Mrs C A Nurse

Primrose House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 May 2018 and was unannounced.

Primrose House is a small, family run home for up to five people learning disability, Asperger's or Autism. On the day of the inspection five people were using the service.

Primrose House is a large terraced house and offers residential care without nursing. There were shared bathrooms, a communal kitchen, a communal lounge, a dining area and a garden.

At the last inspection on 15 May 2017, the service was rated as requires improvement in two key questions, Safe and Well-Led. This was due to staff recruitment processes not being thorough, risks to people and the environment not being well assessed and managed and quality assurance systems needing improvement. At this inspection we found some improvements in these areas but further development was required to medicine management, staff training and the governance systems to ensure regulatory requirements were understood, met and the service continued to improve. Therefore we rated the service again as Requires Improvement overall.

Throughout the inspection we were assisted by the registered manager who was also the provider. The service had a registered manager in post. 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.

Medicines were administered consistently and safely. No one was on medication without their knowledge (covert) and no one was prescribed medicine which required additional storage for safety purposes. Staff confirmed they understood the importance of safe administration and management of medicines. We looked at medicines administration records (MAR) and noted all had been correctly completed. Some people managed their own medicines and staff checked they were doing this safely at intervals. The service had a medicines policy but it required updating to reflect current best practice. Some staff had not had formal medicine training either or an assessment of their competency. We also talked to the registered manager about developing "as required" medicine support plans and a recorded system to check the medicine administration records. Although we did not identify medicine management was unsafe at the inspection and there was no impact on people's care, systems needed to be more robust to reduce potential error.

Primrose House was run like a traditional family home might be. There were some informal quality assurance systems / checks in place for example room checks and checks on people's medicines. Feedback from people, staff, relatives and professionals was noted, listened to and action taken. Learning and reflection took place in the event of an incident or concern raised and these were used to help drive improvements to people, but there was limited documentation to support these processes. Links with

forums which discussed best practice in this area was limited and policies and procedures required updating to reflect current practice. More formal governance processes to checks that standards were maintained would support the development of the service.

People were supported by staff that had received an induction programme and some staff were undertaking further qualifications in health and social care. Staff training however required updating in some areas, for example safeguarding, fire training, medicine management and the Mental Capacity Act.

People were protected by the service's safe recruitment practices. Staff underwent the necessary checks which determined they were suitable to work with vulnerable adults, before they started their employment. The registered manager (also the provider) was committed to employing people with the right skills, values and attitude to work with vulnerable people.

On the day of the inspection staff within the service were relaxed, there was a calm and friendly atmosphere. People went about their usual routines and led busy, active lives swimming, shopping and meeting friends. Staff had a clear role within the service and knew what their plans were for the day. Information we requested was supplied promptly, support plans were organised, clear, easy to follow and comprehensive.

Some people had limited verbal communication skills but we observed they felt comfortable with staff. People's individual communication styles were known if people were unable to communicate verbally. Care records were personalised and gave people as much control over aspects of their lives as possible. Staff responded quickly to people's change in needs and were sensitive to people's moods. People or where appropriate those who mattered to them, were involved in regularly reviewing their needs and how they would like to be supported, however we found more formal reviews of care involving professionals were overdue. We contacted the local authority so people's care was reviewed as required. People's preferences and routines were identified, known by staff and respected.

Staff put people at the heart of their work; they exhibited a kind and compassionate attitude towards people. Strong relationships had been developed and practice was person focused and not task led. Staff had appreciation of how to respect people's individual needs around their privacy and dignity. Staff were conscious of behaviours people might display which could compromise their dignity, for example wearing clothes which were inappropriate for the weather.

People's risks were managed well and monitored. People were promoted to live full and active lives. Staff were motivated and creative in finding ways to overcome obstacles that restricted people's independence.

People we observed were as safe as possible. The environment was clean, uncluttered and clear for people to move freely around the home. Staff discreetly monitored people's behaviour and interactions to ensure the safety of all the people and staff at the service. All staff understood safeguarding and signs to look for, they displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated.

