to mitigate risks required improvement to keep people safe and healthy.

People were protected by safe recruitment and staff knowledge around the protection of vulnerable adults

The service was clean and processes in place to mitigate the risk of cross infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who were trained and supported to meet their physical and emotional but further training was required in respect of understanding and actioning people's health care needs.

People were enabled to make decisions about their care and support and staff obtained their consent before support was delivered. Some improvements were needed to ensure the service acted within Mental Capacity Act 2005 to ensure best interest decisions were recorded.

Most people's dietary needs were met. However, for those people being assisted using specialist equipment improvements were needed in ensuring they were provided with adequate nutrition.

Mealtimes were unrushed and enjoyable for people.

Is the service caring?

Requires Improvement

The service was mostly caring, but improvements were needed in how end of life care was being planned and how pain relief was delivered.

People were mostly treated with dignity, kindness and respect. Signage on people's doors meant privacy and dignity was not always maintained for some people.

People were consulted about their care and support and their wishes respected.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care and support was not always well planned. Changes to people's needs was not always quickly identified and acted upon.

People were afforded choice and there was a range of activities offered throughout the week.

People or their relatives concerns and complaints were dealt with swiftly and comprehensively.

Is the service well-led?

Requires Improvement

The service was not well-led.

Systems were in place to ensure the records; training, environment and equipment were monitored but they had failed to pick up on the issues we identified.

People and the staff team felt the management team promoted an open and inclusive culture.

People's views were taken into account in reviewing the service and in making any changes.

Deer Park Nursing Home

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 checked 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 20 and 21 June 2017 and 5 July 2017. The first day was unannounced. The inspection team included two adult social care inspectors, a specialist advisor on nursing and palliative end of life care and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service.

We spent time observing how care and support was being delivered and talking with people and staff. We met with most of the people living at the home. We spent time in communal areas of the home to see how people interacted with each other and staff. This helped us make a judgment about the atmosphere and values of the home. We spoke with people to hear their views on their care. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with three relatives who were visiting the service.

We spoke with three nurses, eight care staff, the registered manager, development manager, registered provider, housekeeping staff and the cook.

We reviewed nine care plans and daily records, medication administration records, four recruitment files as well as audits and records in relation to staff training and support, maintenance of the building and safe safety records.

We looked at all the information available to us prior to the inspection visits. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law. We also reviewed the service's Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and

improvements they plan to make.

Following the inspection we asked for feedback from four health care professionals to gain their views about the service. We received feedback from three.

Inadequate

Is the service safe?

Our findings

People were not fully protected against the risks of unsafe medicine management. This was because the morning medicine round took up to 2 hours and one person who was prescribed insulin at 10 am did not get this until 11.45. The last person did not receive their morning medicines until 12.10pm. This could have a serious impact for people if their insulin was not given at the correct time or if pain medication was not given within the right intervals as this may mean there was a potential for an over medication.

We observed poor and unsafe practice in relation to the way used needles were disposed of. There was no sharps box on the medicine trolley. The nurse walked up a long corridor to dispose of the sheaf of the needle. The potential risk was of someone being jabbed with a sharp. We also observed unsafe practice in the way medicines were delivered to people using a syringe pump. The nurse attempted to fit the new syringe into the machine whilst connected to the person. We asked the nurse to stop this procedure as we deemed it unsafe practice. There was a risk of accidently giving the person a bolus dose (whole dose which should be delivered over a course of hours instead of all in one dose) of the whole of the syringe whilst trying to fit into the machine. The treatment area where medicines were stored and nurses used to prepare medicines for administration was cluttered. For example, there was not enough space for nurses to change the syringe drive pump and prepare the medicines. They did not have the right equipment for drawing up the correct doses for the syringe. The disorganisation of the treatment room made it hard to find the right equipment. For example nurses were unable to find the correct syringe for the amount of medicines needed to go into the syringe driver.

We saw one person being assisted to eat their meal whilst in bed. They were in a prone position which presented as a risk of choking. We asked the care staff member who was assisting the person if they were aware of any risk assessment in relation to how to support this person to eat. They said they had not had time to read the care plan, but the person was difficult to get into an upright position. The care plan for this person showed they had been assessed by a speech and language therapist as being a risk of choking. They had advised to ensure the person was supported to eat in an upright position to reduce the risk of choking. We fed this back to the registered manager who agreed she would ensure all staff were aware of the need to assist people to eat in the right position for their safety and wellbeing.

