# Stonehaven (Healthcare) Ltd

# Primrose House

## Inspection report

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Date of inspection visit:
10 October 2017
11 October 2017
17 October 2017

Date of publication:
22 December 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 10, 11, and 17 October 2017. The first day of inspection was unannounced. This was the second comprehensive inspection of this service since it registered in October 2016. The previous inspection was completed in December 2016, following a number of concerns raised about the quality of care and support being provided. The previous inspection rated this service as overall requires improvement and found a number of breaches of regulation. These included Regulation 12- safe care and treatment. Improvements were needed in relation to medicines management, risk assessments and monitoring for pressure damage and poor nutrition and hydration. We also found people's rights were not always being fully protected. This was because the service had not always applied the principles of the Mental Capacity Act 2005 to ensure people's capacity had been fully assessed. Where people lacked capacity the service had not considered Deprivation of Liberty Safeguards or best interest decisions. We also found care planning was not person centred and their quality assurance systems had failed to ensure the service was safe and providing quality outcomes for people. We met with the provider to discuss the outcome of the December 2016 inspection. We also received an action plan about how they intended to make the necessary improvements to ensure they met the breaches we had identified.

Primrose house is registered to provide care and support without nursing for up to 30 older people. At the time of the inspection there were 15 people living at the service.

Primrose House is a purpose built service which sits alongside another home run by the same provider. Primrose House and the sister service Donnington House are run by the same registered manager. 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. The home also had a deputy manager who was fully involved in all aspects of the home.

During this inspection completed in October 2017, we found there had been some improvements. In particular to the way medicines and topical creams were being managed. We found risk assessments were being considered and documented, although records showed that where concerns had been identified such as weight loss, the care plan had not been updated to reflect the actions taken to mitigate this risk. We found some improvements with care plans, but some still lacked relevant details to enable staff to provide safe and effective care.

We saw staffing levels had been variable and at times lower than the providers preferred numbers. This had placed people at risk. For example on the weekend prior to the inspection there had only been three staff on duty and two people went missing within the building for a period of time. Both were vulnerable and should not have been left unsupervised.

The introduction of an activities staff member had impacted to some degree, but not enough, to demonstrate people's social needs and stimulation were being met. We saw long periods where people

were disengaged. At lunch time we observed a twenty minute period where vulnerable people had been left unattended. This was due to one person suddenly becoming unwell. However, staff from another area should have been alerted to cover the lunch period where people could have been at possible risk of choking.

People and relatives were complimentary about the care and support they received for. Comments included "The staff are really caring and cannot do enough for Mum." and "If I ask one of the staff for help with anything they are always more than willing to stop what they are doing and make sure I get what I need." We observed staff interacting with people in a kind, respectful and compassionate way.

The environment was kept clean and homely, although we fed back that there appeared to be a lot of information for staff pinned up in people's lounge areas. This was removed once we gave feedback.

There was a good choice of meals and snacks being offered throughout the day. People said they enjoyed the food and were offered a variety. Comments included "The food and the choice is excellent." and "My special dietary needs are catered for and I'm putting weight back on gradually now I'm here."

Staff knew how to report any suspicions of abuse or concerns and were confident they would be dealt with. Staff recruitment ensured only staff who were suitable to work with vulnerable people were employed. There had been a number of staff leaving and new staff being recruited. This had affected staff morale. Staff said they were often asked to assist with care and support in their sister home next door, but when they were short this arrangement did not appear to be reciprocal. We fed this back to the management team. Having to cover for shortages at the sister home had further impacted on staff shortages at Primrose House.

Staff recruitment was robust and ensured staff were only employed once all the relevant checks were completed to ensure they were suitable to work with vulnerable people.

Some improvements had been made to quality audits but further improvements were still needed.

We found four breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

Since this inspection was completed we have received a number of concerns about low staffing numbers. We have liaised with the provider who had assured us the staffing levels were being maintained at a safe levels. However a diarrhoea and sickness bug had meant that on some days, despite their best efforts staffing levels had fallen below the provider assessed and preferred levels. They have recruited more care staff, used agency workers and said they would not admit any new people into the service until mid-January once new staff had completed their induction.

