Primrose Court Care Limited

Primrose Court Care Home

Inspection report

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Date of inspection visit:
12 August 2020

Date of publication:
15 October 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Primrose Court Care Home is a care home that was providing personal care to 15 older people and people living with a dementia at the time of the inspection. It can provide care for up to 20 people. The home is an adapted building, providing care over two floors.

People's experience of using this service and what we found
Risks to people were not actively managed and recommendations from health professionals were not consistently followed. The quality of record keeping needed to be improved and staff had not received up to date training. People and relatives were happy with the care provided. One relative said, "The home is smashing. The staff are smashing. I am happy with everything."

The overall quality of the home had deteriorated. There was a lack of effective management and oversight of the home. Checks to monitor the quality of the home had not led to improvements. Staff were committed to the home and said they felt part of a team who could rely on one another.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 June 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last four consecutive inspections. At this inspection, it has now been rated inadequate.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 8 May 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. In addition, we also followed up on concerns which we received in relation to the care of people living at the home, staffing and oversight of the home.

This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has

changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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

We have identified breaches in relation to the care which people receive and how the risk of harm is managed. We also identified breaches in how people are safeguarded from the risks of potential abuse; the competency of staff to deliver safe care and the procedures in place to oversee the home.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Primrose Court Care Home

Detailed findings

Background to this inspection

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

Inspection team
One inspector carried out this inspection.

Service and service type
Primrose court care home is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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
We gave a short period notice of the inspection. This supported the home and us to manage any potential risks associated with COVID-19.

What we did before 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service and six relatives about their experience of the care provided. We spoke with eight members of staff including the provider, registered manager, deputy manager, acting deputy manager, a senior care worker, two care workers and a cook.

We reviewed a range of records. This included four people's care records. We looked 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 looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

At our last two inspections of the home people were not protected against the risks associated with the cleanliness of the home as effective health checks were not in place. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● Equipment to manage the risks of infection was not consistently worn. There was no evidence of training completed to support the use of personal protective equipment (PPE). A risk assessment to support PPE and the current pandemic was not in place.
● Staff practices did not support infection control. For example, some staff did not have uniforms and there were no assurances clothes were changed before and after each shift or washed at the right temperature to manage the risks of infection. Practices such as nail polish, stoned rings and watches were not in-line with the home's infection control policy.
● Aspects of the environment did not support safe infection control measures. Furniture, doors and skirting were worn exposing bare wood. Flooring had come away from skirting in bathrooms. The material on chairs was worn exposing the inside fabric. This meant they could not be cleaned safely.

The risks associated with infection control were not safely managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● A safeguarding alert was not raised when needed because staff did not recognise the incident as a safeguarding concern. An incident record was not completed, and no review of the person's care records took place to manage any further risk of harm.
● The home said refresher training in moving and handling would take place as a measure to manage any further risk. This training did not take place.
● Staff did not follow their safeguarding training or the policy in place to manage this incident. There has been no review of this incident at management level to ensure lessons were learned.

There was a failure to manage the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Recommendations from health professionals were not followed. People who needed specialist diets in-line with their health needs did not receive them. We raised two safeguarding alerts about this. Staff did not have good knowledge about how the diets needed to be provided.

● Behaviours were not effectively managed. They were not consistently recorded or reported. Staff did not have training to manage people who displayed behaviours.

● Records to support the management of risk needed to be improved. Records were not in place to support key areas such as diabetes, hip protectors and behaviours. Reviews of risk were not adequate.

● Bedrooms required to be locked for safety were found open. These rooms contained materials and equipment which could cause potential harm to people. Two wardrobes were not secured to the wall. A baby-gate was in use at the top of the stairs despite no safety reason for this. A certificate to check equipment was safe to use had expired.

There was a failure to assess, manage and respond to risks of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives said they felt safe and received good care. They were extremely complimentary about the staff who supported them. Comments included, "The care is good. The staff are really good. I don't have any concerns about [person's] care," and, "They [staff] ring me straight away if there is a problem. The girls [staff] are really good. They are so caring with [person].

