

Primroses Care Limited

# Primroses Home

## Inspection report

95 Primrose Avenue  
Romford  
Essex  
RM6 4PS

Tel: 02031722860

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### Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

Primroses Home is a 'care home', specifically caring for adults under 65 years of age with mental health conditions. 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. This service is registered to provide a service for three people.

We inspected the service on 06 June 2018 and this was their first inspection since they registered with the Care Quality Commission (CQC).

The service had a 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.

Safeguarding procedures were in place and staff demonstrated a clear understanding of what abuse was and how to safely report any concerns. The service had detailed, person centred care plans and risk assessments in place to guide staff to best support people using the service, including their skin management and personal care plans. A recommendation was made to include more detail about people's mental health to ensure staff were understanding of how best to support people receiving support and manage risk.

Pre-employment checks had been carried out to ensure staff were suitable to support vulnerable adults and staffing levels were sufficient, which allowed the service to meet people's needs. Medicines were managed safely. A recommendation was made about record keeping to ensure staff could safely audit people's medicines. Infection control was being managed in a safe way and staff were provided with personal protective equipment to prevent the spread of cross infection.

The service completed pre-assessments to gather information about people's needs and ensure it was able to meet those needs. Records and observations showed that the staff worked in a person-centred way and there was clear evidence of organisations working together to deliver safe and effective care. People had choices around their meals. A weekly menu was prepared with people and they could review this each day. There was evidence of healthy food on the menu and in the fridge.

Records confirmed that staff had completed training and received an induction to allow them to provide high quality support. A recommendation was made to ensure all staff had completed training specifically on mental health to ensure they could support the people receiving care in line with best practice.

Staff understood the Mental Capacity Act 2005 (MCA). MCA is law protecting people who are unable to make decisions for themselves. People who had capacity to consent to their care had signed their care plans and risk assessments and where consent was not applicable, the appropriate authorisation procedures had

been completing following a recommendation. These are referred to as the Deprivation of Liberty Safeguards (DoLS).

Staff were observed to deliver personalised care to people and demonstrated an understanding of their individual needs. Records were written in a person-centred way and detailed people's individual preferences and support needs. All people received a welcome booklet that gave information about the service, what to expect and who they could talk to about any concerns.

The service was due to run weekly forums for people to feedback about the service. People were observed to be able to approach staff at any time for emotional and practical support and staff were seen to be caring. Advocacy services were available to help people have their views and wishes heard. Staff demonstrated an understanding around equality and diversity and how to maintain people's privacy, dignity and independence. Records were treated confidentially and stored securely and care plans evidenced people were involved in decision making around their own care and support package.

The service had a complaints procedure in place and complaints had been fully investigated and actioned. People were informed of the complaints procedure in the welcome booklet they received. People were able to engage in activities of their choice, for example reading and watching television.

Staff spoke positively about the registered manager and there were auditing tools in place to monitor the running of the service and gather feedback to ensure the service could continue to learn and improve. The provider supported the team by working shifts as well as being available as part of an 'on call' service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Systems were in place to safeguard people from abuse and staff had a good understanding of their responsibility around safeguarding.

Risk assessments were in place to guide staff on how to support people safely.

Medicines were managed in a safe manner, however; we found some inconsistencies with the recording processes.

There were sufficient numbers of suitable staff employed by the service to meet the needs of people in the service.

Staff had been recruited safely with appropriate checks on their backgrounds completed.

People were protected from cross infection and protective equipment was used.

### Is the service effective?

Good ●

Pre-assessments were carried out to ensure the service was able to meet people's needs.

The service worked with other professionals and organisations to provide people with holistic care.

Staff undertook most training, received an induction to the service and supervision to help support them to provide effective care. However, staff had not completed specific training in mental health.

Staff understood the Mental Capacity Act 2005 (MCA) and sought their consent to care and support.

### Is the service caring?

Good ●

The service was caring.

Staff were observed to have positive and caring relationships with people using the service and demonstrated an understanding of their individual needs.

