Select Primecare Limited

Primecare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Primecare is a residential care home providing personal care to up to 41 people aged 65 and over. At the time of the inspection, 30 people were using the service.

People's experience of using this service and what we found
At the inspection we found the service did not have effective arrangements in place to identify and manage risks appropriately to support people to stay safe and protect them from harm. People at risk of falls did not always have the equipment they needed, and safety concerns were not always identified or acted upon. Individual care plans were in place, but these were not always reflective of people's needs and how risks should be managed. People were not being repositioned in line with their care plan.

Staff had access to Personal Protective Equipment (PPE) and were subject to regular testing to identify if they were symptomatic or had contracted COVID 19. However, we were not assured the provider was doing all that was practical to ensure COVID 19 outbreaks could be prevented. The service was not consistently following the government guidance, about how to operate safely during the COVID 19 pandemic, in areas such as the wearing of masks, handwashing and social distancing.

Safeguarding procedures were not fully understood and incidents escalated by the management team.

Staff told us there were sufficient staff to meet people's needs and they were supported by the management team. There was a lack of social activities taking place and the registered manager told us they were recruiting to this role. Relatives told us individual staff were helpful.

We found shortfalls in the way the service was led, and governance arrangements did not ensure the delivery of quality and safe care. Audits did not identify the shortfalls found as part of this inspection and there was no effective improvement plan in place to drive improvements and change.

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

Rating at last inspection
The last rating for this service was requires improvement (published 6 December 2019).
The service remains rated requires improvement. This is the second consecutive inspection where the service has been rated Requires Improvement.

Why we inspected
The inspection was prompted in part due to concerns received about areas of concern including medicines, the oversight of risk, staffing and the management of the service. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Primecare on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Primecare

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of three inspectors. Two inspectors carried out a site visit, whilst a third coordinated documents sent by the registered manager and spoke with staff and relatives.

Service and service type
Primecare is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

Prior to the inspection we asked the provider to give us details of staffing levels, quality assurance audits

and overview of all complaints received, and actions taken

During the inspection.
During the inspection we spoke with nine staff including the registered manager, deputy manager and area manager. We spoke to the relatives of five people. We reviewed a range of records. This included seven people's care records and ten medication records. We looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We held a teleconference call with the registered manager and area manager on 29 September 2020.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement, at this inspection we found this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be placed at risk of harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

• There was not always evidence available to demonstrate risks to people had been assessed, recorded and appropriately managed.
• One person had been identified as being at high risks of falls and being unsteady on their feet. Their care plan stated they had, 'an alarm mat by the bed to alert staff if they attempt to get out of bed'. We observed the person lying in bed but the sensor alarm mat was unplugged and located on the opposite side of the room. This would not alert staff to the person being out of bed and mobilising. This placed the person at potential risk of harm.
• We observed another person walking without socks and shoes carrying a fire extinguisher which had not been secured to the wall by a safety mechanism. Staff told us this was something they liked to do but took no further action and did not recognise the safety concerns. Both inspectors intervened and supported the person to part with the fire extinguisher. This placed the person and others at risk of potential harm of injury.

• In one person's daily records it was recorded they were very unhappy and spoke about the act of suicide. The care plan for emotional support was not sufficiently detailed, there was no evaluation of the risks or a clear plan in place to support this person. We asked the registered manager to escalate these concerns to ensure the person received the support they needed.
• We reviewed the systems in place to reduce the risks of people developing a pressure ulcer. Several people had been identified as being at high risk and as requiring regular repositioning of their body, but there were significant gaps in the repositioning records. We could not be assured people had their body repositioned in line with their care and support needs or to minimise the risks of developing a pressure ulcer.
We observed one person who had been identified as being at high risk of skin breakdown sitting on a sling during our inspection. We were told they had been assisted into the chair by night staff and we observed during the inspection they were not assisted to the toilet or offered personal care. This placed the person at increased risk of skin breakdown.

