

Primrose House Ltd

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?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Primrose House Care Home on 8, 10 and 11 May 2018. Primrose House is a 'care home' located in Gateshead. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate 63 people in one adapted building and on the date of this inspection there were 55 people living at the home.

During this inspection we found a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations: Safe care and treatment, regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations: Good governance, regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notification of other incidents and regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. This was because the provider had not adequately assessed the risks to the health and safety of people using the service, the management of medicines was not safe, renewal applications for the deprivation of liberty safeguards were not notified to the Commission and the provider did not display the previous rating within the home clearly or on the website. In addition to this provider did not operate robust governance arrangements to monitor and improve the service provision they provided to people. You can see the action that we have asked the provider to take at the back of the full version of this report.

There was a registered manager in post who has been registered with the Care Quality Commission (CQC) to provide regulated activities since November 2015. 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.

People told us that they felt safe at the home and relatives agreed with these comments. We found there were policies and procedures in place to help keep people safe. Staff had received training and attended supervision sessions around safeguarding vulnerable adults. Staff were safely recruited and they were provided with all the necessary induction training required for their role. The registered manager continued to provide on-going training for staff and monitored when refresher training was required but not all staff had attended refresher courses. Staff had received training in end of life care and the service worked closely with partnership agencies to deliver this when required.

Accidents and incidents were recorded correctly and if any actions were required, they were acted upon and documented. We observed that there were enough staff on duty to support people appropriately in line with their assessed needs.

During our inspection we found that the premises were not always safe for people living at the home. We found the main conservatory doors open, sluices unlocked, fire doors stating, "keep locked" were open, the

laundry room was open for people to access, clinical waste bins were open and bathroom pull cords were propped out of reach.

Regular checks of the premises, equipment and utilities were carried out and documented. Infection control measures were in place and the service was clean. We saw domestic staff cleaning the home regularly during inspection.

The home did not always provide safe medicine management. During the inspection we observed an unattended and unlocked medicines trolley left in front of the open conservatory door. Procedures were in place to ensure the safe receipt, storage, administration and disposal of medicines. There were records regarding other professionals involved in people's care. People's medicine care plans did not always fully document all of the information needed to fully support people.

People were supported to maintain a balanced diet and we saw people had access to a range of foods and fluids throughout the day. We observed a positive dining experience at the home and relatives also commented to us that they were pleased with the range of food provided.

The premises were 'dementia friendly' as the walls, floors and doors were painted in contrasting colours and there was pictorial signage to help people orientate themselves.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Applications had been made on behalf of some people to restrict their freedom for safety reasons in line with the Mental Capacity Act 2005. Staff demonstrated their understanding of the MCA. The registered manager had made applications on behalf of most people living at the service to restrict their freedom for their own safety in line with the MCA. The registered manager had not notified CQC of these applications.

We saw staff asking people for consent when supporting and asking for people's choices for meals and drinks. Staff treated people with dignity and respect. They showed kind and caring attitudes and people told us the staff spoke nicely to them. We observed people enjoyed positive relationships with staff and it was apparent they knew each other well. People and relatives knew how to raise a complaint or concern. There was information on how to make a complaint displayed within the service and this was accessible to everyone. Feedback was sought from people, relatives and visitors to help continuously improve the service.

People had person-centred care plans and risk assessments in place to keep them safe. People, relatives and external health professionals were all involved in best interest decisions and mental capacity assessments. People's care records were accurate and up-to-date.

The provider and registered manager had a clear vision to care for people living at the home. Staff told us that they could approach the registered manager if they needed support or guidance. Relatives said that they were always welcome at the service. The registered manager carried out regular checks and audits of the service and worked with the provider to achieve positive outcomes for people who used the service.

People's privacy and dignity was respected by staff. During the inspection we observed staff asking people discretely if they could carry out personal care and if they required support. The service promoted advocacy and there was accessible information available detailing what support people could access to help make choices about their individual lives.

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.

The premises were not always safe for people using the service.

Medicines were not always stored safely and people did not always have corresponding care plans to ensure safe administration of medicines.

There were suitable staffing levels at the service. People received care from staff who were trained in and were aware of safeguarding procedures.

Is the service effective?

Good 

The service was effective.

People received care that was delivered in line with the Mental Capacity Act (2005) MCA. Consent was sought before staff provided care to people.

Staff providing care to people had received appropriate training but not all staff had completed their refresher training.