People could approach staff at any time for emotional and practical support and advocacy services were available.

Staff demonstrated an understanding around equality and diversity and maintained people's privacy, dignity and independence.

People were provided with information about their care and records and people knew their information was treated confidentially and stored securely.

### Is the service responsive?

Good ●

The service was responsive.

Person centred care plans were in place and these reflected people's individual preferences around, for example, daily activities and meals. People were supported to engage in activities of their choice within the home.

The service had a complaints procedure in place and complaints had been fully investigated and actioned.

### Is the service well-led?

Good ●

The service was well-led.

Staff working within the service and visiting professionals spoke positively about the registered manager.

The service had quality assurance and auditing tools in place and demonstrated enthusiasm to monitor the ongoing development of the service.

# Primroses Home

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out an inspection of 95 Primrose Avenue on 6 June 2018. This inspection was unannounced and carried out by two inspectors. This inspection was prompted by feedback about potential concerns related to safe care and treatment. During the inspection, the potential concern was evidenced to have been appropriately managed and no concerns were identified.

Prior to the inspection we contacted Healthwatch and health and social care professionals for feedback. Healthwatch confirmed they had not heard anything adverse about the service.

We did not receive a Provider Information Return (PIR) prior to the inspection as we had brought this inspection forward and therefore we had not yet requested one. The PIR contains information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, one care staff, one visiting health professional and one person who used the service. We reviewed documents and records that related to people's care and the management of the service, including one care plan, risk assessments, two staff files, staff rota, Medication Administration Records (MAR), service audits and health and safety records.

# Is the service safe?

## Our findings

People felt safe living at the service. One person said, "I feel safe." Staff knew what abuse was and gave examples of the different forms of abuse. One staff member said their role was to, "Protect people from abuse." Staff could explain what they would do if they suspected abuse was taking place. One staff member said they would, "Report to manager and if the manager was not in, report to the Police, Social Worker or the Care Quality Commission [CQC]." Staff understood what whistleblowing was and the processes to follow. One staff member said they would keep, "No secrets." Records showed there had been no safeguarding reports raised since the provider registered with the CQC. The service had safeguarding and whistleblowing policies in place and all staff had attended safeguarding training.

The registered manager advised the service was in the process of putting an information board in the reception area with information about safeguarding for people and their visitors.

There were risk assessments in place to ensure people were protected from harm. We reviewed these and found they covered areas such as mobility, mental health, physical health, personal care, medication, falls and handling, managing finances and consent to treatment. Staff knew the risks that affected people and what steps were needed to manage them. However; we found that risk assessments did not always provide detailed information regarding people's mental health conditions. We have made a recommendation that the provider seeks advice from best practice guidelines in assessing risks associated with people's specific mental health conditions. This detail will ensure staff are aware of how to keep people safe.

There were enough staff to meet the needs of people who used the service. The service was staffed 24 hours a day and the rota ensured there was always at least one member of staff on shift. The service had an on-call system shared between management. One staff member said they were managing with the staffing levels. The registered manager advised if the needs of the service increased they would increase staffing levels.

Pre-employment checks had been carried out to ensure staff were suitable to support vulnerable people. Staff recruitment records showed completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks and an induction to the service. The DBS is a national agency that holds information about criminal records.

One person received support with the management of their medicines. Information had been included in their care plan and risk assessment. For example, it said, "To remind me and educate me about the importance of medication compliance." However, some essential information was not included, such as the person's understanding of their medicines, side effects and what the medicines were prescribed for. After the inspection the provider sent us an updated medicines risk assessment, which provided more specific details on each medicine including information on 'when required' (PRN) medicines, people's capacity and ability to self-medicate. PRN medicines are to be taken as needed instead of on a regular dosing schedule.

Medicines Administration Records (MAR) were completed and signed by one member of staff when people were given their medicines. MAR were not audited by management. We found that the MAR did not always

detail medicine opening dates, medicines being carried forward and when new prescriptions were due. This meant that the service did not know when medicines were no longer safe to dispense or when medicines were due to run out. We made a recommendation that the service consider current guidance on the management of medicines in line with best practice. After the inspection the provider sent a medicines auditing tool to support management in overseeing the proper and safe use of medicines and allow for lessons to be learnt if things go wrong.