## 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.

There had not always been sufficient staff to meet the needs of people safely.

Staff knew about their responsibilities to safeguard people and to report
suspected abuse.

Robust recruitment procedures were followed to ensure appropriate staff were recruited to work with vulnerable people.

People received their medicines on time and in a safe way.

### Is the service effective?

**Good**

The service was effective.

Healthcare needs were being monitored but this was not always well documented.

People were cared for by staff had regular training and received support with practice through supervision and appraisals.

People's consent to care and treatment was sought. Staff used the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and understood how these applied to their practice.

People were supported to eat a well-balanced diet and they had access to health professionals to help sure they kept as healthy as possible.

### Is the service caring?

**Good**

The service was caring.

People received care from staff who developed positive, caring and compassionate relationships with them.

Staff protected people's privacy and dignity and supported them

sensitively with their personal care needs.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care and support was not always well planned or records updated.

Activities were not always planned or tailored to individuals' needs and wishes.

People or their relatives concerns and complaints were dealt with and people were confident to make any concerns known.

## Is the service well-led?

**Requires Improvement**

The service was not always well led

Systems were in place to ensure the records; training, environment and equipment were all monitored on a regular basis, but these had not picked up on some key areas of improvements needed.

Staff morale appeared low and staff turnover was high.

Incidents which should have been reported to CQC had not always been notified.

# Primrose House

**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 10, 11 and 17 October 2017. The first day was unannounced. The inspection team included an adult social care inspector, pharmacist inspector and an expert by experience. An expert by experience is someone who has had direct experience or their relative had used registered services such as care homes.

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 and spoke in detail to eight. 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 eight 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 four relatives who were visiting the service.

We spoke with eight care staff, the registered manager, two deputy managers, one housekeeping staff, handyman and the cook.

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

We looked at all the information available to us prior to the inspection visits. This 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 one.

Requires Improvement

# Is the service safe?

## Our findings

When we inspected in December 2016, we found risks had not been fully assessed or monitored. We also found improvements were needed in relation to the way people's topical creams were being managed and monitored. We issued a requirement in relation to these areas. The provider sent us an action plan stating how they intended to make improvements and meet the breach. We found at this most recent inspection the improvements had been achieved and risks and management of topical creams were being fully assessed, recorded and monitored.

People said they felt safe. One person said for example, "I feel very safe and supported here, which I would not do if I left Primrose House. "One relative said "The family feel the home provides a safe environment for our elderly relative."

Staffing levels had fallen below the provider's own preferred staffing which had placed people at risk at times. For example on the weekend prior to the inspection there had been three care staff available during most of the day. Two vulnerable people who required constant supervision for their own wellbeing and safety went missing within the building. They were found on the top floor which is not currently being used. Staff confirmed that despite the use of agency staff they had been short on at least two to three shifts each week over the last several weeks. Several staff members said they were also required to help out when their sister home next door was short staffed. For example the sister home Donnington House currently had a shortage of senior staff who were able to complete medicines administration to people. This meant on some days the senior care staff member from Primrose House would have to spend several hours in Donnington to administer medicines. The deputy manager said a support worker from Donnington should swap with the senior worker so the staffing levels remained the same. However this had not been happening.

The registered manager and deputy manager explained that they had some gaps in the numbers of care staff needed to cover shifts. They said they had been using agency workers to cover where there were known gaps. They explained the situation had been exacerbated by some staff leaving and some staff sickness. They said this was being addressed via an active recruitment drive to employ more care staff. The registered manager said their aim was to have five care staff on each shift with two waking night staff. They also said that as new people came to live at the service, staffing levels would be kept under review. This would help to ensure that any increased need was reflected in the staffing numbers needed. The registered manager said they used a tool to determine individuals' needs with number of care hours needed. She acknowledged there had been occasions when they had been short staffed.