People were not fully protected from the risk of pressure sores. This was because 'turning charts' were not always completed. We could not be confident people who were assessed as being at risk from developing pressure damage were being assisted to change position as frequently as they should. For example, one person had developed grade four pressure damage, (significant skin damage), and their 'turn chart' showed they required repositioning 'two or three hourly.' However records showed gaps of between four and six hours between re-positioning. Where people are not repositioned for extended periods they are at increased risk of skin damage. We also found the wound care plans lacked detail about whether wounds were healing. For example, although some photos had been taken, the wound care plan did not give details of the exact measurements of the wound. This mean it was difficult to assess whether the wound was healing. There was also a lack of clarity around wound care plans. For example, one person we visited had an exposed wound

which presented as a risk of infection. The nurse said the person sometimes took their dressing off. Records were inconsistent as to when and how often the dressing was being changed. There was also an inconsistency in the description of the wound to the way it presented on the day of the inspection. This meant wounds had not been regularly monitored or evaluated to promote healing and ensure accurate information was available.

Although people were being weighed on a weekly or monthly basis, this did not feed into the review of their care plan in relation to nutrition. For example, two people had lost up to four kilos over a period of three to four months, but their review of their care plan stated "no change". This meant no actions had been taken to look at why these people had had significant weight loss.

These areas as described above place people at risk and are in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the third day of this inspection actions had been taken to mitigate some of the risks we identified. The registered manager had made changes to the way the morning routine was organised. They had agreed the nurses would receive a written handover about people's changing needs from the night staff. This meant they could begin their morning medicines round by 8am. The registered manager said this had been working to good effect and allowed the medicines to be completed by 10.30 at the latest. She had also checked the nurse competencies in respect of safe management of syringe drivers, updated their end of life care plans to include what actions were being taken in resolving pain relief. Nursing staff had been reminded to ensure a sharps disposal box was always carried on the trolley. Staff had been reminded at each handover of shift about those people who were at risk of choking and staff were asked to ensure they were assisting them to sit up to help with the prevention of possible choking incidents. This was also being detailed in the written handovers.

The registered manager wrote to us following the inspection and stated "I have arranged with North Devon hospice to book all of our nurses on the next available syringe driver course which is to be held on 13th October 2017, in the meantime I have purchased online training through CME medical for the nurses to complete whilst they are awaiting the face to face training. This training will be completed within the next week. All of the nurses are in the process of completing competency documents ahead of this training."

One social care professional who visited the service had been concerned about the lack of risk assessments in relation to one person's behaviours and suicidal intentions. They described how despite the person having said they had suicidal thoughts; the staff had still placed a call bell alarm around their neck. They reported this to the local authority safeguarding hub and the commissioning team completed a further review to ensure this person's needs were being met. When we discussed this further with the registered manager, she assured us call bells were on a lanyard which had quick release straps and so the person would not have been able to use this as a means of suicide. We reviewed their care plan in relation to their emotional behaviours and needs. This gave staff some brief details about what this person may become anxious about and what their Deprivation of Liberty safeguard had advised about recording. They had specifically asked for staff to record when this person showed any verbal or non-verbal expressions to leave the service.

Another healthcare professional provided feedback about concerns they had raised in relation to someone they had assessed as being under weight. The staff had been unable to find the weight records for this person, despite being advised by the dietician to keep the person's weight under review. The health care

professional said they were concerned when they viewed the records relating to food and fluid intake. They were also concerned with the small amounts of nutritional intake recorded and so asked for further dietician input. This reactive approach rather than a proactive approach indicated that risks were not always being reviewed or managed well. Since this review the person had been prescribed fortified drinks and their weight had remained stable. Records of their fluid intake were being recorded.

People's needs were being met by sufficient numbers of staff, although some people said they felt the service was short staffed at times. One person said they had to wait long periods at night for care staff to be available to meet their needs. We fed this back to the registered manager and asked that they review call bell response times. Prior to this inspection, we had received some information of concern about staffing levels. We asked the registered manager to send us the staffing rotas and found they were in line with the stated levels as determined by the service. There were odd days when there were staff shortages of one or two care workers due to short notice of sickness.

Staffing levels were currently set at two nurses per shift with two senior care staff plus eight care staff per morning shift. The afternoon shift was reduced by four care staff with two nurses and two seniors. The night cover was one nurse and four care staff, all waking nights. The care team were supported by a registered manager, development manager (part time), compliance manager (part time), receptionist, three administrators, a senior house keeper, and three cleaners per day. Plus a bed maker and laundry person. There were also three cooks each day and a full time maintenance person. The service also employed an activities coordinator who worked 28 hours per week, but also organised activities at the providers other home as well as at Deer Park Nursing Home.

People's comments about staffing levels and their approach included "The staff are very nice, I get lots of help from them" And "They do everything for you [me], they do everything well, they keep smiling and that means a lot" One person said "They can't always get the night staff so I have to wait awhile. There is sometimes a problem during the day."