Records showed that staff had completed training in medicine management. Staff advised that if they had any concerns around medicines, they would, "Take advice from NHS, the Pharmacy or GP."

Records showed staff had completed training on infection control, food hygiene and health and safety. However; during the inspection it was found that the food in the fridge had not been labelled with opening dates or to identify what food was for staff and what food was for people using the service. This was important to ensure people were given meals that had not expired and were in line with their support needs. The manager advised this would be done.

Staff had access to policies and guidance on infection control. Staff could inform us of people's specific health needs and were observed to wear protective clothing when required. There was sufficient personal protection equipment available for staff and visitors. This meant people were protected from potential cross infection.

Checks had been made on portable appliances, electricity, water temperature and gas to ensure the premises was safe to live in. Daily checks were carried out on other areas of health and safety including infection control and food hygiene. Fire alarms and fire safety equipment had been tested and fire safety records were up to date. Staff had completed training on fire safety. The service had building plans and environmental risk assessments in place. This meant people were protected from harm in the event of a fire or other emergency.

The service had systems in place for recording accidents and incidents and lessons to be learnt from these. There had been no accidents and incidents recorded since the service opened.



# Is the service effective?

## Our findings

Pre-admission assessments were completed which detailed the specific support that people required so the service could ensure these needs could be met. This information helped staff to develop care plans that were personalised and took account of individual needs and preferences.

Staff had completed an induction before they started supporting people to ensure they developed the skills they needed. One staff member said this was, "Helpful." The induction involved shadowing the manager, understanding the day to day running of the home, reading policies and procedures and care plans and risk assessments, as well as completing training courses.

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 the 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).

During the inspection the person receiving support expressed a wish to access the wider community. We were advised by staff that at present the person was not being supported to access the wider community due to the associated risks to the person and others. However, there was evidence of the service having communicated with the professional network to manage this. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. A DoLS application had not been made to restrict the person's liberty. Since the inspection, the registered manager informed us that an application had been made and sent us a copy of this application.

Staff demonstrated they understood the principles of the MCA and DoLS. For example; one staff member said they would always assume people, "Can make decisions." Where people cannot make decisions in line with their best interest staff would, "Get all professionals involved." Where possible people had been involved in making decisions about, and consenting to their care and treatment. This was confirmed through people's signatures in their care plans and daily records. For example; where people declined personal care or medication their decisions were respected and this was clearly documented and discussed with the person later.

Staff members confirmed that they had received the training they needed for their role. One staff member said everything was explained to them and they, "Gained so much information." Records confirmed staff had received most of the training for their role, which would ensure they could meet people's individual needs. Training included MCA, manual handling, handling violence and aggression, basic life support,

control, restraint and complaints handling. However, we found that staff had not completed training around mental health conditions, which was an area of specialism for the service. This meant that staff may not have had the knowledge and understanding they needed to support people with their mental health needs. We fed this back to the registered manager and following the inspection we received evidence that staff had completed mental health awareness training.

Staff were provided with monthly supervision. Supervision looked at any issues arising for staff and for the service as well as any training and development needs. One staff member told us, "I get all the support I need." Annual appraisals were to be completed with staff when they had worked over 12 months. However, as the service has not been open for this amount of time these had not yet been completed.

The service provided a weekly menu that promoted a healthy and varied diet alongside individual preferences. The menu gave people a choice of food for each meal. Daily notes evidenced that healthy eating was discussed and the person receiving support was documented to have said, "I am eating well, the food are good." The person always had access to the communal kitchen and daily notes and care records indicated that staff would encourage the person to prepare food themselves, with the support of staff.

During the inspection we saw evidence of communication between the staff and people's professional networks, including requests for additional information and referrals to other health services including a new GP, District Nurse and Physiotherapist. One person had recently moved into the home and these referrals had been made in a timely manner to best support them. The communication clearly demonstrated the provider's understanding of the changing needs of the person. This was confirmed by a visiting professional who said the staff, "Seem quite on the ball."