People were supported by staff that confidently made use of their knowledge of the Mental Capacity Act (2005), to make sure people were involved in decisions about their care and their human and legal rights were respected. Families were involved in decision making where appropriate and advocacy services were used when required. We found the recording of best interest decisions made by staff required improvement. The service followed the laws and processes in place which protect people's human rights and liberty. Deprivation of Liberty Safeguards (DoLS) were understood by the registered manager and staff. Those who

had restrictions in place had the required legal authorisations.

No complaints had been received by the service. The registered manager advised if a complaint was received it would be managed in line with the provider's policy and procedure. Easy read, pictorial formats were available for people who were unable to verbally communicate their concerns if required.

The service had started to work alongside the quality assurance team to make improvements.

We found two breaches of regulations.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service required improvement to ensure it was safe in all areas.

Medicines were administered safely but staff required training and policies and medicine systems required updating to reflect best practice.

People's risks were well managed, known and recorded.

People were supported by staff that had been safely recruited.

People were protected by staff that had an understanding of abuse and how to raise concerns; however, staff required training in this area.

People lived in a clean environment.

People lived in a service that reflected and learned when things went wrong.

Is the service effective?

Requires Improvement

The service remains effective.

People received care and support from staff who understood their needs but we found staff training in some key areas required updating.

Staff sought people's consent and ensured if people did not have the ability to consent to aspects of their care and treatment, this was done in their best interests however, documentation required improving.

People were supported to have their health needs met.

People enjoyed a balanced diet.

Primrose House was a safe, maintained environment for people to live in.

Is the service caring?

Good

The service remains caring.	
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service was not always well-led. Management systems and governance processes required development. People lived in a home which had a positive culture and open, family run atmosphere. People had strong links with the local community. Staff and people felt involved in the running of the service.	**Requires Improvement**

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 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.

The inspection was undertaken by one adult social care inspector, took place on 17 May 2018 and was unannounced.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

Prior to the inspection, we asked the provider to complete a Provider Information Return. 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. We reviewed this information as part of the inspection.

During the inspection we spoke with the registered manager and the two staff on duty. We discussed the care of all the people who lived at Primrose house, met and spoke with four people who lived at the home and read three care files. These included support plans, risk assessments, daily dairies and medicine records. We observed people's interactions with staff throughout the day.

We discussed staff recruitment with the registered manager as the files were not available during the inspection. We also discussed staff training. We talked to the registered manager about the quality assurance processes in place to monitor the service. We discussed the complaints process and enquired about any complaints the service had received.

Following the inspection we contacted the quality assurance team who met with the registered manager to discuss reviewing people at Primrose House and offered support to develop governance processes at the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in May 2017, the service was rated as Requires Improvement. This was due to staff recruitment processes not always being followed thoroughly and risks to people and the environment not always been assessed and well managed. We found these areas had improved at this inspection but found more robust procedures were required to ensure the safe management of medicines and fire safety.

Medicines were administered consistently and safely. No one was on medication without their knowledge (covert) and no one was prescribed medicine which required additional storage for safety purposes. Staff confirmed they understood the importance of safe administration and management of medicines. We looked at medicines administration records (MAR) and noted all had been correctly completed. Some people managed their own medicines and staff checked they were doing this safely at intervals. The service had a medicines policy but it required updating to reflect NICE guidance (National Institute of Clinical Excellence). No staff had received formal medicine training in their role at Primrose House either or an assessment of their competency. We talked to the registered manager about developing "as required" medicine support plans and a recorded system to check the medicine administration records. Although we did not identify medicine management was unsafe at the inspection, "as required" medicines were rarely used and there was no impact on people's care, the systems needed to be more robust to reduce potential, future error.

We recommend the provider seeks advice to review medicine policies regarding best practice and staff training in relation to medicine administration and safeguarding.

