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?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 12 April 2016. We returned on 19 and 21 April 2016 as arranged with the unregistered manager to complete the inspection. At our last inspection in April 2014 we found the service was meeting the regulations of the Health and Social Care Act (2008) we inspected.

Deer Park Nursing Home is registered to provide accommodation for 56 people over the age of 18 years old who require nursing and personal care. At the time of our inspection there were 46 people living at the home.

There was no registered manager in place. However the new manager was currently in the process of registering. 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.

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.

Staff received a range of training to keep their skills up to date in order to support people appropriately. However, 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. There were effective staff recruitment and selection processes in place. Staffing arrangements were flexible in order to meet people's individual needs.

We heard staff referring to people who required their food prepared in a manner that supported them to not choke being referred to as 'feeds' as if this was their surname or name. This was not respectful. We raised our observations with the manager and provider. They told us they would raise this with staff and monitor the situation to ensure other unacceptable language had not become the norm. However, staff relationships with people were caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate. People said there were plenty and varied activities which they could engage with or not as they chose. The organisation's visions and values centred around the people they supported.

A number of methods were used to assess the quality and safety of the service people received. However, these methods had not picked up on the issues we identified as part of our inspection. For example, the correct application of the Mental Capacity Act (2005). We were assured by the manager their quality assurance processes would look more closely at the areas we identified for improvement.

People were safe and staff demonstrated a good understanding of what constituted abuse and how to

report if concerns were raised. Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were safely managed on people's behalf.

Care files were not personalised to reflect people's personal preferences. However, their views and suggestions were taken into account to improve the service. They were supported to maintain a balanced diet, which they enjoyed. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

End of life care was undertaken with compassion for the person and their family and with regard to the person's dignity.

Staff spoke positively about communication and how the manager worked well with them.

There were two breaches in regulation. You can see what action we took at the end 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?

Good

The service was safe.

People were safe and staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

People's risks were managed well to ensure their safety.

Staffing arrangements were flexible in order to meet people's individual needs.

There were effective recruitment and selection processes in place.

Medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not comply with the legal requirements to make sure people's rights were protected.

The service had a range of training in place but no systems to review staff training and support needs.

People's health needs were managed well through regular contact with community health professionals.

People were supported to maintain a balanced diet, which they enjoyed.

Is the service caring?

Requires Improvement

The service was not always caring.

We heard staff referring to people who required their food prepared in a manner that supported them to not choke being referred to as 'feeds' as if this was their surname or name. This was not respectful.

However, people said staff were caring and kind.

Staff relationships with people were caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

Staff provided compassionate end of life care.

Is the service responsive?

Good

The service was responsive.

Although records included some personal information, they were not always clear enough to demonstrate how staff could ensure a person centred approach.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance was not always effective. We were assured by the manager their quality assurance processes would look more closely at the areas we identified for improvement.

Staff spoke positively about communication and how the manager worked well with them.

People's views and suggestions were taken into account to improve the service.
The organisation's visions and values centred around the people they supported.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 12 April 2016. We returned on 19 and 21 April 2016 as arranged with the unregistered manager to complete the inspection.

The inspection team consisted of two adult social care inspectors.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR 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. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

Some people who used the service at Deer Park Nursing Home had a diagnosis of dementia and were unable to tell us about their experiences. To help us to understand their experiences we used our SOFI (Short Observational Framework for Inspection) tool. The SOFI tool allowed us to spend time watching what was going on in the service and helped us to record how people spent their time, the type of support they got and whether they had positive experiences.

We spoke with 12 people receiving a service, two relatives and 17 members of staff, which included the unregistered manager.

We reviewed seven people's care files, 10 staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. After our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from four professionals.

Good

Is the service safe?

Our findings

People felt safe and supported by staff. Comments included: "I feel safe living here"; "I have no concerns. If I did I would speak to the staff"; "I can always speak to staff if I am worried. They are lovely" and "I feel safe here and the staff are nice." A relative commented: "I can always go to the management team if I had any concerns."

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission. Staff records confirmed staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

The manager demonstrated an understanding of their safeguarding roles and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. There were clear policies for staff to follow. Staff confirmed they knew about the provider's safeguarding adults' policy and procedure and where to locate it if needed.