The service ensured people's needs were being met through the design of the premises. The service had one ground floor bedroom and two ground floor bathrooms, wheelchair access into the property and into the garden and sufficient space for wheelchair access through the communal areas. The second floor had two bedrooms and three bathrooms as well as space for the staffroom. The communal lounge had a television, there was room in the kitchen to eat at a dining table and the garden was spacious. There were window restrictors in place.

## Is the service caring?

### Our findings

Staff had caring relationships with people and demonstrated a compassionate and empathetic approach and an understanding of their individual needs. For example; one person expressed a wish to talk about a specific concern and staff sat down to listen to them and reassure the person they would support them. This person was observed to appear more comfortable afterwards and able to continue with their daily activities in a more calm and relaxed manner.

Staff were observed to regularly encourage people to keep hydrated as well as ask if they required any support. A staff member told us they would, "Sit down with [person] and ask, to find out what [person] likes and doesn't like." The daily notes confirm that people using the service approached staff and asked for support to meet their daily needs, for example asking for help with their laundry and to purchase essential items. A visiting professional told us the staff were, "Very caring." This demonstrated staff were compassionate and the environment was comfortable for people to live in.

Staff told us that people receiving support had an advocate in place via their Social Worker to help them have their views and wishes heard in relation to their care, treatment and support. The registered manager told us that the service was in the process of putting an information board in the reception area with information about advocacy for people using the service to access to ensure people had access to information in a variety of ways. This demonstrated a caring approach and ensured people could actively express their views about the service.

The provider gave each person a welcome booklet to provide them with essential and important information about the home including the rules and regulations and details about health and safety, equality and diversity and their care within the home. The welcome booklet discussed weekly forums that will run weekly where people, "Will have the opportunity to express themselves." As the person receiving support had only recently moved in to the home, these had not yet commenced. We saw that this person had opportunities to discuss their thoughts and feelings with staff throughout the day. The welcome booklet stated that the service would fully involve people receiving support in the planning of their care and keep them informed of the progress of any service developments. Individual care plans and risk assessments were written in a person-centred format and had been signed by the person receiving support which demonstrated their involvement.

Staff completed training on equality and diversity and demonstrated a clear understanding in this area. For example; they recognised the importance of respecting individual choice around sexuality and relationships. When staff were asked how they would support people of different backgrounds, one staff member said the service would, "Look after anyone." The service had a policy on equality and diversity in place. This demonstrated staff would care for people regardless of their circumstances. The welcome booklet gave details of who people could talk to if they felt the service approach was not in line with supporting equality and diversity.

Staff told us privacy and dignity was respected and independence promoted. This was evidenced in the care

plans and daily notes. For example, one person's care plan stated, "I have my own routine." During the inspection the staff introduced us to this person as soon as they were free and advised us of when would be best to speak to them in more detail, knowing at times they may be busy participating in activities of their own choice. One person receiving support was observed to be wearing clothes of their choice. A staff member told us they would ensure the, "Door closed and curtain closed," when attending to personal care and said they would encourage the person to manage their personal care where possible before staff would intervene. We observed that when staff supported people with personal care then this was done privately and people's dignity was respected. This demonstrates staff supported people to be as independent as possible and supported them in a caring and respectful way.

## Is the service responsive?

### Our findings

People received person-centred care from the service. For example, people were able to participate in activities of their choice. During the inspection staff showed us the daily newspapers that had been purchased for the person and the person was observed to spend time reading them. This person's care plan said staff were to, "Offer [person] diversional activities like reading newspapers as a way of occupying [person] mind in a positive manner." One person's care plan said the person liked to place small, weekly bets and the daily notes showed staff supported the person with placing these bets in a safe and supportive manner. This person was then able to look through these bets in their own time.

