National Neurological Services Ltd

Primrose Neurological Centre

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Primrose Neurological Centre is a specialist care home for adults who have experienced a brain injury or have a neurological condition, which may include associated complex needs. The service can support up to seven people. At the time of the inspection five people resided at the service.

People's experience of using this service and what we found
There was a lack of direction and leadership in the service. There had been a turn-over of registered managers and periods when there had been no manager in post. A new manager had started the week after our inspection and along with a new operations manager, had produced an action plan to address our findings.

People were not always receiving consistent care and support that met their needs. People's care plans and assessments were not clearly focused on achieving positive outcomes, such as goals and steps to become more independent. Some people were not sure of the purpose of their stay or what the next step would be.

Risk assessments were not written or routinely available to staff to advise them on how they should support people safely. We identified three areas of risk that we informed the operations manager about and these were addressed on the inspection.

Staff were not always available in sufficient numbers to take people out or to give them one to one time. Some people assessed as requiring support and supervision at all times did not consistently receive this support. This potentially placed people at risk.

Staff did not receive the training, support or supervision needed to meet the specialist needs of people in the service.

We have made a recommendation about staff recruitment.

Medicines were being safely managed for the majority of people. However, for one person who was self-medicating there were insufficient checks to ensure they were safe to do so.

People told us they had built trusting relationships with staff and we observed some positive interactions between staff and people in the service. They were treated with dignity and respect. Staff were knowledgeable about people's likes and dislikes.

People told us they enjoyed going out with relatives and staff when they were available. However, a number of people spoke of being bored and a lack of things to do in the service. Some people were spending long periods in their rooms.

People were not always offered variety in their diet and people said there was a limited choice at mealtimes.

People's capacity to make decisions was not being carried out in enough detail, in particular the support people required with different types of decisions.

Where people had been supported to access to healthcare and specialist support from external professionals these people had made good progress.

Quality assurance systems were not robust and had not identified the failings found at the inspection.

The new manager had experience of both being a registered manager of a care service and of working with people with neurological conditions, including brain injury. External healthcare professionals spoke highly of the new manager. People in the service and staff were keen to be part of developing the service under the new leadership.

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

Rating at last inspection
The last rating for this service was good (published July 2016). Since this rating was awarded the registered provider of the service has changed (23/07/2018). We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
This was a planned inspection.

Enforcement
We have identified breaches in relation to protecting people from avoidable harm, failing to have robust governance systems, and failing to ensure there were enough competent and trained staff deployed at the service.

Please see the action we have told the provider to take at the end of this 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 was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive .

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was now always well-led.

Details are in our Well-led findings below.

Primrose Neurological Centre

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of two adult social care inspectors.

Service and service type
Primrose Neurological Centre is a 'care home'. 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 service did not have a manager registered with the Care Quality Commission at the time of the inspection. However, a new manger had been appointed and was due to start the following week and begin the process of registering with us. This means that they, when registered, and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to our inspection we looked at all of the information we held about the service. This included any safeguarding investigations, incidents and feedback about the service provided. We looked at any statutory notifications that the provider is required to send to us by law. We used a planning tool to collate all this

evidence and information prior to visiting the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with everyone who lived at the service. We spoke with the operations manager, the team leader and five support workers. We spoke with two professionals who regularly visit the service. We looked at a variety of records which included the care files for four people who used the service, incident and accident records and four staff recruitment files. We also reviewed a number of records related to the operation and monitoring of the service, staff training and medicines management.

After the inspection
We continued to seek clarification from the provider to corroborate evidence found. We looked at training data and quality assurance records. We were sent an action plan to address the concerns and issues raised at the inspection.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider had not made sure that people were protected from the risk of avoidable harm. The service failed to carryout comprehensive assessments before admission and as people's needs changed. For example, we found people were admitted to the service without proper assessments and this led to placement breakdown. We were told one had been particularly unsettling for other people in the service.
- The provider had not ensured up to date risk assessments had been carried out. We found people with high risk health needs did not have a risk assessment to instruct staff on what to do in an emergency. One staff member when we asked what actions they would take to a potentially high risk, replied, "I haven't a clue but I would use my common sense."
- The provider failed to ensure lessons were learnt and effective action was taken to understand the behaviours of people in the service and the risk this posed to themselves, other people and staff. Systems in place to record lessons learnt were not being used. De-brief and post incidents forms to try to work out what had triggered people's challenging behaviours not been completed.
- We found a door to a store cupboard was unlocked and it contained materials that placed one person at risk due to their behaviours. We told staff and they made sure it was locked.