Staff confirmed there were sufficient staff to meet the current needs of people living at the service. They said that there had been a short spell of sickness and staff being off on annual leave. The registered manager said where there were known gaps in the staffing rota they used their own staff or agency to fill these gaps. She acknowledged that there had been a few days where staff had rung in sick at short notice and they had not been able to provide cover. One relative told us "There have been odd occasions where they have been short staffed, but they work as a team and everyone gets what they need. One day I offered to help give out the teas. They can't help sickness. I have no worries about staffing levels.

Sufficient staffing levels were rostered. However, their deployment needed some improvement. Staff were not always deployed to ensure their presence in communal areas at all times. We found at various times, particularly late in the afternoon and prior to lunch, staff were not visible in communal areas or on the floor. In the ground floor lounge one person had a cup of tea in their lap and was falling asleep. We had to intervene to remove their cup to prevent them from spilling the hot tea on themselves. We observed at times there was only one staff member available on the first floor during the afternoon. One person required to use the toilet and needed staff to help them. They were told they would have to wait until a staff member providing refreshments on the ground floor was available. There was only one staff member for up to a ten minute period. The impact was that people's needs could not have been met in a timely way.

One person was sitting in the conservatory with a relative; the person was screaming and appeared very distressed. The relative explained the person often behaved like this but said the heat in the conservatory had probably made the situation worse. It was a very hot day, and although there were fans and open

window, the conservatory was stifling. Staff did not approach the person or relative to check if everything was alright until we asked the registered manager to check the temperature of the conservatory. This was over 30°C. Staff had not been proactive to see if there was an additional reason for the person's distress.

In contrast to this some people said they felt safe. One person said "I feel perfectly safe living here." Another said "Yes, I feel safe living here." And "Yes I feel safe. It is nice here; people have been very nice to me. I have a pendant to call staff but they are always around, I never have to shout for them…"; "I do feel safe. I feel well looked after. They (staff) do everything they can for you here. They come quickly, as quickly as they can, when I need them. Night staff are very good. They help me without delay; check I am safe. They are wonderful. Never rushing us. All very calm."

The service was experiencing difficulties with the recruitment and retention of nursing staff. As a result they were working with the local authority quality assurance team and other personnel to review the staffing model. Agency nurses were used on a regular basis. The agency nurse on duty at the time of the inspection said they had worked at the service for several shifts; they had received a good induction and handover and that staff were welcoming and friendly. Two people spoke highly of the agency nurse, describing her as "gentle" and "kind."

Medicines were stored securely in a trolley and in a locked treatment room. Medicines requiring extra security were kept double locked and only signed out by two nurses when administered. The medicine administration records (MARS) tallied with the medicines in blister packs. Staff were required to complete annual online medicines training, but their competencies were not checked. We observed medicines being administered. People were asked about pain relief and the nurse worked at a pace to suit the person, waited to ensure they had swallowed their tablets before recording they had been administered. Medicines which were required to be kept at a lower temperature had been stored in a lockable fridge and the temperature of this was monitored daily. The registered manager completed monthly audits of MARS to check if there were any gaps. This did not include any actions for areas of improvement.

We had been made aware of a serious medicines error prior to this inspection. Staff involved had been investigated following the services disciplinary processes. Actions were taken which included further training being organised and for an independent audit of medicines to take place. The registered manager also gave us assurances that their audits would in the future include action plans and monitoring the competencies of staff to administer medicines safely and in line with policy and procedures.

Some risk assessments contained clear guidelines for staff about how to manage risks. For example, in relation to some people's mobility. Moving and handling risk assessments were in place to ensure any risk of harm to the person or the staff was identified and minimised. During the inspection we observed staff using equipment when assisting people to move. This was done in an unhurried and safe manner and staff informed the person about the procedure throughout, putting them at their ease.

Staff understood the types of abuse that could occur and how to report concerns. Staff had received training in understanding abuse. This included ancillary staff, for example kitchen staff; housekeeping and maintenance staff had also completed safeguarding training. The registered manager understood their responsibilities in working with the local safeguarding team when needed. One alert raised by the registered manager was dealt with appropriately to keep people fully protected.

Safe recruitment practices helped to protect people. Staff recruitment files showed checks were completed in line with regulations to ensure new staff were of good character and suitable to work with vulnerable

adults. New staff were required to complete an application form. We were assured that any gaps in employment histories were followed up during the interview process. No new staff were offered employment before all their checks and satisfactory references were received.

Emergencies were planned for. For example, each person an emergency evacuation plan and regular fire evacuations were done to check people understood about what to do if the fire alarm went off. Fire equipment such as extinguishers had been serviced and maintained in August 2016.