People's individual risks were identified and risk assessment reviews were carried out to keep people safe. For example, risk assessments for falls management, moving and handling, personal care, nutrition and skin integrity. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. These included providing the necessary equipment to increase a person's independence and ability to take informed risks.

People confirmed staffing arrangements met their needs. Comments included: "I think there are enough staff" and "If there were more staff they would be falling over each other." One person was wearing a call pendant around their neck. They said, "The staff come straight away." Staff confirmed that people's needs were met promptly and felt on the whole there were sufficient staffing numbers. A couple of staff felt more staff were needed in the mornings to help people with personal care. We fed this back to the provider who explained the staffing levels were based on the number of people currently living at the home. When numbers increased, staffing would increase accordingly to meet people's needs. We observed during our visit when people needed support or wanted to participate in particular activities, staff were promptly available and call bells were answered in a timely manner. Staff spent time with people, for example, chatting with people about subjects of interest.

The manager explained that during the daytime there were two qualified nurses and 10 to 12 care staff on duty. An activity coordinator worked Monday to Thursday so people could participate in a range of activities in and out of the home. In addition, there were members of the management team, kitchen, domestic and maintenance staff throughout the day who supported the nursing and care staff. At night there was one qualified nurse and four care staff on duty. We asked how unforeseen shortfalls in staffing arrangements due to sickness were managed. They explained that regular staff would fill in to cover the shortfall so

people's needs could be met by the staff members that understood them. If regular staff were not available, the service used agency staff from two specific agencies and care staff from their sister homecare service. In addition, the service had on-call arrangements for staff to contact if concerns were evident during their shift.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

People's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicine. The home received people's medicines from a local pharmacy on a monthly basis. When the home received the medicines from the pharmacy they had been checked in by a registered nurse and the amount of stock documented to ensure accuracy.

Medicines were kept safely in locked medicine cupboards. The cupboards were kept in an orderly way to reduce the possibility of mistakes happening.

Medicines were safely administered. Medicines recording records were appropriately signed by staff when administering a person's medicines. Certain additional checks had been put in place by the home to ensure that people received the correct type and dose of medicines. For example audits were carried out on a monthly basis.

The premises were adequately maintained and a maintenance programme was in place. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. However, we found the water temperature in one of the bathrooms too hot. We raised this with the management team. They immediately put an 'out of order' sign on the door and the maintenance person adjusted the temperature to ensure a safe temperature. This demonstrated that people were protected because the organisation took safety seriously and had appropriate procedures in place.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) (2005) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Ten people had Lasting Power of Attorneys for property and financial affairs and three also had Lasting Power of Attorneys for health and welfare. A Lasting Power of Attorney (LPA) is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if they are unable to at some time in the future. However, relatives were consenting to care and treatment on people's behalf without the necessary legal authority to do so. For example, consent to care plans when they only had LPA for property and financial affairs. For someone to make decision about care and treatment they need to be a LPA for health and welfare. Then they can make decisions about, for instance, where a person should live and medical care. This meant that consent was not being sought in line with the MCA. Some people had bed rails in place to keep them safe. There was no documented evidence of who consented to these being used. The manager had already recognised this as a problem on their appointment. They understood these needed to be done, however they said other issues had needed to be attended to as a priority. In addition, the information in one person's care file was contradictory in relation their mental capacity to make decisions. In one section it said they did not have capacity to make decisions, and in another that they had consented to their care plan. This could lead to inappropriate practice when supporting them to make day to day decisions.

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

However, other people's capacity to make decisions about their care and support were assessed on an on-going basis in line with the MCA. Where staff were concerned a person was making unwise decisions due to a possible lack of capacity, they had worked closely with other health and social care professionals. For example, a person's need to remain at Deer Park Nursing Home for their care and treatment

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visits we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted to spend their time. For example, sitting in the conservatory or spending time in their bedroom watching television.

Staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. For example, what actions they would take if they felt people were being deprived of their freedom to keep them safe. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. Appropriate DoLS applications had been made to

the local authority. Two people had recently been assessed and others were awaiting assessment.

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. Staff told us they had not received formal supervision or appraisals for some time. Records confirmed this. They informed us that it they had been receiving this support they would have been able to express an interest in undertaking a nationally recognised qualification in health and social care. The manager had identified this on their appointment and was in the process of commencing appraisals. However, staff did state that they felt well supported by the management team.