At lunch on the first day of the inspection we observed vulnerable people being left unassisted for a twenty minute period. When a staff member came into the dining area, they explained that someone had suddenly become very unwell and needed to be taken to their room to await emergency services. We fed this back to the management team, they said the staff should have alerted them and the rest of the care team to the fact they needed extra help to supervise the lunch as there had been a medical emergency. The staff member felt they were unable to leave the person and there was no other quick way of summoning additional help

due to the layout of the building. . At lunch time we observed a twenty minute period where vulnerable people had been left unattended. This was due to one person suddenly becoming unwell. However, staff from another area should have been alerted to cover the lunch period where people could have been at possible risk of choking.

We receieved information of concern about the staffing levels at the home. This had impacted on the care people received. The provider explained that some staff had gone off sick due to a diarrhoea and vomiting outbreak. Agency staff had been used, but there were occasions where there were staff working who did not know people very well, and there were not enough permanent staff. We kept in contact with the provider during this period to ensure that there were enough staff on duty. We also alerted the commissioners and safeguarding team about the staffing concerns.

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

Since the inspection new staff have been recruited and about to start working at the home. Staffing levels are more stable. The provider said they would look into walkie-talkies to help staff have quicker and more immediate support for during a crisis.

There had been some improvements to the way medicines were managed since our previous inspection. New systems had been introduced for recording the administration of creams and other external preparations. These records included clear guidance for staff as to how and where these preparations should be used. Staff signed record sheets when creams had been applied. Staff now completed weekly and monthly medicines audits. We saw audits had identified some issues and actions had been taken to prevent them happening again. Since our inspection, the deputy manager has sent us a copy of this investigation, and we are satisfied that this discrepancy was due to inconsistent recording. Actions have been taken which should prevent this from happening again.

We checked 13 people's current medicine administration record (MAR) charts. These charts were completed when people were given their medicines or reasons had been recorded if a dose had been omitted. Records of medicines received into the home were recorded onto these charts, and separate records were kept of medicines sent for destruction. However we found one person's records where the number of doses recorded as being received did not match with the number of doses that had been signed as given before supplies were recorded as running out. The provider told us that they would investigate this through their incident reporting process, in order to find out what had happened and take any necessary action.

Medicines were stored securely. The temperature ranges where medicines were stored in the home were monitored and recorded daily. The service was aware that the main storage room was frequently too warm for storing medicines and were making arrangements to move to a new storage area where more ventilation could be available. In the meantime medicines had been moved to a cooling cabinet to make sure they were stored at correct temperatures, so that they would be safe and effective for people. However we found that one medicine requiring refrigeration had been stored for over 2 days in the cooling cabinet by mistake. When this was discovered the medicine had been moved to the fridge. However no action had been taken to check that it was still safe to use. The medicine was no longer being used at the time of our inspection, but the provider told us that they would check it would be safe with the supplying pharmacy if further doses were needed.

We observed some medicines being given at lunchtime, and we saw that these were given safely. People were asked if they needed medicines that were prescribed 'when necessary' and there were also protocols

kept with people's medicines to record how and why these medicines should be given. There were no people looking after their own medicines, however systems were in place so that they would be able to do this if it was safe for them. Staff had received recent updated training in medicines administration and further e-learning was being arranged. A system of annual competency checks had been introduced and we saw examples of these checks having taken place.

People were protected from risks because risk assessments had been developed and reviewed. Where risks had been identified, measures were put in place to reduce those risks. For example, where someone was at risk of developing pressure damage, equipment had been purchased and if needed turning charts used. These instructed staff as to when the person would need support to help move position so that their risk of developing pressure damage was reduced. Where people were at risk of falls, records showed what equipment they needed to mobilise safely. We observed staff reminding people to use their walking aids. Where people were at risk due to poor eye sight or deteriorating health, staff were reminded to ensure the environment was clutter free and safe for people. Risk assessments were also used, for example; with the use of bedrails to keep people safe and moving and handling. Staff said they were aware of the risk assessments, but these were not always accessible to them. The electronic system only worked intermittently in some areas of the home and the care files were kept in the main office at the front of the service, so not easy accessible to staff on the ground floor of the building. The deputy manager had been contacting their internet server to try to get this resolved. She agreed short care plan summaries should be made easily accessible on each floor. This would make it easier to staff to access relevant information when the electronic records were not available.