The home was kept exceptionally clean and free from odour. The housekeeping team worked hard to ensure the environment was clean and risk of cross infection was minimised by the use of good infection control procedures. There were ample supplies of protective equipment such as disposable aprons and gloves. Staff described how they used this equipment appropriately, for example, when delivering personal care.

Requires Improvement

Is the service effective?

Our findings

At the last inspection completed in April 2016 a requirement was issued as staff did not always comply with the Mental Capacity Act (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. This was not being done and had led to relatives making unlawful decisions on other people's behalf. For example, consent to care plans. The provider sent us an action plan, telling us how they planned to make improvements. At this inspection we found some improvements had been made but these were not consistent.
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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager demonstrated they were aware of the requirements in relation to the MCA and DOLs. They had ensured they had recorded the details of people's Lasting Power of Attorney (LPA), but other aspects of MCA records still required improvements. For example, one person who lacked capacity to make decisions had moved to the service several weeks prior to the inspection. No mental capacity assessment had been completed although a Deprivation of Liberty Safeguards application had been submitted to the local authority. The person had a pressure mat in their room, which alerted staff to their movements as they were at risk of falling. However, no consent had been sought for the use of the equipment and no best interest decision had been undertaken with the person's next of kin or other professionals to ensure the equipment was used in the least restrictive way.

The person's 'care plan consent' form was blank. The person was also non-compliant with some aspects of their care and treatment due to their lack of understanding but this had not been considered or planned for. We discussed this with the registered manager who accepted our findings. They explained the person had initially been admitted for respite and their discharge had been delayed. We therefore judged that although the aspect of consent to care in relation to the regulation and ensuring LPAs were fully documented, other aspects of this regulation had not been met.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found other examples where people's mental capacity to make decisions had been assessed and best interest decisions had been made involving people who knew the person well, other professionals where relevant and staff at the service. For example, decisions relating to personal care and support. The registered manager was aware that relatives could only consent on behalf of people if they had the legal authority to do so.

People confirmed that before they received care and treatment staff asked for their consent and acted in accordance with their wishes. For example, when providing personal care or assisting people to move. We saw staff involving people in their care and allowing them time to make their wishes known. One person said, "Yes, staff ask if I want to get up and if they can help me."

Some people using the service were not free to leave and were under constant supervision. As a result, Deprivation of Liberty Safeguards applications had been made to the local authority in relation to 20 people. Two applications had been approved and the registered manager was awaiting a decision for the others submitted.

Records did not show if people received effective care to meet nutritional and hydration needs. This was because care and treatment was not always well planned. For example, one person required all of their nutrition to be delivered via a special tube as they were unable to maintain adequate nutrition with oral intake. The community dietician had been involved in the person's care and a regime had been established to ensure they had sufficient nutrition and fluids. However, there was no care plan to confirm the daily goal or the time nutrition and fluids were to be given. There was no separate nutrition and fluid records. The nurse said there had been a fluid balance record some weeks before the inspection but no records could be found. Some information was held in the daily notes about the nutritional feed given but not about the fluids. Entries stated, "Frusubin and water as regime". The total amount of fluids given daily was not recorded or tallied. From the records we could not confirm the person received the recommended and required nutrition and fluid to maintain their health. The community dietitian confirmed they would expect to see fluid/nutrition charts in place to help monitor the person's daily intake. This lack of records meant we could not be assured the person was receiving effective care and treatment in relation to their nutritional intake.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the third inspection day we found these records had been implemented and it was clear the exact amounts of fluid the person had been given each day to ensure their health.

People not requiring specialist equipment were offered a varied and nutritious diet. Comments were generally positive about the food and included, "The food is very good. We get a choice for breakfast, lunch and supper and lots of tea and coffee and cake. There is plenty to eat here"; "I am a fussy eater but I have found the food very nice. I am enjoying it and there is always a choice" and "Everything I get I am happy with…we have a menu and can choose what we want…"; "The food is very good. I've lost a lot of weight eating healthily." The cooks confirmed that various dietary needs were catered for, including diabetic, vegetarian and pureed meals. They were told about any changing needs and were aware of people's preferences and allergies, as this information was recorded for them. Some people required fortified foods as they were at risk of weight loss. The cooks were aware of who was at risk and ensure they used additional cream or butter in foods where people required additional calories. Mealtimes were unrushed and people appeared relaxed.

At the last inspection we found staff had not been receiving on-going supervision and appraisals in order for them to feel supported in their roles and to identify any future professional development opportunities. We issued a requirement. The provider sent us an action plan, telling us how they planned to make improvements. At this inspection we found improvements had been made and the regulation was met.