People were kept safe by staff who understood what keeping safe meant and how to support people to remain safe within Primrose House and in the community. Staff knew people's vulnerabilities, were able to recognise potential abuse for example, bruising or if people were unhappy and took steps to support their safety. Staff told us if they were concerned about abuse, neglect or harassment they would report this to the deputy or the registered manager. Some people were vulnerable to discrimination due to their protected characteristics and staff had good relationships with local people who reported any concerns or harassment which might occur. However, we noted that only two of the four staff we spoke with had received safeguarding training at the start of their employment. We spoke with the registered manager about all staff receiving updated training in safeguarding to maintain and update their knowledge. When previously required, the registered manager had discussed concerns with the local authority.

People were encouraged to remain safe in the community and were well known in the village. Those who did not need to have staff support in the community were given an identity bracelet and people were familiar with the "Safe Place" symbol, an initiative in the local community where people could access local places such as shops if they felt unsafe when out and about.
Safety at the service was at the forefront of staff minds due to people's vulnerability. Visitors to the service were met at the door, and had their identity checked. The doorbell at the entrance to the service alerted people to visitors being in the building. During the day the door was unlocked as some people who lived at

Primrose House were independent and went out and about during the day without staff. We spoke with the registered manager about a signing in and out book to record who came in and out of the building and about the security at the front door it was unlocked and accessible to the public. They agreed to discuss possible options with the fire service as the front door was also a fire exit.
People were supported by suitable staff with the right values, skills and attitude. At the last inspection photo identification was not obtained. This had now been actioned for all staff. The registered manager confirmed improved recruitment practices were now in place, including two references checked, picture ID in place and full employment histories obtained with any gaps in employment history considered. People met and contributed to the staff selection process where possible. New staff visited on an informal basis initially prior to the formal interview process. Staff confirmed recruitment checks had been undertaken prior to them commencing their employment with the service. For example, disclosure and barring service checks had been made to help ensure staff were safe to work with vulnerable adults.

People were supported by sufficient numbers of staff to keep them safe because safety was a priority. The staff group was small and consistent. Staff told us they ensured consistency from people during annual leave and sickness and agency staff were not used. Staff told us, "We cover for each other, everybody works together, and we cover each other's shifts." Some people had additional staffing requirements during the day to support their activities (one to one staffing). This meant there were enough staff to enable people were able to enjoy going out safely.

Staff sought to understand the cause of people's behaviour, especially when people were less able to communicate verbally. Staff knew by people's moods and behaviours when they were anxious, unhappy or agitated because they knew them well. Staff were mindful of potential triggers which might cause people to exhibit behaviours which were challenging to staff for example, people being aggressive towards staff. Staff worked together to alleviate people's anxieties. Staff knew individual people's characters and the dynamics between people who lived at the home and situations which could trigger and increase people's anxiety. We discussed with the registered manager staff whether staff training in de-escalation and breakaway was required to support these situations being safely and consistently managed as staff had not been specifically trained in this topic. We also discussed the specialist advice and support received from the mental health and local learning disability teams to support the service. We signposted the registered manager to Devon local authority for advice with people and who they should be reviewed by given the service's location and people's different funding authorities. The local authority made contact after the inspection.

People were supported by staff that understood and managed risk effectively. Since the previous inspection the provider's action plan advised first aid boxes were in place and robust fire risk assessments had been in place since 2010 and were reviewed annually. External contractors checked fire safety at the service twice a year. Electrical equipment was checked monthly and the gas boiler was service annually. Although people at the service were mobile, we discussed with the registered manager developing individual fire evacuation plans as we were informed they did not always respond when the fire alarm sounded. We also discussed all staff completing fire training to ensure they felt confident and were competent with taking action in the event of a fire as not all staff were up to date with fire training although they knew what to do when we discussed this.

Risk management plans recorded concerns and noted actions required to address risk and maintain people's independence. For example, those people who posed a potential fire risk by hoarding items had frequent checks of their rooms, those who chose not to take all their prescribed and recommended medicine for health conditions were monitored closely and those at risk of slips after showering were encouraged to stand on the bathmat. Some people could approach strangers when out and about because

they were less risk aware so staff monitored this closely to increase their awareness when visiting local places. People had pictorial support plans and were involved as much as possible in decisions around the risks they took. Staff confirmed they followed risk management plans to ensure restrictions on people's freedom and choice were minimised. For example, some people were supervised when using the kitchen due to the sharp utensils, hot equipment and chemicals people might not be safe around.