We found no evidence that people had been harmed. However, we found a failure to adequately assess, monitor and mitigated risk meant people were being exposed to the risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A Personal Emergency Evacuation Plan (PEEP) had been completed for everyone to ensure that there were arrangements in place to support them to evacuate the building safely in the event of an emergency and these were reviewed regularly. Staff told us they understood them.
- An external fire safety assessment had recently been completed and had identified no risks.

Using medicines safely

- Staff were not always following safe systems for the storage and administration of medicines. There was one person in the service who managed their own medicines and staff were not checking they were doing this safely. This person had previously been assessed as being at risk of self-harm and some of their medicines could be dangerous if misused. We alerted the operations manager who took action to ensure this support was put in place.
- Protocols for 'as and when required' medicines were not always completed with actions of what to do if they did not work. For example, what actions staff needed to take if a person continued to be in pain or to be

agitated. We discussed this with the operations manager and they assured us protocols would be implemented.

We found the systems to ensure medicines were safely managed was not being effectively applied by staff. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received medicines management training and had their competency regularly assessed.
● People's medicines were regularly reviewed and reduced, where appropriate, to achieve more positive outcomes for people.

Staffing and recruitment
● The provider had not ensured staffing levels in the home were sufficient to meet people's needs and keep them safe. Some people in the home were assessed as requiring one to one support or to be supervised by staff on a 'line of sight basis'. Staff told us, and we saw on the inspection, this was not always possible and taking people out in the community was also restricted by insufficient staffing levels.
● The staff team did not have the expertise and skills to support people with complex needs and to ensure they received safe and effective support. One staff member told us they had not been able to safely support a person to come back to the service and had called the police for help.
● There were two examples we found were people had been placed at risk of harm as a result of not being properly supervised. These were referred to the local authority and a safeguarding investigation had been carried out.

We found no evidence that people had been harmed. However, the provider had failed to ensure there were enough suitably qualified, skilled staff deployed to meet people's needs and to ensure their safety. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a system in place to help ensure staff were of suitable character to work with vulnerable adults. All staff had a police and identification checks before working at the service. However, we found recruitment checks needed to be more robust. For example, people's references were not always from the last social care employer and some references were not dated or signed making it unclear who had sent them.

We recommend the provider reviews the recruitment procedure against current good practice to ensure it is fit for purpose.

Systems and processes to safeguard people from the risk of abuse
● Staff had completed training in safeguarding adults. Staff were aware of their responsibility to pass on any safeguarding concerns. One support worker told us "I feel able to report concerns to a senior person. If I didn't agree with how it was handled I would escalate it."
● Information about how to report safeguarding concerns was displayed in the entrance hall, so it was clearly visible to everyone.

Preventing and controlling infection
● The provider had an infection control policy and procedure with best practice information. Staff had access to protective clothing and cleaning schedules were followed.
● The service was clean and people were encouraged to maintain cleaning skills as part of their daily living

routine.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The provider had not made sure people's physical, mental and social needs were being assessed, and in a timely way. The service was not fully recording and finding out what people's individual preferences were and how they wanted to be supported. Staff were not always knowledgeable about some of their needs. For some people this included details of important health care needs. For example, for one person experiencing epilepsy and seizures there was only a brief note with no details for staff on how to support them.
- Healthcare professionals we spoke with said while the service made appropriate referrals to them the advice given and follow up was not always consistently applied. They spoke of having to chase the service up for paperwork and having to making sure all staff knew what approach to follow with people.
- People told us they had enough to eat and drink. However, they said there was a limited choice at mealtimes. They told us they had cereal and toast for breakfast and sandwich for lunch every day. We saw one evening meal made by staff was a pasta bake using a jar of sauce with no additional meat or protein element. One person chose to use high protein substitutes. This had not been checked out by a referral to a dietician or its use monitored by staff.

We found people were not consistently supported in a person-centred way. This included promoting choice of a healthy diet and applying individual approaches recommended by other professionals. The provider was in breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had access to health care professionals such as the GP, social workers and care co-ordinators. People told us they were supported to attend appointments.

Staff support: induction, training, skills and experience

- Staff did not have the training or expertise to meet people's needs.
- The provider's statement of purpose and brochure stated the service offered 'specialist care by providing maintenance rehabilitation and complex disability management for adults following a brain injury or with a neurological condition.' Staff had not received specialist training.
- The provider's training matrix showed some staff had received basic brain injury awareness training for a half day, and on the same day training on how to manage behaviours that may be challenging. However,

two staff on duty including a senior had missed this training day. From our observations and discussions with staff, it was clear they had not received enough training to make sure they could support people with such complex needs.
● The provider had not ensured staff were receiving regular supervision about their work practice from a senior person. Some staff reported not having had a face to face supervision for several months.