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.

Staff understood what abuse was and what concerns they should pass on. Some were less aware of who outside their own organisation they would report concerns to. However they said they would be able to find out as there was a policy on safeguarding. There had been no new safeguarding alerts made since the last inspection.

The home was clean and fresh smelling. We observed staff using protective clothing and gloves to help prevent the spread of any infections. Staff said there was a plentiful supply of gloves and aprons and they received training in infection control.

Good

# Is the service effective?

## Our findings

When we inspected in December 2016, we found people's rights weren't being fully protected. This was because staff were not aware of whether people had deprivation of liberty safeguards in place. The provider sent us an action plan about how they intended to meet the breach of Regulation 11.

At this most recent inspection, we found improvements had been made. There was clear documentation when best interest decisions had been made and staff had a list of who had DoLs authorisations had been applied for or granted.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions of authorisations to deprive a person of their liberty were being met. Some people had such safeguards in place.  Most people had applications pending. Some staff were not aware who may be subject to such safeguards, but did understand the principles of why they were needed to protect people's rights. However, staff had been provided with a list at handover of who was subject to a DoLS. We observed staff offering people choices and gaining consent before care and support was delivered. For example, making sure people were being offered a choice about what meals, drinks and snacks they would like. We observed one person being assisted to move safely using specialist equipment. Staff talked to them about what they were doing and gained consent before moving them.

People and their families were confident in the ability of staff members to meet their everyday health needs. They also felt that they could talk to staff members to arrange contact with relevant health care professionals if they felt their health needs required this. For example one person said "I had an operation on my knee recently and when it was painful the staff arranged a GP visit. A visiting relative said "The family can ask for our mother to see a doctor and the staff arrange it straight away."

Staff confirmed they received training and support to do their job effectively. Training included updating skills in all aspects of health and safety as well as more specialised areas such as pressure care, dementia, diabetes and end of life care. The deputy manager said they had been making use of the local nurse educators from the care homes team who provide free education, training and support. They were also using some of their documents to help identify people's health care needs and fall risks. Several staff said they had not always received one to one supervisions but were aware more had been planned. One staff member said "I can't remember when my last supervision was but if I have any issues I just go to the office and speak to the manager or deputy." Supervision records showed sessions were planned and these were at

regular intervals.

Staff who were new were expected to complete an induction process which included three shadow shifts with more experienced staff. Staff new to care were expected to complete a nationally recognised induction called the Care Certificate. This helped to ensure new staff understood the key elements of delivering safe, effective and compassionate care. One newer member of staff said they were still in the process of completing their Care Certificate and hoped to go on to do a diploma in care.

People benefitted from being offered a variety of meals to suit their tastes and promote their health and well-being. There was a choice of at least two options for lunch and people chose this the day before. If there was nothing they liked on the menu choices it was possible for people to ask for something else to be provided. People were encouraged to do this. People using the service, and their family members, were very happy with the food provided. They said it was plentiful, nutritious and appetizing and they reported that they enjoyed mealtimes. They were able to take meals in their rooms or in a lounge chair using a tray table, but most people chose to eat together at dining tables. Snacks were available throughout the day.

Special dietary needs were catered for, and typical quotes from people living at Primrose House were: "The food and the choice is excellent." and "My special dietary needs are catered for and I'm putting weight back on gradually now I'm here."

People's weights were monitored as part of their well-being checks. Where people were at risk of poor hydration and nutritional intake, food and fluid charts were kept. The kitchen staff were aware of how to fortify foods to increase calories and ensured people had additional snacks and high calorie drinks where they were needed.

Primrose house is a purpose built care home designed to provide a safe environment for older frail people with dementia needs. As such the building had been designed to ensure corridors were wide enough to allow people with mobility difficulties and walking aids to easily move around. The décor had been designed to be dementia friendly with muted colours. These were chosen in consultation with Sterling university. There was also clear signage with pictures to help people orientate and find communal lounges and bathroom facilities.