The service was clean and well maintained to support people to be as safe as possible. People were encouraged to help with the cleaning and tidying of the house as in a family home. Daily chores such as dishes and laundry were undertaken with staff support as required. People proudly showed us their tidy, clean bedrooms.

Action had been taken and lessons learned in some areas following the last inspection but further work was needed to reduce the likelihood of an incident or near miss occurring.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in May 2017, we found the service effective. At this inspection we found improvement was required to ensure all staff had received training in essential areas to ensure their competency and that people were receiving care from staff who followed best practice guidelines.
We found there was not a formal system in place to monitor staff skills and training. Although staff who worked at Primrose House had qualifications in health and social care which covered essential topics like infection control, equality and diversity and safeguarding, we found some staff had not had formal medicine training or competency checks. Some staff had not had refresher training in safeguarding, fire, food hygiene or mental capacity act training at the start of their employment although they did cover this in additional health and social care qualifications they had completed or were undertaking. Staff not having up to date training may mean their practice was not kept up to date.
Although the registered manager had many years caring for people with learning disabilities, autism and Asperger's, staff new to the service did not always. Reading material was available for staff but many learned through working alongside people. Training in these areas would support staff to have a better understanding of people's conditions, behaviours and needs. Some people had behaviours which could challenge staff, for example verbal aggression. Staff managed this in the best way they knew using their common sense, life experience and knowing the person, however de-escalation strategies would support staff to have a consistent approach. The service was located between two local authorities and the registered manager had struggled to know which external services and groups to link into, to maintain training and best practice. We found staff had gaps in essential training including training on mental health needs, autism and Aspergers in addition to fire training, food hygiene training, medicine training, mental capacity act and safeguarding training.
This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Following the inspection, the local quality assurance team met with the provider and support was going to be provided to the registered manager to develop a training matrix.
The registered manager told us they were committed to developing staff and encouraging further health and social care qualifications to ensure staff had the skills and knowledge required to care for people effectively. One staff confirmed they were doing their health and social care qualification. Staff felt confident if they felt they needed training or asked for training in a particular area, this would be agreed and arranged if possible. The registered manager told us they would look at training courses available as a priority to ensure staff knowledge was updated.
Staff received an induction programme which included shadowing more experienced staff when they started with the provider. The induction also included the workings of the house, the routine and appliances. Staff shared their in-depth knowledge of people with new staff, gave them time to learn and understand their behaviours, communication styles and individual mannerisms. The registered manager monitored staff progress through informal methods and one to one meetings (supervision) with staff. We were told if staff did not have a previous health and social care qualification, newly appointed staff where necessary would complete the new care certificate recommended following the 'Cavendish Review'. The outcome of the review was to improve consistency in the training health care assistants and support workers received in social care settings. Staff told us they had found the induction they received met their needs when they joined.

Supervision and annual appraisals were in place for staff to support them in their roles. All staff told us they felt supported by the deputy and registered manager, "I love it here. Relaxed, nice job, supportive and things are done."

People, when appropriate, were assessed in line with the Mental Capacity Act 2005 (MCA). The 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. Staff displayed an understanding of the requirements of the act, which had been followed in practice. However, care records did not clearly evidence where the service had been involved in and supported best interest's decisions that had been made for example discussions about how much money people were given a day. For example, one person was given small amount of money a day which staff did in their best interests but the recording around why this decision was in the person's best interest and who had been involved in this decision was lacking..

We also checked if any conditions on authorisations to deprive a person of their liberty were being met. People can only be deprived of their liberty when receiving care and treatment when this is in their best interest and legally authorised under the MCA. The application procedure for care homes is called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was up to date with changes in law regarding DoLS and had a good knowledge of their responsibility under the legislation. Records showed where DoLS applications had been made and people authorised were kept under review to help ensure they remained appropriate and as least restrictive as possible.

Communication between the small team was effective. Communication methods were in place such as handovers. Staff told us these helped ensure they were up to date with any changes in people.