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

People thought the staff were well trained and competent in their jobs. Staff had completed an induction when they started work at the service, which included training. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. The induction formed part of a probationary period, so the organisation could assess staff competency and suitability to work for the service.

Care was taken to ensure staff were trained to a level to meet people's current and changing needs. Staff received a range of training, which enabled them to feel confident in meeting people's needs and recognising changes in people's health. They recognised that in order to support people appropriately, it was important for them to keep their skills up to date. Staff received training on subjects including, safeguarding vulnerable adults, the Mental Capacity Act (2005), moving and handling, equality and diversity and first aid. Some staff had also completed varying levels of recognised qualifications in health and social care. However, staff felt they would benefit from more hands on, face to face training to further develop their skills. Nursing staff kept clinically up to date through various courses and reading evidence based literature. For example, Royal College of Nursing articles.

Staff knew how to respond to specific health and social care needs. For example, recognising changes in a person's physical or mental health. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported with personal care. Staff felt people's care plans and risk assessments were useful in helping them to provide appropriate care and support on a consistent basis. For example, knowing how to support people with pressure care by ensuring they changed position regularly and applying prescribed creams to maintain their skin integrity.

People confirmed they were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, GP, community mental health professional and optician. The GP visited the home every Tuesday and Wednesday. The nurses would highlight in the diary who needed to be seen based on their observation of people's healthcare. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion.

People were supported to maintain a balanced diet. Their comments about the food included: "The food is very nice"; "I find the meals are very nice and sufficient. If you wanted more you could ask" and "The food is lovely." We found on the first day of our inspection that the mealtime experience did not lend itself to be a social occasion for people and there was a lack of condiments for people to use. We fed this back to the

manager. By the second day of our inspection, the mealtime experience had been improved, with table cloths, condiments and flowers on each of the tables. There was a weekly menu which took into account people's likes and dislikes. Alternatives were always available, such as jacket potatoes, curry and lasagne. One person didn't like the fish that was the main course. A care worker said "If you could have anything you like, what would you have? Is there anything at all that you fancy?" Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. Staff were observed to be skilled at assisting individuals with eating and encouraging others to eat. Staff recognised changes in people's nutritional intake with the need to consult with health professionals involved in people's care.

People had been assessed by the speech and language therapist team in the past. As a result, people were prescribed specific diets, such as food being pureed or thickened. Speech and language therapists work closely with people who have various levels of speech, language and communication problems, and with those who have swallowing, drinking or eating difficulties.

Requires Improvement

Is the service caring?

Our findings

We heard staff referring to people who required their food prepared in a manner that supported them to not choke being referred to as 'feeds' as if this was their surname or name. We heard, "We have an extra person to help us with the 'feed' time" and "Staff work as a buddy to help with the 'doubles'" (referring to those who needed more than one person to assist them with their care needs). On one occasion a member of staff was heard in the dining room, in front of people saying, "I am just going to take a feed." This was not respectful. In one care plan it also referred to 'she is a feed in bed but if sat at table she will pick up a spoon and manage.' We raised our observations with the manager and provider. They told us they would raise this with staff and monitor the situation to ensure other unacceptable language had not become the norm.

However, people felt cared for by staff. Comments included: "The staff are very pleasant"; "The staff are lovely"; "I am so happy here. The staff are lovely, so kind. I get the care I need and when I need it" and "The staff are very kind and good. I like it here, I am very happy here." Relatives commented: "I am happy with the care (relative) gets. Always looks comfortable" and "Absolutely excellent, excellent staff and care well done. Couldn't wish for my Mum to be anywhere else."

People felt they were treated with dignity and respect when being supported with daily living tasks. Comments included: "The staff treat me very well" and "The staff treat us with respect." Staff told us how they maintained people's privacy and dignity when assisting with personal care. For example, asking what support they required before providing care and explaining what needed to be done so the person knew what was happening.

Staff adopted a positive approach in the way they involved people and respected their independence. For example, encouraging people to do as much as possible in relation to their personal care. Comments included: "The staff encourage me to do as much for myself as possible" and "I am encouraged to be as independent as possible." Staff recognised how important it was for people to be in control of their lives to aid their well-being. For example, offering people choices about whether they have a bath or shower, what activities they wanted to do and what clothes they would like to wear.