People were supported to eat and drink well to maintain a balanced diet.

Is the service caring?

Good 

The service was caring.

Staff upheld people's privacy and dignity.

People were treated with kindness and respect by staff.

People and their relatives were consulted and supported with planning their care.

Is the service responsive?

Good 

The service was responsive.

People received person-centred care which met their needs and was regularly reviewed and updated. People enjoyed a wide range of social activities.

People were supported with end-of-life care.

The provider had a robust complaints procedure in place. This information was used by the service to learn and continuously improve.

Is the service well-led?

The service was not always well-led.

There was a registered manager in post. The registered manager understood their role and responsibilities but had not submitted statutory notifications in relation to renewal applications for people subject to a Deprivation of Liberty Safeguard (DoLS).

The provider and registered manager had a clear vision, strategy and plan to deliver quality care. The provider had quality and assurance processes in place to monitor the quality of the service and rectify any issues identified.

The provider had not displayed the previous CQC ratings on their website or clearly within 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.

This comprehensive inspection took place over three days on 8, 10 and 11 May 2018. The inspection was unannounced on the first day, which meant the staff did not know we would be visiting the home, and announced for the second two days.

The inspection was carried out by two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, the registered manager completed a Provider Information Return (PIR). This is a form that the registered manager sends to CQC with key information about the service, what improvements they have planned and what the service does well. We also reviewed the information that we held about the service. This included any statutory notifications received. Statutory notifications are specific pieces of information about events, which the provider is required to send to us by law.

We sought feedback from the local authority contracts monitoring and safeguarding adults teams, and reviewed the information they provided. We contacted the NHS Clinical Commissioning Group (CCG), who commission services from the provider. We also contacted Healthwatch, who are the independent consumer champion for people who use health and social care services.

During the inspection, we spoke with 11 people who lived at the home, six relatives and nine members of staff including the registered manager, two representatives from the provider organisation, one nurse, one cook and four care assistants. We reviewed the care records for six people living at the home and the recruitment records for five members of staff.

We looked at quality assurance audits carried out by the registered manager and the provider. We also

looked at the staffing rotas, training records, meeting minutes, policies and procedures and information related to the governance of the service. We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

Primrose House was not always safe for people living at the home. On arrival we observed some practices which did not keep people safe. A member of staff opened the ground floor door which was secured by a keypad lock. We were allowed access to all floors and were not asked to show our identification or to sign in. This was a risk to people living at the home as this may result in a potential safeguarding risk to vulnerable people. The Clinical Lead Nurse informed us that the registered manager was on annual leave but they were responsible for the home. The registered manager was present for the second day of inspection.

The Clinical Lead Nurse was administering medication when we arrived at the home and allowed us to carry out a premises tour whilst they completed their task. On accessing the first floor we found the main conservatory doors unlocked and open on to the main street and the medicines trolley left unlocked and unattended. The unattended medicines trolley was not safe medicines management, as people who did not have full mental capacity and anyone passing the home could have accessed the trolley through the open conservatory. The open doors also posed a risk as people could leave the premises who were subject to a deprivation of liberty safeguard (DoLS), without staff knowing.

During the tour of the home we found other risks to people's safety. The laundry room door was propped open with no staff in attendance. The laundry door had a keypad lock to keep it secure and should have been locked closed. People living at the home had access to the laundry which contained machines and laundry detergents. Five emergency pull cords in operational bathrooms and toilets were tied up and could not be used by people if they needed to summon urgent assistance from staff.

We found five boxes of a nutritional supplement in the main ground floor corridor. The ease of access of the boxes to people with swallowing difficulties may pose a risk of aspiration and its location also caused a potential tripping hazard. All sluice doors that should have been locked were open and accessible. Fire doors which had 'keep locked' written on were unsecure. For example, a store cupboard which should have been locked was open and unlocked on the first floor. The clinical waste bins outside of the premises were not secure and were accessible.

We discussed these findings with a regional manager from the provider. They took immediate action to address the issues we had identified. On the second day of inspection we found the laundry door was still open and unlocked with no staff in attendance, pull cords remained out of reach in bathrooms, and fire doors labelled 'keep locked' were still unsecure. We also found three boxes and two full rubbish bags on one of the main fire escape routes.

We discussed our findings with the regional and registered manager. They immediately took action and locked the laundry and fire doors. The registered manager confirmed they had addressed the importance of health and safety of the premises with staff after our first day of inspection. The registered manager also completed a targeted supervision around health and safety with the laundry assistant.