People where appropriate, were supported to have sufficient amounts to eat and drink. People ate together in the evening as a family might but during the day due to people's activities and different routines, meals were flexible. Although some people had limited ability to be involved with cooking and preparation of meals, discussions with people and knowing the foods they preferred people understand the options available and plan the menu and shopping list. We observed some people enjoying a hearty cooked breakfast in the morning. No one at the service had any cultural dietary needs or dietary needs in relation to health conditions such as diabetes.

Staff commented how they monitored people's food and fluid intake where this was needed and communicated with each other to help ensure people maintained a healthy balanced diet. Some people needed support to maintain their weight and staff worked alongside people's Gp where weight monitoring and dietary support was required. Staff were conscious of those prone to weight gain also and encouraged healthy eating habits whilst balancing people's right to choose their foods and make unwise choices if they had the ability.

Records showed staff sought advice in people's best interest when changes to health or wellbeing had been identified, mainly people's doctors as some people did not have allocated social care staff involved. People saw their doctors if they were unwell, for annual health checks and medicine monitoring. Healthy lifestyles and well-being was encouraged by staff through informal discussions about exercise, social activity and friendships. Explanations about people's health needs and treatment were given to people in ways they

were able to understand, for example simple conversations and pictures.

Primrose House was an older, terraced building, not a purpose built service. People were mobile and independent around the service so there were not many adaptions required. A large kitchen extension meant there was plenty of room for people to come in and make drinks and food if they wished. A moderate size garden and garden seating area was available for people to enjoy the warmer months. People could spend time together in the dining area or lounge or take visitors to their private bedrooms.

Good

Is the service caring?

Our findings

People were well cared for by staff that had a caring attitude and treated them with kindness and compassion. Staff knew people's histories and backgrounds, the kindness exhibited by all staff and management enabled trusting relationships to be built with people. Staff commented, "Everyone gets on, it's like a family."

Equality and diversity was understood and people's strengths and abilities valued. Staff had genuine concern for people's well-being; they were committed to working together to ensure people received good outcomes and had the best quality of life possible. Staff commented they felt passionate about the support they gave, and explained the importance of adopting a caring approach and making people feel they mattered.

Staff took time to get to know people by spending time with them, reading their care records, talking to their family and discussing people with their colleagues. Relationships with people were fostered because staff invested time in people. They nurtured and paid attention to people so they were cared for. Staff knew people's particular mannerisms which might mean they were overstimulated or anxious because they knew them well, for example someone clapping or biting their fingernails. They took prompt action to address what might be causing someone's anxiety for example, by providing one to one time with people, listening to music they liked, taking them out to help calm and distract them or giving them space and time alone. Some people were under close supervision and some had one to one care due to their health needs. Staff demonstrated how effectively they balanced protecting people with promoting and encouraging independence and freedom of movement to enrich people's lives. Staff preserved people's dignity in the community by escorting people discreetly, not wearing uniform or visible identification. Staff were prepared for events which might occur in the community and carried spare clothing and essentials for people if needed dependent upon people's needs.

People's privacy and dignity were respected; people were encouraged to be as independent as possible. People were able to lock their private space. Staff ensured they knocked on people's doors and asked if it was okay to go into their bedrooms before they entered. People's confidential information was kept secure and staff understood the need to respect people's private information and not discuss this with others not involved in their care.

Staff responded to people's needs in a caring way, and promoted people to be as independent as they wanted to be within safe boundaries. The service and people were well known locally and staff would receive feedback if there were concerns about people in the community.

We observed people felt comfortable around staff and appropriate touching and physical contact between people and staff indicated people felt they mattered and belonged. We observed one person enjoyed sitting close to staff and nearby as they worked and talked with us. People were comfortable approaching staff, warm in their interactions and clearly valued the relationships with all staff.