Good

# Is the service caring?

## Our findings

People and their families felt staff were kind and caring towards them. Comments included "They (staff) are all lovely" and "I have no complaints, staff very good, very attentive." Relatives also commented on the caring approach of staff. One said "The staff are really caring and cannot do enough for Mum." Another said "If I ask one of the staff for help with anything they are always more than willing to stop what they are doing and make sure I get what I need." One relative said things were not always perfect but they felt listened to, For example they said "Soon after my mother came here I visited her and I saw another resident wearing Mum's t-shirt. I was upset and spoke to a staff member who explained that the other resident sometimes picked up other people's things. The shirt was washed and returned to Mum's room and there have been no further incidents."

People were able to have visitors at any time and family and friends were made welcome. One confirmed they were always offered a drink and another said they had been asked if they would like a meal with their relative. People could see their visitors in the privacy of their own room or in communal lounges.

People's dignity and privacy was respected. We saw examples of how this worked in action. Staff made sure one person was quickly assisted when they had needed to use the bathroom in an emergency. Staff were attentive in ensuring people had clothes protectors at lunch to keep their clothes clean if they wished. People were assisted after lunch to clean their hands and face if help was needed. We observed people being well dressed and groomed and it was clear staff saw this as important. A few relatives raised the issue of people not always being in their own clothes. The staff said this was sometimes a combination of clothes not being labelled and people wandering into rooms and taking items occasionally.

People and staff interacted well and there was lots of chat and laughter with people sharing a joke. Staff treated people in a kind and supportive way. Staff supported one person to remain calm when they became distressed and agitated, as their dementia meant they were not oriented to time and place. People were supported to personalise their rooms with photos, pictures and knick knacks. Most bedroom doors had either a photo of the person or a picture of something that was significant to them. This was to enable people to remember where their bedroom was. People said they liked their bedrooms and could spend time there if they wished.  Staff promoted people's choice in everyday decisions such as what they wished to wear, what drinks and snacks they would like.

Requires Improvement

# Is the service responsive?

## Our findings

When we inspected this service in December 2016, we found improvements were needed in the way care and support was being planned and in how care plans were being written as they were not personalised enough. We gave the service a requirement notice in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan showing how they intended to meet this requirement.

At this inspection we found there had been some improvements in the way care and support was being planned. For example, new people were only admitted once a full assessment of their needs had been completed. This helped the staff plan for their care needs and provide them with details about how this should happen.

However some care plans still lacked enough detail to ensure staff knew how to provide person-centred care. For example where people had prescribed 'when necessary' (PRN) medicines, there were also protocols kept with people's medicines to record how and why these medicines should be given. However this guidance was not always detailed or specific for the person concerned. We could therefore not be assured that all staff would be consistent in when they used PRN medicines.

One person had lost significant weight and their daily notes had recorded this and what staff had done to ensure they were being offered additional snacks. It was also recorded that staff had referred the person to their GP. However the person's care plan had not been reviewed and changed in light of this increased risk.

Another care plan had no medical history to help inform staff about any conditions the person had. When talking with staff, they were aware this person was living with dementia. However there were lots of new staff joining the team and the use of agency filling gaps so having all care plan details completed was important.

Improvements had been made in respect of planned activities for people. A member of staff who organised activities was working more hours than when we previously inspected, but continued to work across both Primrose House and Donnington. This meant that on some days and periods of time, care staff were expected to ensure activities and meaningful engagement occurred. This had been difficult for care staff as they had been short staffed. One said "We always make sure people have their care needs met, we do this really well, even when we are short staffed, but we are run off our feet and can't always then have the time to provide one to one time to people. I would love to be able to sit and chat, read a newspaper to someone but I am usually running around making sure people are cared for."

The issues identified above were a continued breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

The provider information return showed there were some external activities and some thought given to meeting people's spiritual needs. It stated "We have Pat dog visits every Thursday, we have a knit and natter group coming in once a month, holy communion and church services. External activities such as singers, we

have quizzes and bingo. Hair dresser and chiropodist visit regularly." One person said "The staff help me with getting to my church regularly and my daughter and son-in-law are able to take me to church most weeks."