We found staff training and supervision did not equipped staff to meet people's needs in the service. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Staff followed a system to assess people's mental capacity prior to requesting their consent or making decisions on their behalf. People's consent to care was recorded in their care plans. However, the service was unsure of the details of the renewal date for DoLS and if some people's had been reapplied for. The operations manager was in the process of doing this during the inspection and found the details for the second day of the inspection.

Adapting service, design, decoration to meet people's needs
● The building had been purpose built for people with an acquired brain injury and for people who may have limited mobility. The garden was fully accessible and corridors were wide enough to accommodate people who used wheelchairs. Bedrooms had ensuite facilities with walk in showers or adapted baths.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- The service did not have a consistent approach to make sure people's independence was being actively promoted. This was because staff lacked direction and leadership. Care plans were not up to date and goal setting with people was not co-ordinated.
- Staff were trying with some people to encourage and maintain their independence around meal preparation and shopping. However, this was limited to staff availability and individual staff approach. We observed staff supporting some people to make snacks and drinks. While for other people staff made snacks and meals for them. One person, had with staff support made a meal but this had been several months ago and their plan had not been updated with how to continue this progress.
- Staff lacked the skills and knowledge to actively promote independence. However, they were kind and compassionate in their approach and did their best to support people. Sometimes this meant that they did things for people rather than supporting people to be able to do things for themselves.
- People told us they would like more support to be independent. Such as having small pieces of equipment and activities designed to help with their memory and general recovery. One person told us, "I would like to take a shower on my own and have a go at taking my own medicines but I've been waiting for the medicines cupboard in my room to be lowered and some handles put in the bathroom."

Supporting people to express their views and be involved in making decisions about their care
- People told us they didn't always feel involved in making decisions about their care and not all care records showed people's involvement in the care planning process. Staff we spoke to felt that due to people's conditions, such as a brain injury, they had forgotten the plans. However, we did not see any consistent approach to improving communication or ways to promote and aid people's memory. Such as the use of communication aids, technology, story lines or memory boards.
- One person told us they felt "in limbo" and did not know what the plan was for their future. They were not aware of any development plans to help them achieve a wish to go home or to be more independent. We were told this by three other people in the service.
- People were allocated keyworkers to work on support plans, spend time with, and to share their views. We saw this had not been happening on a regular basis for a number of people. Where these were happening people had seen supported to make good progress, such achieving milestones of doing activities independently. One keyworker told us the plans for the person they supported, "We are going to try using public transport as the next step."

Ensuring people are well treated and supported; respecting equality and diversity;

● Staff treated people with respect and showed kindness towards them. People appeared relaxed in staff company. We observed people approached staff to inform them if they were not happy with a situation and seek out staff support when needed. They were supported to maintain their individuality.
● People told us, "Yes the staff are nice" and "Everyone is kind to me." We saw people had built trusting relationships with staff and were keen to spend time with them outside of the service.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were not always involved in decisions about their care, treatment and support in a meaningful way. Information about people's backgrounds and known risks before admission were not always risk assessed and kept up to date when their health or needs changed. We saw some plans had not been reviewed for over a year. Their care was often task-focused and did not consider their whole life needs. This meant the provider could not be sure staff had the information and skills available to provide person-centred care.
- Staff were not aware of what approach they were taking with people. We asked about different approaches, such as positive behaviour support and goal setting, staff were not aware of these. Staff reported that some people were hard to motivate. We saw limited intervention plans to show how staff could better support them.
- The provider failed to consistently ensure people were supported to achieve their goals and aspirations. Goal setting for people with acquired brain injury is often an essential technique to help them feel positive and in control of their lives.
- People's abilities and self-help skills had not been measured on admission. These are sometimes referred to as 'Assessments of Daily living'(ADLs) and are good practice tools to provide a measure for goal-setting and for monitoring progress. Healthcare professionals told us that they had tried to get the service to have more structure and a focus in their work with people in this way. They told us they were hoping this would improve with the new manager coming into post.