People were proactively supported to express their views as far as possible. Staff gave people time and were skilled at giving people explanations and the information they needed to make decisions. Social stories, pictures, photographs and objects were used to help explain events to people to help prepare and involve them in decision making. For example, objects of reference and key words helped staff explain to people what they were doing if required and they had limited verbal communication skills. Some people had their

own styles of communicating and we observed staff were patient as they tried to understand people expressing what they wanted through hand gestures, facial expressions and sound. People's individual communication styles were clearly documented in their support plans.

Advocacy support services were available for people if needed, however staff and families also advocated on people's behalf to ensure their care was person centred and in their best interests.

People were encouraged to be as involved in their care as much as possible despite the challenges they faced. Relatives where appropriate were involved and kept up to date. The staff supported people to stay in touch with family and some people spent weekends with their family.

Special occasions such as birthdays were celebrated. People had enjoyed special days out to celebrate these occasions such as family meals. Christmas was celebrated with a traditional meal and presents for those not away with family.

Good

Is the service responsive?

Our findings

People received consistent personalised care, treatment and support. Once the service agreed to support a person, an initial assessment took place. Staff made every effort to empower the person and their family (if appropriate) to be actively involved in the whole process. Evidence was gathered about the person's background, medical history and life. People were supported to move to live at Primrose House at a pace which was right for them. The registered manager told us admissions to the service were carefully considered due to the complexities of the people at the service and to ensure this was right for the people already living at the home.

People and their families where possible, were involved in planning their ongoing care and making regular daily decisions about how their needs were met. Barriers to communication were known and creative ways thought about so people could be involved in their care as much as possible. Staff were skilled in supporting people to do this and in assessing people's needs. Staff told us how they discussed ideas about what would make a positive difference in people's daily lives and encouraged people to try new things.

The service responded to people's needs and preferences by reviewing their activity plans with them or their approach to people if required. People's changes in care needs were identified by staff, family and professionals as required. Reviewed plans were then put into practice by staff and regularly monitored. Regular staff handovers and staff meetings shared important changes to people's care. This meant staff knew what had changed and how to care for people as they required. The service shared with us how some people's needs meant they did not always meet the threshold for mental health or learning disability services. The registered manager had found it difficult to get advice and support where this was the case. The service was also located between two different local authorities and they were not always sure who to contact when people needed a more formal review of their care. Following the inspection, we contacted the Devon local authority quality team who made contact with the registered manager and put a plan in place for people's reviews.

Individualised care-planning and the in-depth appreciation staff had of people's needs supported responsive care. Staff knew people's likes and dislikes, people's preferences and those who preferred baths over showers, for example. They knew who liked to keep active and participate in sporting activities and those who preferred to get the bus in to Plymouth.

People had activities personalised to their needs. For example some people attended the local day centres which they enjoyed; other people enjoyed eating out, walking groups, voluntary work and swimming. During the inspection everybody had a different plan for the day which they enjoyed sharing with us for example one person had gone shopping for new summer clothes in town and came back and proudly showed us their new summer wardrobe. Others went swimming or were out at the leisure centre or taking public transport into the city.

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are

given. Information about people recorded their communication needs and preferences for communication. Care plans reflected people's unique needs, choices and preferences, and gave detailed guidance to staff on how to make sure personalised care was provided. For example, staff had noted that when one person touched their nose that meant they were not interested in what someone was saying. Simple, pictorial support plans were also in place. We spoke to the registered manager about developing hospital passports for people should they need to go into hospital. These are simple plans which inform hospital staff about people's needs and are particularly helpful if people have a learning disability, communication or sensory needs. The registered manager advised staff would always support people in hospital but would consider this.

People were protected from the risk of social isolation and staff recognised the importance of companionship and keeping relationships with those who matter to them. Staff supported the people in the home to stay in touch with their family if appropriate. Other people had friendships and relationships in the community with were supported.

The service had a policy and procedure in place for dealing with any concerns or complaints. This was in a pictorial format people could understand and information was also available in the information people received about living at Primrose House. The registered manager told us that no formal complaints about the service had been received. One concern had been received by a member of the public regarding one person and the service had put plans in place to address this and ensure their safety.