The protocols that were in place for 'as required' medicines were insufficiently detailed. They failed to

provide staff with clear guidance on when 'as required' medicines should be administered or how often people required additional medicines such as pain relief. One person's plan detailed the use of Lorazepam when required but incorrectly referred to this medication within a care plan for constipation, which is not what the medication is prescribed for. The plan did not detail what the maximum dosage per day should be. One person's MAR showed that Lorazepam had been administered but there was no record of this medicine in the person's care file or medicine's care plan. We raised this with the registered manager who said that they would review the protocols to ensure they were accurate.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations: Safe care and treatment.

We looked at the arrangements for the management of medicines. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Medicine stocks were recorded when medicines were received into the home. This meant accurate records of medicines were available and nursing staff could monitor when further medication was required.

Medicines were given from the container they were supplied in and we observed staff explained to people what medicine they were taking and why. People were given the support and time they needed and were offered a drink of water and staff checked that all medicines were taken. People's medicine support needs were accurately recorded in their care records and the medicine administration records (MARs) showed staff recorded when people received their medicines. Entries had been initialled by staff to show they had been administered.

We looked at the care plans for six people. Appropriate risk assessments were in place to help ensure people stayed safe. These included the risk of choking, moving and handling, use of bed safety rails, nutrition/hydration, falls and pain. All risk assessments were documented and were completed in partnership with people, relatives and professionals.

We also observed that one person who was being nursed on a specialist pressure relieving mattress did not have this set to the correct level for their weight. This posed a risk to their skin integrity and we raised this with the registered manager who stated they would review mattress settings for all people throughout the home.

People we spoke with living at Primrose House told us that they felt safe and comfortable. One person told us, "I'm safe of course I am." A relative told us, "He's had no accidents or falls so yes, he's safe."

Staff were aware of safeguarding legislation and what their role was in keeping people safe, training was up to date and staff had received supervisions where safeguarding was discussed. We saw evidence of safeguarding issues being discussed as part of lessons learned and continuous learning. There was information throughout the home about safeguarding so that people and their relatives knew what to look for and who to contact. One member of staff told us, "I can raise anything I want and it will be investigated by [registered manager]. They always make sure we know what to do and that we are comfortable raising any safeguarding concerns."

Staff recruitment was safe. We saw evidence that all staff had a current Disclosure and Barring Service (DBS) check in place. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. Other pre-employment checks had been carried out such as gathering references from previous employers. Where applicable, the registered manager had also completed a check of the nursing staff's registration details with the Nursing and

Midwifery Council (NMC).

There were enough staff to support people to stay safe and this was in line with the provider's dependency of needs tool. Dependency assessments were completed which ensured there was a summary of people's care requirements. This helped to ensure sufficient with the skills to provide appropriate care were deployed. One person told us, "There's always someone around and if I need them I just push my buzzer."

We reviewed maintenance records for the testing of equipment, water, electrical, gas and other premises testing to keep people safe. The home had current certificates to show it was fully compliant with health and safety requirements. We saw evidence of infection control procedures being followed and cleaning took place throughout the inspection. A relative commented, "It's always clean and smells fresh." We observed staff using personal protection equipment (PPE) whilst supporting people to reduce the risk of infection.

There was a business continuity plan in place which clearly detailed what would happen in case of emergency or if something happened unexpectedly. For example, if the service could no longer operate from the premises. A suitable fire risk assessment was in place and this was used in partnership with people's personal emergency evacuation plans (PEEPs). A PEEP is an individual escape plan for a person who may not be able to reach an area of safety unaided or in a safe amount of time in an emergency situation.

Is the service effective?

Our findings

People living at Primrose House received treatment and support delivered in line with current national best practice standards and guidance, such as National Institute for Clinical Excellence (NICE) and The Mental Capacity Act (MCA). The registered manager discussed learning opportunities and there was evidence of themed supervisions taking place with staff around best practice.

People received care from skilled staff who had completed training that the provider deemed as mandatory for their roles, such as safeguarding vulnerable adults, infection control, first aid, dementia awareness and moving and handling people. All new care staff who did not have previous qualifications or experience in health and social care, received a detailed induction in line with the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective and compassionate care. One staff member told us, "We get all the training and it keeps going. There's always something we have to read or go to. It's good though because it means we're on top of it."