We found people were not consistently supported in a person-centred way. This was a in breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff supported people to take part in activities they enjoyed outside of the service, such as going to the gym, swimming and watching football. However, a number of people spoke of being bored and a lack of things to do in the service. When people were not out they spent long periods in their rooms or had little stimulation. There were very few therapeutic activities taking place.
- Staff supported people to maintain and develop personal relationships and contact with family and friends. People told us they enjoyed going out with relatives, and staff when they were available.

Meeting people's communication needs; Improving care quality in response to complaints or concerns

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The service had not fully implemented the AIS to identify, record and meet the information and communication needs of people with a disability or sensory loss. The provider had a strategy for implementing AIS across its services. Some literature was available in easy to read format including the complaints procedure and statement of purpose.

● However, the service was not using technology to aid people's understanding and to help with communication. Apart from some easy to read literature the service had not used IT or Aps to help people who had a brain injury and who may have short-term memory loss.

● People told us they could speak up to staff if they were unhappy about something. The providers complaint policy was on the notice board and given to people when they arrived at the service. However, people told us they had not felt able to complain or been confident that things would have been dealt with when the last manager was in post. They did say that they could speak to staff individually and any problems had been resolved informally in this way.

End of life care and support

● There was no one receiving end of life care at the time of our inspection. Staff had not received training in end of life care or bereavement awareness. We looked at people's care records which evidenced end of life preferences.

Requires Improvement

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- People told us the service had not been well-led. The registered manager had changed three times in two years, with gaps in between. This had led to the service being poorly managed over this period. Both staff and people using the service told us that it had been a difficult time.
- However, a new manager had been appointed who had experience of both being a registered manager and of working with people with neurological conditions, including brain injury. We spoke with the new manager the week after the inspection, at the end of their first week in post. They had been given a copy of our feedback form from the inspection and agreed with our findings. Together with a new operations manager they sent us an action plan to address the shortfalls and measures to reduce any risks.
- The new manager told us they were determined to turn the service around. They had, as well as producing an action plan, held meetings with people and staff in the service and reviewed care plans and assessments to address any immediate potential risks. This gave us reassurance that the service would be a safer place and people would begin to receive much more person centred-care and support.
- The provider had not ensured effective quality assurance processes were in place. This meant the provider did not identify the shortfalls we found during this inspection. These included poor records management, lack of therapeutic activities for people, shortfalls in staff training and a lack of robust risk management.

We found the provider's systems and oversight were not robust enough to demonstrate safety and quality was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider had not made sure people were receiving person-centred care and support to maximise their progress and independence.
- The service's vision, values and strategic goals had not been translated into a credible strategy with well-defined objectives. The service's brochure stated, "We offer long term care, providing maintenance rehabilitation and complex disability management." Staff and people in the service were unclear of the purpose of the service. Senior staff we spoke with were insistent that the service was not providing 'rehabilitation' and were reluctant to use the term. Support staff said that people only stayed for short-term up to about two years maximum.

● The new manager was very clear on the future direction of the service. They told us, "I've received full support from the director and operations manager. We know what we need to do and I'm determined to make this a really progress and forward thinking service."
● Health and social care professionals had worked with the new manager before and told us they were looking forward to working with them again and were sure the service would quickly improve.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The service had not always had an open and transparent culture. Staff had felt isolated and had lacked direction. They to told us they were looking forward to the changes and felt the past experience had made them stronger as a team.
● People had limited opportunities to have a say in the running of the service and stakeholder involvement had been limited. There had been staff meetings but not meetings for people in the service. However, key workers were assigned to people so that they could feel comfortable about speaking up and voicing any concerns on an individual basis.
● The service had limited engagement with external social care initiatives or forums. This type of partnership working improves best practice and access to local resources including training.
● Staff were not given champion roles. This is when staff take a lead in a key area, have extra training, attended forums and conferences so they can share good practice with the rest of the staff team.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had developed policies and procedures and training around the duty of candour responsibility if something was to go wrong. We saw they contacted families and other professionals and had notified CQC of any incidents they were required to tell us about.

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 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person-centred care and treatment. Care plans were not up to date and did not detail how people's holistic needs were to be met. Regulation 9(1)(2)(3)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure robust systems were in place to assess, monitor and mitigated risk. This included ensuring that medicines were managed safely. This placed people at risk of harm. Regulation 12(1)(a)(b)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and oversight were robust enough to demonstrate safety and quality was effectively managed. Regulation 17(1)(2)(a)(c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

People were not being supported by suitably qualified, supervised and skilled staff. Staff were not being deployed or in sufficient numbers to meet people's needs and to ensure their safety.

Regulation 18(1)(2)(a)