Staff supported people in an empathic way. They demonstrated this empathy in their conversations with people they cared for and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, one person enjoyed staff talking to them about things of interest to them which provided them with reassurance. We saw a member of staff sitting with them talking about family members and particular events which they had enjoyed in the past, such as family weddings.

Staff relationships with people were caring and supportive. One person commented: "I can have banter with the carers, which I thoroughly enjoy." We observed staff working in partnership with people whilst supporting them with personal care and whilst transferring to other areas of the home. Staff spoke confidently about people's specific needs and how they liked to be supported. Staff were motivated and inspired to offer care that was kind and compassionate. For example, staff demonstrated how they were

observant to people's changing moods and responded appropriately. For example, when a person was feeling upset. They explained the importance of supporting them in a caring and calm manner by talking with them about things which interested them and made them happy. This showed that staff recognised effective communication to be an important way of supporting people, to aid their general well-being.

Staff spoke of the importance of empowering people to be involved in their day to day lives. They explained that it was important that people were at the heart of planning their care and support needs. People confirmed they were treated as individuals when care and support was being planned and reviewed. One person commented, "I am always involved in my care and feel in control of the support I receive."

People received end of life care with dignity and compassion. The service had recently secured 'beacon' status following undertaking the Gold Standards Framework (GSF) accreditation programme. The GSF provides a framework for a planned system of care in consultation with the person and their family. It promotes better coordination and collaboration between healthcare professionals. The tool helps to optimise out-of-hours' care and can prevent crises and inappropriate hospital admissions. A health professional commented: "I was thrilled to hear that they had been awarded GSF Beacon Status earlier this year, demonstrating the hard work and dedication shown by the staff at Deer Park; this is the highest status a care home can be awarded." They had created a family room at the home, with a sofa bed and kitchenette for relatives to stay in if someone was unwell.

Good

Is the service responsive?

Our findings

Staff adopted a strong and visible personalised approach in how they worked with people because they knew them well. People commented: "Staff make sure they get to know me"; "The staff know me very well" and "I am treated as an individual and feel staff provide a personalised service." However, care files lacked personalised information about people. For example, people's likes and dislikes. They did not include information about people's history, which would provide a timeline of significant events which had impacted on them, such as, their physical and mental health. However, the lack of personalised information in care files did not impact on the care and support people received. The manager recognised that care files needed to be more personalised and planned to delegate staff to develop people's life histories, including preferences, likes and dislikes.

However, care files identified the relevant people involved in people's care, such as their GP and mental health practitioner. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate. Relevant assessments were completed and up-to-date, from initial planning through to on-going reviews of care.

People were involved in making decisions about their care and treatment through their discussions with staff. One person commented: "I feel involved in my care and staff talk to me about my needs." Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. Care plans were broken down into separate sections, making it easier to find relevant information, for example, physical and mental health needs, personal care, communication, mobility, skin care and eating and drinking. Staff said they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health.

People said there were plenty and varied activities which they could engage with or not as they chose. Activities formed an important part of people's lives. The activity organiser worked 26 hours a week and provided a range of activities from a Monday to Thursday. Currently nothing was available from Friday to Sunday. A proposal was being discussed with the provider to increase the levels of activity. Activities included games, quizzes, bingo, outside entertainers, yoga, trips out etc. The activity organiser arranged a different programme each week focusing on meeting peoples' religious, cultural, emotional and physical needs. As well as larger group sessions, they held sessions with smaller groups of people or on a one to one basis. For example, cooking with one person, taking someone shopping for a house plant the following week. A 'sensory suitcase' had been purchased, with a range of fibro active lights, a projector and stones. They could use this individual people in their rooms which were proving popular.

For people who tended to remain in their rooms, they offered a one to one session and would record how much time each person had with them. One person really liked a certain style of music, and so they spent time together listening to both their favourite tracks. They had made up a CD for them. They carried out hand massages for those who wanted them. Over a month period each person would have had at least one session with them.

There was a minibus that eight people could use which enabled the service to offer weekly trips out. There was a support group for families. On the morning of the first day of the inspection a group of people were playing bingo. The activity organiser ensured that all the people in the lounge were able to join in. In the afternoon 11 people gathered to listen to a new entertainer, who was a fiddle player and singer. Everyone thoroughly enjoyed this. People's feet were tapping and some were joining in with the singing. The activity organiser again ensured that all people were involved, spending time with each person as the session progressed.