A schedule of staff supervision and appraisals had been established by the registered manager and development manager. They explained the vast majority of staff had received regular supervision (usually bi-monthly) since the last inspection. Supervision was provided by the registered manager; development manager senior housekeeper and nursing staff. Not all staff providing supervision had received training about the role, however, the development manager, who had training and experience, provided supported and advice to people undertaking this role. This included, observing a session with the development manager, and planning and undertaking an observed supervision meeting with the supervisor.

The registered manager and development manager explained staff had not previously received regular supervision and staff were apprehensive at first, but staff were now "really enjoying" regular one to one meetings. Supervision records showed staff had the opportunity to discuss training needs; their performance; their welfare and any changes within the service. Staff said they were offered regular one to one supervisions sessions which they found useful. One staff member said "We are asked about how our role is going and what training we have completed and what further training we would like to do. If I had an issue with work I wouldn't wait for my supervision, I would speak to the manager straight away."

The registered manager undertook an 'initial' supervision with all new staff to discuss the aims and ethos of the service and to ensure staff were receiving the support they required. New staff were supported with induction training to help them work safely and to get know the needs and preferences of people using the service. They were supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. New and inexperienced staff undertook induction training in line with the Care Certificate when first in post. The Care Certificate sets out competencies and standards of care that are expected, which enables them to develop the skills they need to carry out their roles and responsibilities. One care worker we spoke with confirmed they were being assisted to complete the Care Certificate. Others confirmed they were offered opportunities to do shadow shifts with more experienced staff to help them understand the role and needs of individuals.

The registered manager had a list of when each nurse needed to have their registration number checked with the nursing and midwifery council (NMC). She said she had an access code and checked this on line. She also explained how she had been involved in assisting nurses with their revalidation process. In light of some of the areas of concern we have identified, the registered manager had set up some additional training for nurses and care staff in areas of pressure and wound care, hydration and care planning. Records showed that only one of the five registered nurses had completed pressure ulcer and damage prevention. None had completed training related to wound assessment and management.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The additional training in wound care was being facilitated by an external nurse educator and dates were planned through July 2017. The provider said they were booking agency nurses to provide cover so all nurses and most care staff would be able to attend these sessions.

Annual staff appraisals had been completed in September 2016 and personal development plans had been created for staff, to promote and support their learning and development. Appraisals included a self-assessment completed by the staff, along with an assessment completed by their line manager. Plans included staff's goals; actions to meet the goals; evidence of achievement and a target date. Plans were individualised to the staff member. Staff reported there was good training available to them to help them do their job effectively. This had included a dementia tour bus, which simulates what it is like to live with

dementia. Staff said this had been really useful training and had helped them understand the needs of people with dementia better.

Staff training was recorded on a database to ensure core training was kept up to date. The records made it easy to see which training staff required. Records showed training included topics to help staff work safely, such as safeguarding; moving and handling; health and safety; fire safety and infection control. Other training related to the specific needs of the people using the service was also undertaken, for example, managing challenging behaviours; dementia care and diet and nutrition.

Healthcare needs were not always responded to in a timely way. One healthcare professional said they felt the nurses were not always proactive in ensuring the right healthcare professionals were consulted. They gave the example of them having to request the service ask of an occupational therapist assessment for one individual who was struggling to get out of bed. Another healthcare professional said the service agreed to take on an emergency admission. The individual quickly became unwell and displayed signs of paranoia and the nurses did not test for a urinary tract infection (which is a common illness in older people which could cause increased confusion). The healthcare professional had to ask for the person to be tested and it was found they did have an infection. They said "The home had decided they could not manage x over the course of a weekend, and asked for x to be moved because they could not manage x. I would expect a nursing home with trained nurses to at least consider that a client might be unwell and require treatment which would enable them to be managed in that home, before demanding they are moved because they cannot be managed."

This lack of a proactive approach placed people at potential risk and is a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from daily records people had access to health care professionals to meet their needs. For example, GPs; podiatrist; tissue viability nurses; speech and language therapist, and hospice care nurses. Where one person had been at risk of falling, a referral was made by the service to the community physiotherapist for advice about equipment and how to improve the person's mobility and reduce the risk of falls. The person was able to confirm they had been given a walking aid, which they found useful.

Requires Improvement

Is the service caring?

Our findings

When we inspected in April 2016, we found the way some staff described people was disrespectful. People had been described as "feeders" for example. Our observations and review of daily records showed this was not now the case. Staff referred to people by their name and we did not see any disrespectful terminology in care plans or daily records. We did however see people's privacy and dignity was not always protected as various signs about their personal care and health needs were displayed on the front of bedroom doors. We discussed this with the registered manager to see if there was a more discrete place to keep information. By the second day these signs had been removed.