A visiting professional told us about the registered manager, "Anything I've suggested they've taken on board," and told us the staff were, "Very receptive to things." For example, one person needed to have made-to-measure shoes ordered to access the community to prevent the risk of falls. The registered manager showed us evidence of this being explored with the person's professional network. This demonstrates that the service was responsive to people's support needs and wanted to ensure they were in the best of health while doing what they wanted.

The care plans focussed on people's strengths. They were detailed and looked at specific areas including personal care, sleep, mobility, mental health and physical health and things that the person enjoyed and didn't enjoy. For example, one care plan said, "Staff to allow me to get in bed when I want." Daily notes confirmed that this person was able to go to bed at any time they chose. The registered manager told us care plans were to be reviewed annually or when the person's needs changed and the person would be engaged in the care planning process. Staff found the care plans to be helpful, and where people's preferences were recorded staff could tell us about this. For example, they told us one person liked "rice and curry", which was further demonstrated in the daily notes about what that person was having for their meals. In addition, when we were shown the fridge it had food the person liked in it. This demonstrates the service has been responsive to ensure people's needs are at the centre of the care and support provided.

However the welcome booklet did not always demonstrate a person-centred approach. For example, it stipulated when meal times, visiting times and laundry times were rather than giving people freedom of choice. This meant people may have felt their care was restricted and not personalised. We discussed this with staff and advised they seek guidance from a reputable source about supporting people to receive person centred care, treatment and support and reflecting this in their documents.

The provider had a system in place to receive and respond to compliments and complaints. This included timescales for responding to complaints and details of who people could escalate their complaint to, if they were not satisfied with the response from the service. The complaints procedure was contained in the welcome booklet, which was given to all new people when they first moved in to the service. The registered manager advised the service were in the process of putting an information board in the reception area with the complaints procedure for people using the service to ensure people had access to information in a variety of ways. Complaints had been fully investigated and actioned. For example we discussed the complaint we received prior to the inspection, regarding potential concerns relating to safe care and

treatment with the registered manager. This complaint was evidenced to have been appropriately managed and no concerns were identified. This shows the service were responsive to feedback and willing to learn and develop to improve.

## Is the service well-led?

### Our findings

There was positive leadership at the service. The registered manager worked closely with the care staff to support the people using the service as well as managing and overseeing the day-to-day operation of the service. Staff told us that they were supported in their role and enjoyed working for the service. One staff member told us, "If there is an issue [registered manager] comes straight away," and, "[Registered manager] is always ready to help." The registered manager demonstrated a clear understanding of the people living at the service and their needs and they were observed to engage positively with people. For example; during the inspection they supported one person to speak to and express their views with the CQC and attended to their personal care. This showed the registered manager was prepared to meet people's needs and make them feel comfortable and supported in their own home. The service clearly demonstrated they were open to creating a service that met the needs of people while continuing to try and learn and develop.

There had been no notifiable incidents at the service at the time of our inspection. A notification is information about important events which the provider is required to tell us about by law, such as safeguarding incidents or serious injuries. The registered manager was aware of their regulatory responsibilities and knew about notifications and when to send notifications.

There were systems in place for quality assurance. Audits of the service had not yet been completed, due to the short time frame in which the service had been operational. The registered manager showed us future templates including audits on medicines management, care plans, policies and procedures and health and safety and advised us these would commence soon.

The service was responsive to feedback about the safe management of medicines and demonstrated a willingness to make improvements to the service.

Staff meetings and resident forums had not yet been set up as staff were new to the service and the person receiving support had only recently moved in to the home but the registered manager advised us these would commence soon.

The registered manager told us that they had recently sent surveys to professionals, which asked questions around the quality of the service being offered to people they supported. They had not yet received responses. They planned to send surveys to people too. They said the feedback gathered would help them learn and improve the service.

There was evidence of the service working in partnership with other organisations to ensure the best quality support was provided to people using the service. For example, the registered manager had requested a review of the placement with the person's social worker, community mental health team, district nurse and general practitioner to ensure people received safe and effective support at all times. This shows the service understood the importance of working holistically to ensure people's individual needs were being met.