We reviewed the staff training matrix at the home and saw that some staff required up-dated training in certain modules. We addressed this with a senior manager from the provider who assured us the training sessions had been booked but due to availability not all staff had attended.

Staff received regular supervisions and appraisals from the registered manager. These were pre-planned and in line with the home's supervision policy. The registered manager also conducted clinical supervisions for the nursing staff and recorded these separately. The regular monthly checks of the nursing staff's qualifications and registrations were also kept separately.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For the four people whose records we reviewed applications had been submitted to the 'supervisory body' for authorisation to restrict their liberty, as it had been assessed that this was in their best interests to do so.

For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed for their care and treatment, for example for bed rails and life changing choices about

serious medical treatment or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff. The MCA and Code of Practice states that a person's capacity must be assessed specifically in terms of their capacity to make a particular decision. We saw clear documented evidence to show the home was following the principles of MCA, whilst still ensuring people's rights to make particular decisions were upheld and their freedom to make decisions was maximised. One relative told us, "They always ask us to help make the decisions and I have to sign forms to show I was there."

Care records included people's Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) status. This meant that if a person's heart or breathing stops unexpectedly due to their medical condition, staff were aware that no attempt should be made to perform cardiopulmonary resuscitation (CPR). The DNACPR records were up to date, included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals who were involved in the decision.

Care plans demonstrated regular referrals were made to other professionals and there were communication records in the files documenting this. Care files showed appointments and referrals with outcomes from visits. Care plans showed regular updates when people had attended appointments and an area of their specific needs had changed.

We saw initial assessments for people when they first moved to the home, detailing what care they needed and how that care was to be provided. We saw regular reviews of people's needs to make sure that people received the correct support for them. .

Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped staff identify the level of risk to people. The Waterlow scale was used to assess people's risk of developing pressure ulcers. Assessments were regularly reviewed and up-dated to ensure they reflected people's current level of risk. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin. We saw a system was in place for people being cared for in bed to ensure they were re-positioned at regular intervals to maintain their skin integrity.

There were daily accountability records for each person, which showed what support each person had received. The records also detailed if people's well-being had changed or if their needs had changed. There were staff handover meetings which discussed the needs for each person and any up-dates from the previous shift. Staff communicated effectively with each other to make sure that people had a consistent level of support.

Some people received support with nutrition and hydration. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. The MUST was used to help staff complete individual risk assessments in relation to the risk of malnutrition and dehydration. This helped staff identify the level of risk and apply appropriate preventative measures. Staff monitored some people's food and fluid intake to minimise their risk of malnutrition or dehydration and recorded this on a chart which the nursing staff checked and evaluated in order to decide if further action should be taken. For example, referral to a GP, dietician or speech and language therapist. A relative told us, "[Name] once was poorly and they [staff] got the Doctor in quickly. They act quickly."

Care records showed that notification of dietary requirements had been given to the kitchen staff regarding food likes, dislikes and preferences. This meant there was good communication between care staff and kitchen staff to support people's nutritional well-being. Staff were able to tell us if people were on specific diets and the reasons for this. One person told us, "I like the soup and they mash my food for me." A relative told us, "[Person] has been seen by the hospital and needs to have smooth food. They [staff] changed the

dinner's straight away to follow the hospital's orders."

We observed the dining experience at the home over all days of inspection. Tables were set with table cloths, cutlery and napkins. Relatives were also welcome to join people at meal times. People had a choice of food and drink. Staff asked people what they would like and showed people the different options. The food looked appetising and well-presented. One person told us, "I like my food and I like this food. I'm getting heavier though because it's nice." If people required support with their meals this was carried out discretely and protective clothing was provided for people if they wanted it.

The home was appropriately adapted, nicely decorated and had elements of a 'dementia friendly' environment. There were contrasting walls, handrails and doors. The ground floor was decorated like a street with coloured doors. There was pictorial signage on bathrooms and toilets. Pictorial signage and menus help people visualise the planned meals, if they are no longer able to understand the written word. The corridors and doorways were wide enough to allow for wheel chair access.

Is the service caring?

Our findings

People and relatives told us the staff at Primrose House were caring, kind and nice. We saw many positive interactions between people and staff. Staff were aware of people's likes and dislikes, and these were reflected in their care plans. We saw staff asked people if they would like support at meal times and offered them fluids during the day. Staff demonstrated a caring attitude by comforting people when they were distressed. We observed one member of staff comforting a person who had become distressed. They distracted them by offering them a cup of tea and biscuits and talking to them in a comforting manner. A relative told us, "One day [Name] was upset and crying. They [staff] brought [Name] to the lounge and talked to them. They know [Name] likes company." Another relative told us that staff provide, "Loving and excellent care."