People said staff were kind and caring. Their comments included, "The staff have been very nice to me; respectful and kind…not bullies…I find them very good"; "I am very happy with the staff. They treat me well…they are good, helpful people" and "Yes, I feel I am always treated with respect and that my dignity is preserved"

Prior to this inspection we received some information which indicated some healthcare professionals were not assured the service had the right skills to care for people who were nearing the end of their life. The service had been awarded a Beacon Standard for the gold standard framework (GSF) for end of life care in April 2016. This is an external training and accredited programme to provide training to staff for good quality end of life care. Two staff from this service had completed the training and had regular meetings with the GP practice to discuss people who were nearing their end of life. We found that good practice was not fully embedded. For example, some staff required updated training in ensuring their skills as nurses were up to date in syringe drivers for example. We also found that care plans and records relating to people's end of life care were more of a tick box exercise and not person centred. For example, one plan had ticked pain control was being managed, but did not describe how this was being done. We fed this back to the registered manager who said she would look at expanding the forms to include explaining what actions they were taking to ensure people's end of life care needs were being met.

Several people chose to stay in their room or were cared for in bed. Most bedroom doors were open during the day (which was their choice); however, staff ensured they were closed when personal care was being provided. Staff knocked on people's door before entering their rooms and greeted them in a friendly manner. One person who spent the majority of time in bed, "I am comfortable, they (staff) come and check on me regularly. They are kind and attentive."

Staff approached people respectfully and spoke to them in a friendly tone, using their preferred name. At mealtimes when supporting individuals with their meals, staff sat with the person, made eye contact and chatted with them about what was for lunch. This made the mealtime more sociable. We saw interactions between staff and people were generally positive and there was friendly chat and good humour between them. The bingo session in the afternoon was well attended and with banter and laughter.

Relatives were free to visit at any time. The service had a family room, which relatives could use for overnight stays. There were facilities for making snacks and drinks. There was a 'children's corner' in the conservatory,

which contained a trunk full of toys and activities such as colouring books. The registered manager said this was to ensure visiting children were happy and could be occupied.

The service had received numerous thank you cards and compliments about the care and support being offered. Comments included "Thank you to all the staff for their care and kindness"; "Thank you for your wonderful care and attention. Our praise and thanks cannot be measured. As sad as we are, dad couldn't have received better treatment anywhere."; "Thank you for the kind, caring and dignified manner in which you card for (name of person), and for the compassion we were shown. You truly made her last days comfortable."

Requires Improvement

Is the service responsive?

Our findings

The service was not fully responsive to people's needs. This was because staff did not always have the right information or details to plan for personalised care for individuals. One person admitted to the service several weeks prior to this inspection, had a blank pre-admission assessment in their care file. The registered manager said this was because they had been an emergency admission. However an assessment had not been completed following admission. A copy of the local authority assessment had been shared with the service so they staff had some information available about their needs.

Care plans did not always contain up to date and detailed information about peoples' assessed needs and preferences. Three people's care plans had not been completed at all, even though they had lived at the service for several weeks. Without sufficient information to guide staff about people's needs, preferences and risk, people were placed at risk of receiving inappropriate and inconsistent care. We fed this back to the registered manager who despite having carried out audits on care plans was not aware that some people did not have any plans in place. She agreed to complete these as a matter of urgency. Two were completed by the end of the second day of the inspection and a third was being looked at.

Care plans were not person centred and did not reflect people's needs, preferences, interests, hobbies or past lives. This meant staff would have limited knowledge about people and events that were important to them, and would limit what staff could talk to people about. Reviews were being completed monthly but did not always reflect people's changing needs, such as weight loss. Another person had a special tube for nurses to provide extra nutrition into their stomach. Their plan did not include any details about how this should be kept clean. It was clear nurses had been doing this correctly, but a care plan to detail what regime of cleaning was being used would ensure a consistent approach.

One healthcare professional gave feedback that there had been confusion about how to identify who had been admitted with nursing needs. They said "A client of mine was admitted to Deer Park as a nursing client, which the nursing staff were not aware of, and when his catheter blocked called the community nurses in to change it for him. The management had not identified this client as a nursing client on admission. I understand that a system is now in place to identify which clients are nursing and which are residential." This showed there was not an effective pre-admission assessment in place and that staff were not aware of who was responsible for meeting some aspects of their care.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection the registered manager wrote to us to say she was covering nurse hours for two hours each afternoon to enable them to update care plans and ensure they were more personalised. This was being reviewed at the end of each day by the registered manager. They were suing some care plan prompts which had been developed by Devon County Council.

People told us they were not aware of their care records and hadn't been involved in their development to their knowledge. However, we saw that where people had capacity they had signed their care plan to indicate their involvement and consent. One person said "Yes, I have a care plan but no one has spoken to me about it since it was done."