Staff said they had some difficulty accessing the electronic records in some part so the home. The paper copies were kept in the upstairs office. This meant some staff had difficulty in accessing the right up to date information about people. The deputy manager said they had been trying to resolve the computer issues with their computer provider and hoped this would be resolved soon. They said they could provide short pen pictures and shorter care plan information to be kept in the lounges for staff to easily access.

One relative said they had been actively involved in the development of their family members care and support. They said "Our family have been consulted in the planning of care and support for our mum, which is really helpful and appreciated." They and another family member said the staff were responsive to people's needs. One relative said they had moved their family member from a nursing home to Primrose house and could not fault the care.

People's views were sought in a variety of ways, including having regular 'residents and relatives meetings'. People said they attended these and talked about aspects of the service. People felt their views were listened to. No one we spoke with could think of an example of anywhere they had raised a concern or issue, but all said they were confident their views would be listened to.

The service had a complaints process with written details of who people could make their concerns and complaints known to. The provider information return stated there had been five complaints in the last 12 months. It was difficult to work out which complaints related to Primrose house as the registered manager had one file with complaints for the two services she was registered for.

It is recommended that a separate complaints and compliments folder is held for each service so trends and results of complaints can be easily seen for the individual service.

Requires Improvement

# Is the service well-led?

## Our findings

When we inspected this service in December 2016, we found improvements were needed in the way the provider and registered manager ensured the home's quality assurance systems were fully effective. This was because we had found improvements were needed to ensure audits and other quality assurance tools were used to help drive up improvement. We issued a requirement in relation to Regulation 17 - good governance. The provider sent us an action plan about how they intended to meet this requirement. At this inspection we found some improvements had been made. For example the provider was visiting the service more regularly. They had employed a quality care services manager who also completed audits and checks on the service. These checks included auditing the environment, medicines and care plan records.

However we found there were further improvements were needed. For example the internal audits had not picked up that some elements were missing from care plan information. One of the deputy managers said they were not aware of why staff shortages had not been addressed by asking for staff from their sister home to help cover when there had been short notice sickness. They were aware that senior staff were asked to help with medicines in their sister home, but were not aware that this staff member had not been replaced by someone from the sister home. This lack of communication between the senior care staff and management team meant that deployment of staff had not been fully considered to keep people safe.

We therefore judged there was a continued breach in Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

The registered manager understood their role and responsibilities and had ensured CQC were kept informed of most accident and incidents. However, when we reviewed accidents and incidents we found one which should have been reported to both CQC and the local safeguarding team.

This is a breach of Regulation 18 of the Health and Social Care Act 2009 Registration Regulations 2009.

Staff said they could talk to the registered manager and deputy but did not always feel actions were being taken. For example, in being short staffed and still having to cover the shortages at their sister home. Staff morale was low and staff reported some staff had left due to having to work additional shifts. We fed this back to the registered manager and provider. They said there had been an active plan to recruit more staff and were now almost at capacity for care staff, but some were still waiting checks and references before they could start. The provider acknowledged that staff morale was low and had come in to give staff the opportunity to meet with them and talk about their concerns and the future plans for Primrose House.

The registered manager was covering two services which had impacted on their time. They had appointed another deputy manager to help with some of the management tasks but due to being short staffed this person was frequently supporting care staff with day to day caring tasks.

The service maintained links with the local community. They ensured people remained part of their

community with regular visits to the seafront and local shops when weather permitted. They had also got one of the local church groups to have their regular meeting at the service so people could be included in the chat and knitting group.

The registered manager and provider understood their responsibilities in respect of duty of candour. Where they had reviewed incident reports or complaints and concluded the service could have done things differently, they acknowledged this. For example where one person's family had made a formal complaint, the provider and registered manager was carrying out an investigation.

The rating from the last inspection report was prominently displayed in the front entrance of the service and on the provider website.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The service had not always notified us of incidents which should have been reported |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care plans were not person centred and arrangements for activities did not take into account people's interests and wishes. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and audits had failed to pick up the care plans did not always reflect peoples needs and there was no system for ensuring staffing being shared across both services was equitable and this had placed people at potential risk. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing levels had not always been sufficient to keep people safe. |