• People had a Personal Emergency Evacuation Plan (PEEP) to provide information about the assistance they would need to reach a place of safety during an emergency such as a fire.

Preventing and controlling infection
• The service was not following up-to-date government guidance advising care homes on how to operate safely during the COVID 19 pandemic. The provider was not doing all that was practical to ensure outbreaks of COVID 19 could be effectively prevented.
• The registered manager told us they had sufficient quantities of Personal Protective Equipment (PPE) and hand sanitiser. However, not all staff working in the service were wearing the type of face masks as set out in Public Health England's 'Personal Protective Equipment PPE- resource for care workers working in care home during sustained COVID 19 transmission in England' July 2020. Some staff were wearing reusable face masks rather than the surgical masks as recommended.
• We observed staff not wearing masks correctly, some did not cover peoples face (mouth and nose). One member of staff was wearing their mask inside out and repeatedly removed and touched the front of the mask and their face. The same member of staff was then observed to touch people without washing their hands or using hand sanitiser. These practices put staff and people at a higher level of risk of contracting and transmitting COVID-19.
• A relative expressed concern to us that they had observed staff not wearing masks correctly when supporting people, during a recent visit to the service.
• The environment was not being managed in a way which would prevent the spread of infection. People living on the first floor of the service were brought downstairs in the mornings into a large lounge. Chairs were placed side by side and we observed people sitting next to each other in close proximity and touching each other or others belongings. No consideration had been given to an alternative layout or the use of alternative space to better support people to socially distance at this time.
• Equipment was not for people's sole use or cleaned down between uses. We observed one person being transported in another person's wheelchair by a member of staff.
• The providers prevention and control policy was not up to date and risk assessments on infection control had not been undertaken in line with the guidance. Following the inspection, the registered manager contacted us and sent us updated documents which they were intending to implement.
• The laundry was clean but did not provide a clear separation for clean and soiled laundry which placed items at risk from contamination from harmful bacteria. We spoke to the registered manager about this on the day of the inspection and they subsequently informed us they had separated the areas to address these concerns.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that infection control was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection the provider did not have effective systems in place to manage medicines. Some improvements had been made at this inspection but there was still further work to do to ensure that the system was safe.
• Shortfalls in the recording of people's medicines created risks as important information was not always recorded.
• Medicine Administration Records (MAR) were in place but not always well maintained. We found unexplained gaps on the Medication Administration Record [MAR] charts for five out of 10 viewed, giving no indication of whether people had received their medicines or not, and if not, the reason why was not recorded. However, this was a records issue as the medication had been administered from the blister pack.

• Information was not always included on how people liked to take their medicines. It had been agreed by the GP that one person should receive their medicines in a covert way but there was no guidance to direct staff on how this should be given, for example, in specific food items or in a drink.
• PRN protocols were in place for some people to guide staff on when these medicines should be administered. However, some were missing, and some were out of date.
• Temperature monitoring where the service's medication was stored and kept for safekeeping was not always recorded in line with good practice guidance and improvements were required. However, records maintained showed the temperature was in line with recommended guidelines.
• We checked a sample of medicines, including controlled drugs against the administration records and saw that they tallied.
• Staff received training and their competency to administer medicines was checked at regular intervals.

Systems and processes to safeguard people from the risk of abuse
• There was a system in place to manage safeguarding concerns. However, some incidents were not recognised as safeguarding, therefore, the concerns were not escalated to the Local Authority for investigation or forwarded to the Care Quality Commission. We saw in one person's records that staff had recorded an incident between two people, but this had not been identified as a safeguarding incident and there was no clear plan in place to prevent this incident reoccurring. We asked the registered manager to make a referral to the safeguarding team and following the inspection they confirmed that they had done so.
• Staff demonstrated a good understanding of safeguarding procedures and told us they had received training and would report to senior managers if they had concerns about people's welfare.