People at the service were young and not near the end of their life, therefore discussions had not occurred in this area. We discussed with the manager open conversations where appropriate to discuss with people or their families their preferences and to consider this area of care for the future.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in May 2017 this area was rated as requires improvement due to improvement needed to monitor the quality of service provision. At this inspection, although we found the previous breaches of regulations had been met, there remained the possibility of on-going risk as the provider was not linked in to local forums where best practice was discussed and shared. These forums help service remain up to date with changes in regulation and inspections and discuss new health and social care practice to avoid services becoming stagnant.
Primrose House was an established small, family run service. The registered manager, who was also the provider, was in charge on a day to day basis. The small staff team mainly consisted of family members. Some people had lived at the home for twenty years.

The PIR shared, "As it is a small home, the management is very much on an informal basis as it is considered to be the service user's home and they feel comfortable." This reflected our inspection findings. Although there were reviews of care plans in place, weekly room checks and health and safety environmental checks there was very little documented that these checks occurred. There was a lack of a formal governance procedure. This meant it was difficult to evidence what the registered manager was checking, noting, and what actions had been identified through these systems to ensure continual improvement. For example, although the registered manager checked the medication records, we quickly spotted a pharmacist typing error which may have been identified through a more formal auditing process. There wasn't a structured system or policy in place which identified what the provider deemed as essential training in order for us to check staff had received this. Although care plans were good, there wasn't a formal audit in place to review and audit these. The service ran smoothly but without any clear, organised structure, it was run like a traditional family home might be and there was a risk something being missed which could impact on someone. It wasn't evident that there were systems in place to learn from safeguarding, incidents, complaints or compliments to drive quality although our conversations with staff told us they reflected and changed practice where required.

Policies and procedures were in place but these did not always reflect latest NICE (National Institute of Clinical Excellence) standards for example the medicine policy.

Staff and people were happy and able to feedback informally their views but a more systematic quality assurance system could be developed to ensure continued improvement.

Although people and the service were well known in the local community and had good relationships with the local services which supported people, wider links with key organisations to consider new ways of working and maintain knowledge of best practice and regulation required enhancing.

There was not a clear system which evidenced the registered manager or staff stayed up to date with changes in health and social care legislation or regulation. The provider had failed to have effective quality assurance systems that affected improvements in the service.

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

The provider / registered manager took an active role within the running of the service and had an in-depth knowledge of the staff and the people who were supported by Primrose House. There were clear lines of responsibility and accountability within the management structure. The provider / registered manager were supported by a deputy manager. Together with the staff team they worked together to lead a caring service. Staff employed were caring and dedicated which supported the service to meet people's needs and achieve people's goals. People came first.

Although the registered manager openly admitted paperwork was not their strong point, the service ran smoothly due to the relationships with people, family, local health professionals and the close staff team. The culture at the service was positive and those people who had experienced a number of different services previously, did well at Primrose House.

The management team and staff shared the same values which included supporting people to have as much freedom as possible to make choices, freedom to be given opportunities, person centred care and for Primrose House to be a safe, nurturing home for the people they supported. Staff talked consistently about personalised care and promoting independence and had a clear aim about improving people's lives and opportunities. The service was all about the people they were supporting and making sure people lived the best life possible.

The provider / registered manager told us staff were motivated and encouraged to find creative ways to enhance the service they provided. Regular informal staff meetings were held where staff were updated on information within the house and other relevant issues to keep them informed.

The registered manager and deputy encouraged staff feedback and suggestions. Staff were valued and their ideas appreciated. People's quality of life was being improved due to the dedication of the staff team at the service.

The provider/registered manager created an open, honest culture. This reflected on the Duty of Candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The provider/registered manger encouraged staff to provide a quality service. Staff told us they were happy in their work, understood what was expected of them and were motivated to provide and maintain a high standard of care. Staff told us they loved their work.

The service had a whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager or external agencies, and were confident issues would be acted on.

Inspection feedback was listened to and during the inspection period the service had started to work with the local authority improvement team.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (a) Systems and process were not always established to assess, monitor and improve the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) (a): Staffing Staff did not always have the necessary training to ensure they were skilled and competent to carry out their duties.