The activity organiser also facilitated a Family Liaison group for people who might not have anyone else they could talk to. This provided them with support. One of the meetings had a talk on living with dementia.

There were regular opportunities for people, and people that matter to them to raise issues, concerns and compliments. This was through on-going discussions with them by staff and members of the management team. People were made aware of the complaints system. One person commented: "I would speak to staff if I had any concerns." A relative commented: "I can always go to the management if I had any concerns." The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. Where a complaint had been made, there was evidence of it being dealt with in line with the complaints procedure. For example, a person's room decorated to make it feel more homely.

Requires Improvement

Is the service well-led?

Our findings

The previous manager deregistered with the Care Quality Commission (CQC) in January 2016. The newly appointed manager was currently in the process of registering with the CQC. They were supported by a core management team, which included the provider, a general manager and a development manager. The team worked closely together, undertaking individual specific roles. The provider also met with the manager every Monday morning to ensure they remained abreast of the service provided to people and to attend to any arising issues. The management team had developed an action plan which identified areas needing to be improved, such as staff supervisions, appraisals and training, specific audits and updated policies and procedures. The actions were rated according to risk and not by specific dates. Therefore it was difficult to ascertain when these actions would be completed by. However, we could see they had taken action to start appraisals and update specific policies and procedures.

Audits and checks were completed as part of monitoring the service provided. For example, the audits reviewed people's care plans and risk assessments, incidents and accidents and health and safety. This enabled any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. Where actions were needed, these had been followed up. For example, care plans reviewed or updated and maintenance jobs completed. However, the audits had not picked up on the issues around the correct application of the Mental Capacity Act (2005), care files lacking personalised information, the use of the terminology of certain words such as 'feeds' and 'doubles' and the water temperature being too hot in one of the bathrooms. Following our feedback we were assured by the manager their quality assurance processes would look more closely at the areas we identified for improvement.

Staff spoke positively about communication and how the manager worked well with them, encouraged team working and an open culture. Staff commented: "I have never been so happy. I have been here just over a year. The support is great and all the staff are flexible"; "We work as a team" and "You can always go to the management team about anything, however small."

Staff confirmed they had regular discussions with the management team. They were kept up to date with things affecting the service via team meetings and conversations with senior members of staff. Additional meetings took place on a regular basis as part of the home's handover system.

People's views and suggestions were taken into account to improve the service. For example, surveys had been completed by people using the service and relatives. The surveys asked specific questions about the standard of the service and the support it gave people. In response to the surveys, the manager followed up on any issues raised, such as improving how staff communicated with people. This demonstrated the organisation recognised the importance of gathering people's views to improve the quality and safety of the service and the care being provided.

The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of encouraging independence and people having a sense of worth and

value. Our inspection found that the organisation's philosophy was embedded in Deer Park Nursing Home through talking to people using the service and staff and looking at records.

The service had received several compliments. These included: 'We thank you for the excellent care and support you gave us in (relative) final weeks'; 'Words cannot convey all our thanks well enough. Dad was so happy here and you all played your part in that' and 'Thank you all for being such caring staff. I never had any worries or concerns that my Mum's care was in anything other than in good hands.'

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. People and staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP and mental health practitioner. Regular medical reviews took place to ensure people's current and changing needs were being met. Health and social care professional confirmed that the service worked well with them and took on board everything requested.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, changes to a person's care plan and risk assessment to reflect current circumstances. Actions had been taken in line with the service's policies and procedures. Where incidents had taken place, involvement of other health and social care professionals was requested to review people's plans of care and treatment. This demonstrated that the service was both responsive and proactive in dealing with incidents which affected people.
The manager explained they had carried out a time and motion exercise to look at the staffing arrangements. From the findings they had created a 'bed maker' post, which was an additional member of staff each morning to change and make beds. They also had created various 'equipment stations' throughout the home, which meant that care staff did not have to go searching around the home for hoists and slings. Staff said that these initiatives did help them save time.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There were not suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them. Regulation 11(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate supervision and appraisal in order for them to feel supported in their roles and to identify any future professional development opportunities. Regulation 18 (2) (a) (b)