Staffing and recruitment
• Staff told us there were sufficient numbers of staff to meet people's needs. Staff were visible and we observed caring interactions between people and staff. However, interactions by staff with people using the service were primarily centred around tasks and routines of the day, for example, supporting people with their comfort needs, providing drinks, assisting people to have their meal or to eat and drink
• No activities took place on the day of inspection. The registered manager told us the activity coordinator post was currently vacant but there were plans to recruit.
• Relatives told us there were lots of staff changes which meant that their relatives had to get used to new people supporting them. One person spoke positively about staff and said, "Staff do their best".
• Recruitment records were not viewed at this inspection. The registered manager had previously confirmed that all required checks were being undertaken in line with regulatory requirements . There were several new staff and one had commenced their induction on the day of inspection.

Learning lessons when things go wrong
• Learning from accidents and incidents was variable. We did not see that the service had been proactive in learning from previous events to help prevent a reoccurrence.
• There had been an incident earlier in the year where a resident had sustained a head injury following a fall and subsequently died. This had been investigated by the home, but the report lacked detail and we did not find evidence at this inspection that lessons had been learnt about the management of risks.
• Concerns had previously been raised about care planning and at the last inspection we were informed the service was moving to an electronic recording system. However, at this inspection we found continued shortfalls. The care plans were long, some over 100 pages but information was not easy to find and where people showed anxious or distressed behaviours the plans to guide staff were not detailed and did not provide guidance to staff as to the delivery of care and support to be provided.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had a monitoring system to check quality and safety. This was not effective and did not ensure high quality care was being consistently provided. They had not identified the issues found at this inspection.
- We looked at recent management audits and they demonstrated there were no concerns. They did not identify any issues with infection control, medicines or risk management.
- As part of the inspection we asked the registered manager to provide us with an action plan to identify the improvements they had identified and areas they were working on. However, the action plan provided was not sufficiently detailed.
- Regulatory requirements were not fully understood, and we were made aware that a safeguarding allegation had not been notified to CQC. The registered manager agreed to do this as soon as possible. Notifying CQC of these events is important so that we are kept informed and can check that appropriate action has been taken to safeguard people using the service.

The shortfalls were identified were a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- We received conflicting information about how open and transparent the service was. Complaints were not always viewed as a tool for learning and improvement.
- Prior to the inspection we had received concerns about how complaints had been dealt with. We asked the registered manager to provide us with assurances and saw where two relatives had raised concerns, they had subsequently been asked to consider removing their relative. We spoke to the provider about one of the concerns and they agreed to review the decision to give notice. There was confusion about whether another concern was a safeguarding or a complaint and we could not see that the person raising the issues had been kept up to date or had their wider concerns responded to.
- One relative told us, "The management are not good with dealing with gripes…I am reticent about challenging or making a complaint …My relative is very vulnerable and I don't want to be seen as a

troublemaker." Another said, "I am scared to say anything …. I don't want a backlash."
• On the day of the inspection we identified there were gaps in MAR charts and spoke to the registered manager about our concerns. We later observed senior staff completing the MAR charts retrospectively. No analysis had been undertaken as to which medicines were involved, whether they had been given or which staff member was on duty and the actions to be taken so that lessons could be learned.

The shortfalls were identified are a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• There was evidence the service worked with social care professionals such as the Local Authority, GPs and other healthcare colleagues. However, due to the COVID 19 restrictions, healthcare professionals were not routinely visiting the service to help reduce the infection risk but were providing remote support.
• We saw regular staff meetings were held, and these showed the registered manager spoke with staff about expectations and care delivery.
• Prior to the inspection we received concerns from staff about the culture of the service but the staff spoken with as part of this inspection told us the management team and work colleagues were supportive. One told us, "I love it here, the residents are lovely and the other staff I work with are nice."
• Questionnaires were sent to relatives at regular intervals to ascertain their views.
• The service has been facilitating socially distanced visits by a named relative to the garden so as to enable family members to see their loved one. The registered manager told us they had set up a Facebook group to enable relatives to keep up to date with what was happening at the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. We identified shortfalls in the management of risk and infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers system for monitoring quality and safety was not effective