One person said, "They are all very good to me, cleaning staff and laundry staff " A relative said, " [Name] is always telling me they like it here. They [the staff] are quite good and you can talk to them". We observed people and relatives being acknowledged by staff as they passed them in the corridors or in communal areas. A member of staff told us, "We all get along together, we sing, we dance and we laugh. We're one happy family."

The provider and registered manager had a clear vision regarding their care of people. They wanted to make care special and to do this they recognised that they must know what every person needs and know each person as an individual.

People had person-centred care plans which included involvement from relatives and other professionals. These included signatures from everyone involved and were clearly documented. One relative told us, "They [staff] have explained the care plan and they ask me questions when they are re-looking at it." The care plans we reviewed clearly documented how people wanted to be supported and how frequently but also ensuring people were able to be as independent as possible. One person told us, "I can get out of bed, and get myself a wash down. They [staff] would do it, but I'm trying to help myself but they're on hand if I need them. I could buzz for them but I like to walk along myself."

People's privacy and dignity were respected by staff. During the inspection we observed staff asking people discretely if they could carry out personal care and if they required support. We observed staff knocking on people's doors and asking if they could enter, and asking people if they could support them.

The home promoted advocacy and there was accessible information available detailing what support people could access to help make choices about their individual lives. There was an information pack at the main reception for people and their relatives, and this explained about the support provided by the provider and other partnership agencies. There was also contact information for the local safeguarding team and information on relevant topics of interest.

The registered manager ensured staff encouraged people's confidence, engaged partnerships between families and the home, and maximised independence, choice and control where possible. Equality and

diversity policies were in place to ensure that people were treated with dignity and respect regardless of the sex, race, age, disability or religious belief.

Is the service responsive?

Our findings

We saw that care plans were person-centred and reflected the assessed needs of the person. Person-centred care planning is a way of helping someone to plan their care and support, focusing on what is important to the person. For example, one person like a specific type of shampoo and this was recorded in their personal hygiene plan. The care plans had recorded involvement from people and their relatives. Reviews of care plans had also been completed with people, relatives and other professionals. One relative told us, "[Name] used to love to watch the racing. They asked what [Name] liked to do and they wrote it down."

Before moving to the home people had initial assessments completed to ensure the service could fully support their needs. These assessments were used to shape people's care plans. The care plans were regularly reviewed by staff, the registered manager and the provider.

Some care plans we looked at lacked specific detail and required further development. For example, dementia care plans did not have a focus on promoting people's independence and helping people to achieve these things independently but with minimum support. Another example was in relation to challenging behaviours and whilst staff were able to describe techniques and communication methods they used to de-escalate behaviours that challenge, it was not always recorded in the care plans.

We observed there were activities for people to join in with during the inspection. People were encouraged to sing and clap along with music. There were photographs displayed throughout the home of activities which people had participated in. The registered manager told us that they had arranged for a small pony to visit the home and people really enjoyed this. One relative told us, "They chat and laugh with them. I've come in many times and their fussing with [person] and [person] loves it. There's things for them to do all day but now [person] likes to watch the T.V." One person told us that they visited a local church group. There was an activities planner on the main information board so people and their relatives could see what they could join in with. Activities were documented and recorded for each person. If people did not want to join in there was a reason recorded. The activities offered at the home allowed for the opportunity of social inclusion and engagement. One person told us "They have singers in and they're good. They have knitting, make Easter bonnets, decorations at Christmas, things on for St Georges' Day, and they'll have something on at Harry and Meghan's wedding. They celebrate special occasions." The registered manager also had a dog who visited the home regularly and people enjoyed talking to it.

At the time of our inspection no one was receiving end-of-life care. There were care plans in place to support the delivery of this and staff had received training in end-of-life care. Care records showed that end-of-life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

There was a comprehensive complaints procedure in place at the home. This was available to people and their relatives. We reviewed the complaints log for the service and the actions taken. The registered manager addressed all complaints within the designated timescales and took action where required. Lessons learned were acted upon and shared with staff during meetings and supervisions.