People's individual choices were respected. For example people could choose what time they got up and where they spent their time. Some people preferred to spend all their time in their rooms and this was respected by staff. They delivered meals and snacks to people in their rooms as well as doing regular checks. We observed people being offered a choice of drinks and snacks throughout the day.

People were supported to participate in activities. An activities co coordinator worked Monday to Thursday. People had weekly activities programmes in their bedrooms and said they could join in if they chose to. One person said, "I like the bingo and singing. But we rarely go out. I would like to go out. I am longing for fish and chips!" Another person said, "There are lots going on. I enjoyed the quiz this week", "We go out in a mini bus once or twice a week"; "There are lots of activities most afternoons, yoga, arts and crafts, music where someone comes in and we sing"; "They also bring in a therapy dog and other animals"; "Some of the residents have their own pets there are cats and budgies."

Activities included games; quizzes, bingo; singing. On the first day of the inspection the activity co-ordinator had accompanied one person to a local air field. The person had been a pilot and at a previous visit to the air field they had been invited back to enjoy a flight with one of the pilots. The records for one person who stayed in their room showed they had limited access to activities or social interaction for stimulation and company. The activities coordinator said she had two mornings per week which she dedicated to spending time with people in their rooms. This might involve chatting, reading the newspaper, hand massages or whatever activity the person enjoyed. They explained as there were a large number of people, who spent the majority of their time in their rooms, they were not able to spend time with everyone each week.

The activities person spoke passionately about providing stimulating sessions for people. In addition to her sessions, they had an artist who visited monthly to do art therapy with people. There were regular paid entertainers including a flautist, singers and entertainers. There was also a driver who took people out and about once a week. This was usually to places of local interest and sometimes involved a picnic or ice cream. The service had invested in some specialist equipment for those who were unable to leave their room. This included a sensory suitcase which had fibre optic lights and other sensory equipment for people to touch, hear and experience. When the activities coordinator was not available, staff did not plan activities. On the morning they took one person out for their flying lesson for example, most people sat in the lounge without much occupation or stimulation. They were mostly looking sleepy, asleep or looking around. Two people were engaged in a conversation, but eight other people were disengaged.

In contrast the lunchtime meal was well catered for with staff supporting people either in the dining area of their rooms. Mealtimes were seen as important and people were not rushed. Staff chatted whilst they served and assisted people. The atmosphere was relaxed and calm.

Following feedback form this inspection the registered provider has advertised for another full time activities person and in the interim they were ensuring at least one care worker was positioned in the lounge areas to provide support and offer activities for people to engage in. The registered manager also said the night staff were assisting people to get up and dressed if it was their wish to get up early. In addition they had made some changes to the way breakfast was being delivered. The kitchen staff were delivering this which had also freed up a care worker to help get people up and provide support to those already up and in communal areas.

There were regular opportunities for people their families and friends to raise issues, concerns and compliments. This was through on-going discussions with them by staff and the registered manager and provider. People were made aware of the complaints system. There were also regular meetings held to enable people and their relatives to discuss their views and suggestions. The complaints log showed the registered manager had responded to people's concerns and where possible had provided a resolution. For example, one person was moved to another home and during that process some monies went missing. The registered manager acknowledged that her staff did not get anyone to sign for the money, but had now updated protocols around management of monies to ensure two staff signed where any monies were involved. The police have dealt with this issue.

People confirmed they knew how to make any concerns known. One person said "If I had a concern or complaint I would talk to the team leader." Another person said "If I had any concerns I would talk to nurse, her name is…" One relative said "I always find them very receptive to comments or concerns. They listen and they try to put things right. I would have no hesitation if I was concerned about any issue."

Requires Improvement

Is the service well-led?

Our findings

The service had a team of managers to help run and monitor the quality of provision. The registered manager had overall responsibility for the day to day running of the service. She was supported by a part time development manager whose job description included identifying and delivering training to new staff and revalidation of nursing staff and to provide group supervisions. There was also a part time compliance manager whose job description included recruitment, disciplinary processes and maintaining accurate records of staff management and development issues. The registered provider also had an office presence daily at the service to oversee the management team and support them in their roles.

The Provider Information Return (PIR) stated "Our new schedule of audits makes sure that no stone is left unturned in the monitoring and reviewing of the different areas of our service, e.g. accidents and incidents, complaints, medicine audits, health and safety checks, fire safety audits water temperature checks etc." However, on this inspection we found there was a lack of good governance and audits were not routinely picking up on issues which placed people at potential risk of harm.

The Provider Information Record (PIR) stated a monthly audit was completed by the registered manager to monitor Deprivation of Liberty Safeguards; Lasting Power of Attorney (LPA) responsibilities and best interest decisions. However we found the auditing system in place had not picked up on deficits in relation to the MCA.