Staffing and recruitment

● There were not enough suitability skilled, competent and experienced staff on duty. This had led to gaps in people's care, such as not following recommendations from health professionals and failure to have complete and accurate records in place. Policies had not been implemented correctly and training was not up to date.

This failure to have the right staff on duty to meet people's needs safely increased the risk of potential harm to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives said there were enough staff on duty and call bells were answered quickly. They were complimentary about staff who worked at the home. Comments included, "I'm absolutely happy with the care. The staff spend time with them [people] and that's what's important to me," and, "Staff are very good. They are very friendly and very chatty. [Person] has a buzzer and the staff responded straight away when I've been there."

Using medicines safely

● Records to support medicines needed to be improved. Protocols for dispensing 'when required' medicines for behaviours did not accurately link in with care plans for behaviours. Records associated with these medicines had not been regularly reviewed and were not in-line with the medicines policy.

● A medicine record for one person did not match the prescription. Medicine records were not consistently completed in-line with the guidance on the records.

● No quality checks of medicines had been completed. Training to dispense medicines safely was arranged following feedback.

The risks associated with medicines were not managed because some records were not accurate. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The right action was not taken when accidents and incidents occurred. Analysis of accidents was limited. No analysis of incidents took place. This limited the capacity to effectively manage the risks to people.

● There was no evidence that lessons had been learned since the last inspection. The risk of harm to people had increased. The provider has not taken action to ensure people received safe care.

These concerns demonstrate a lack of effective systems to ensure the safety of people using the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last two inspections of the home the provider did not have effective systems in place to monitor the quality of the service. This was a breach of Regulation 17 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 17.

- Quality assurance procedures were not effective. Where completed, they had not identified areas for improvement. Systems for storing and retrieving paper-based information was limited.
- Staff did not have access to adequate IT resources to share required information with professional organisations and to arrange and manage Covid-19 testing. There was a delay in staff receiving information due a lack of IT systems.
- Prior to this inspection, the home had been rated requires improvement on four consecutive occasions. The home has been in breach of Health and Social Care Act regulations since 2015.
- Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification.' There was a delay in notifying the Commission of a safeguarding incident. We also identified similar concerns at the previous inspection.

This failure to effectively monitor and improve the quality of the service and make required notifications was a continuing breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Leaders did not have the right skills, knowledge and experience to deliver safe care to people. Staff at all levels lacked understanding of risk.
- There was a significant lack of oversight of the home during Covid-19. The staff member overseeing the management of the home during this time was not provided with the right training and resources to carry out the day-to-day management of the home.
- Staff worked together and were supportive of each other. One staff said, "This is the best home I've worked

in. It's like visiting your family. Work colleagues are fantastic and are very supportive of each other. The residents are just like family." One person said, "It's a nice home, you couldn't get a better one. I am quite happy here; the carers are smashing. The owner is lovely."

Failure to effectively lead and support people to receive care had led to a breach of Regulation 17 of the Health and Social Care Act (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

● Action plans were not developed when the home received feedback from health and social care professionals. It was difficult to establish how the home had actioned feedback.
● Information required to be shared with professionals to manage the risks of Covid-19 had not been regularly shared.
● Staff struggled to access equipment to manage the risks of infection. Contact details and important information relating to Covid-19 shared by the local authority to the registered manager had not been shared with the provider and acting deputy manager.
● Feedback from relatives via meetings and surveys was limited. However, feedback was extremely positive. People said they felt able to speak up about any concerns and were confident staff would listen to them.

This failure to have effective systems in place to support the development of the home has led to a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 (1) People did not receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment (1) People were not safeguarded from the risks of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) & (2) There were insufficient suitably trained staff on duty to provide the right care and support to people.

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 17 HSCA RA Regulations 2014 Good governance (1) The lack of oversight, leadership and governance of the home had led to unsafe practices.

The enforcement action we took:

We issued a warning notice.