Compliments received about the service were also shared with staff and used as examples of good practice. Staff were recognised when they received positive feedback from people and they were proud that people's relatives had taken the time to write thank you cards. Any feedback received was recorded and regularly reviewed by the registered manager and the provider. A relative told us, "Have had no problems and if I did I would go straight to the Manager." One person told us, "I've got nothing to complain about. They keep asking for any but I've got nothing."

Is the service well-led?

Our findings

The registered manager and the provider have a legal responsibility to notify us of certain incidents. Our records showed that we had not received any notifications related to the renewal of applications for people whose freedom was restricted through the Deprivation of Liberty Safeguarding (DoLS) process. During this inspection we found 11 renewal applications with regards to DoLS had not been notified to the Commission. The registered manager explained to us that they had been informed by the provider that notifications for renewal applications of DoLS did not have to be notified to the CQC. A regional manager from the provider investigated this and confirmed that the information provided to the registered manager was incorrect.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Whilst planning for and carrying out day one of the inspection we found that the previous CQC rating was not displayed clearly within the home or on their website which is a legal requirement.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found that the provider did not have a sufficiently robust governance arrangement in place in relation to the monitoring of the quality of the service provision. The governance arrangements that were in place had failed to proactively identify findings of this inspection. As such legal requirements were not met and has resulted in breaches of our regulations.

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

We discussed our concerns about the governance system not identifying the concerns we identified at our inspection with the provider and registered manager. We were provided with some assurances in relation to the impact these issues had on the safety and quality of care that people who lived at the home received. For example, the registered manager carried out staff supervisions during our inspection with regards to health and safety issues we had found. A representative from the provider also arranged for a secure area to be built around the conservatory so people could not leave or enter through this. On the second day of inspection this secured area had been created and people were no longer at risk. The provider also arranged for the website to display the ratings for all of the care homes they owned. This was completed by the last day of inspection. The provider also displayed the ratings of the home at the main reception area by the end of the second day of inspection.

There was a long term registered manager in post who had been registered with the CQC since November 2015. This was in line with the requirements of the provider's registration of this service with the CQC. The registered manager was also a registered nurse and told us that they were aware of their responsibilities.

The registered manager was present during the final two days of the inspection and assisted us by liaising with people who lived at the home. They were extremely knowledgeable about the people and able to tell

us about individual people's needs. People and relatives we spoke with knew who the registered manager was and told us they were a visible presence at the service. One relative told us, "I can knock on the door or speak to [registered manager] any time. The doors always open." Another relative commented, "[Registered manager] will always listen and engages with everyone."

The registered manager had a clear vision for the service which incorporated the values described in the provider's statement of purpose. During the inspection we saw the registered manager providing guidance to the staff team and carrying out urgent supervisions with staff. The registered manager and provider worked together to create an open and transparent culture within the home. One member of staff told us, "You can ask anything and they'll be honest with you. I'm valued here and I like working here. I don't have to worry. It's a friendly place to work."

We saw records of regular staff meetings and reviewed the minutes from these. Meetings included lessons learned from incidents within the home, updates around policies, staffing changes and overviews of important information from the provider.

There were regular meetings for people using the service and their relatives to attend, we reviewed the minutes from these meetings too. The dates of meetings were posted in the main corridor so people and their relatives knew when they were. The service carried out regular customer surveys to collate feedback and improvements for the service. These were recorded centrally and used to support improvements to the service.

There was a governance framework in place but this did not fully identify the issues we found during our inspection. Quality audits were carried out by the registered manager and by the provider's wider management team, these included care plan audits, premises audits, training and medication. These were all recorded and provided action plans which could be analysed to see where the home was performing well and it highlighted areas for development. The registered manager carried out daily, weekly and monthly audits of the service and we saw evidence of these. The provider also carried out a quality assurance audit of the service on a monthly basis. These all allowed for the key areas of the service to be monitored and if any faults or errors were identified they could be acted upon. We saw evidence in staff meetings that learning outcomes were shared with the staff.

The service had an open, transparent and honest relationship with partnership agencies such as the local authority and the Clinical Commissioning Group (CCG) and we saw evidence in people's care files of joint working with external professionals to support people.

The provider requested feedback from people living at the home and their relatives via surveys. This information was used to help improve the quality of care provided at Primrose House.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The premises were not always safe for people using the service.
	Regulation 12(1)(2)(a)(b)
	The medicines trolley was unattended and unsecured.
	Regulation 12(1)(2)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have a robust governance framework in place.
	Regulation 17(1)(2)(a)(b)(c)(f)