The care plan audit had not identified care plans lacked personalised detail about people's histories and preferences or that some people had no care plan in place. Audits had not shown wound care plans and end of life plans lacked detail or any meaningful evaluation to ensure they were meeting people's needs in the right way. Medication audits had not picked up the disorganised treatment room or that medicine rounds were taking over two hours each morning. The registered manager and provider did say they were aware of issues round medicine management and were trying to address this with a reorganisation of staff and what duties each took on. The audits also failed to ensure the competencies of nurses were checked on a regular basis. For example despite managers roles and job descriptions including training and records, none had identified that nurses had not completed wound care training, which was fundamental to their role.

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

In contrast there were audits on the health and safety checks for fire, water temperatures and window restrictors. These were well maintained with clear records of action being taken to address any issues. For example when the water temperature was seen to be too hot, the plumber was called out to rectify this quickly. These checks were being managed by the head of housekeeping. We were assured that regular checks were made on bed rails and that the pressure reliving mattresses were set at the right setting, but we did not review the records relating to this.

People and staff said they had confidence in the management team. For example, one person said "You can talk to (registered manager), she listens and I see her when I want to. I also know the owner very well. It's all fairly friendly here…" Staff confirmed the management approach was open and inclusive. Comments included "We can go to the manager anytime. We get told we are doing a good job so we do feel valued." Another staff member said "I think the managers here do listen to us, we could do with more staff meetings." Staff meeting occurred around four times per year. Staff were paid to attend and those we spoke to said their views were listened to. Minutes showed staff were thanked for their hard work and areas for improvement had been discussed. Senior care staff and nurse meetings occurred once a month and included changes to people's needs and training and development.

The registered manager and provider used annual surveys and regular meetings for people and their families to discuss any changes or improvements to the service. The last survey completed in May 2017 showed people were either very satisfied or satisfied with all aspects of their care and support at Deer Park. Some people, staff and relatives had made suggestions for improvement. At a meeting for everyone, held on 16 May 2017, the results of the survey were discussed together with suggestions and actions taken. These included white boards as 'memory joggers' for menus in dining areas, fresh fruit being offered on some days at the afternoon refreshment round and communal toilets having more regular cleaning. All these suggestions had been actioned.

However, one healthcare professional said they did not have confidence in the management approach based on their experience of requesting information about people's needs. Another healthcare professional said "Although there have been positive changes. I'm unable to be confident that the concerns raised in relation to (name of person) care needs would have been addressed if it wasn't highlighted to the home to action."

The registered manager understood their role and responsibilities and had ensured CQC were kept informed of all accident and incidents. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example following a medicines error, disciplinary processes were used to investigate and take actions. Where one person had a number of falls, the GP had been called and asked to refer to a physiotherapist and also to review the person's medicines. There have been a number of pressure ulcers and we asked if this was audited. The registered manager said she did routinely check people's wounds and actions being taken, but did not formally record she had done this. Since the feedback form the first two days of inspection, they had updated their wound care plans to make it more explicit what observations had been done and actions taken to improve wounds.

The last inspection report was displayed in the main foyer of the service. However the website did not prominently display the rating, although there was a link to click which showed the rating and report from the last inspection. We have asked the provider to ensure ratings are always prominently displayed, such as the home care service which is within the same website. This has now been done so that the nursing home rating is displayed on the landing page of their website.

The ethos of the service was described on their website as "Clean, modern and spacious, yet welcoming and homely – Deer Park is a place you can call home." The service was purpose built and was found to be kept clean to a high standard. Some people did describe the place like home and visitors said they were made welcome. Staff felt their values and ethos lay in the care provided to people and in making the service as homely as possible.

In light of the findings of this inspection the management team have decided to voluntarily suspend any new placements to the service for a four to six week period. They want to spend some time consolidating

their training, care plans and other actions taken to mitigate risks we identified.

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 9 HSCA RA Regulations 2014 Person-centred care People were not protected against the risk of inconsistent care or person centred care. this was because some people had no care plan in place or they lacked detail in their social and emotional needs and wishes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not protected against the risks of unlawful decisions being made on their behalf. This was because where restrictive practise had been sued to protect people, their capacity to make this decision had not always been recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Where people required their nutrition to be delivered via a special tube as they were unable to maintain adequate nutrition with oral intake, records did show how they were being supported to take adequate fluids to maintain good health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not had updated training or their

competencies checked to ensure people received safe and effective care and treatment

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 People were not protected against the risks of unsafe medicine management, risk of choking, lack of wound care plans and management of risks associated with being in one position for long periods.

The enforcement action we took:

We have issued a warning notice in relation to the risks identified in not meeting regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems had failed to identify a number of serious risks such as lack of care plans, records and training.

The enforcement action we took:

We have issued a warning notice in relation to regulation 17