We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

<table>
<thead>
<tr>
<th>Primrose Hill Farm</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Meadowsweet Avenue, Kings Norton, Birmingham, B38 9QW</td>
<td>Tel: 01214335666</td>
</tr>
<tr>
<td>Date of Inspection: 18 December 2012</td>
<td>Date of Publication: February 2013</td>
</tr>
</tbody>
</table>

We inspected the following standards to check that action had been taken to meet them. This is what we found:

| Safeguarding people who use services from abuse | Met this standard |
| Records | Action needed |
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Extel Limited t/a Care Through the Millennium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Manager</td>
<td>Mr. Andrew Jennings</td>
</tr>
<tr>
<td>Overview of the service</td>
<td>Primrose Hill Farm provides accommodation and personal care for up to 39 people who have a learning disability and / or autistic spectrum disorders and behaviour that is challenging. The accommodation is provided in seven different houses on an enclosed site. Primrose Hill can provide personal care to people in their own homes.</td>
</tr>
<tr>
<td>Type of services</td>
<td>Care home service without nursing</td>
</tr>
<tr>
<td></td>
<td>Domiciliary care service</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Accommodation for persons who require nursing or personal care</td>
</tr>
<tr>
<td></td>
<td>Personal care</td>
</tr>
</tbody>
</table>
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When you read this report, you may find it useful to read the sections towards the back called ‘About CQC inspections’ and ‘How we define our judgements’.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Primrose Hill Farm had taken action to meet the following essential standards:
- Safeguarding people who use services from abuse
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 December 2012, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

On the day of our inspection, 39 people were using the service. We spoke to two of these people. Several people were not able to give us their views because of their complex needs and conditions. People made positive comments about the service and these included, "I like it here" and "The staff are good."

We observed that care staff were attentive and polite and that people were comfortable and relaxed with care staff. It was clear that the staff had a good knowledge of all of the people who used the service and were familiar with their preferences and health conditions. People's diversity, values and human rights were respected.

We found that since our last inspection of this home that improvements had been made in relation to safeguarding and that people who use the service were protected from the risk of abuse, because the provider had now taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We found that the provider did not always have an effective record keeping system regarding people's care and health needs. This meant that people were not always protected from the risks of unsafe and inappropriate care because decisions and communications about care and support were not always documented within personal records effectively and promptly.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 26 February 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.
Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

**More information about the provider**

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Safeguarding people who use services from abuse  ✔  Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We looked at this outcome during our last inspection of this home in August 2012. At this time we said the provider was not meeting this standard as people were not always protected from the risk of abuse because the service had not taken all reasonable steps to identify the possibility of abuse. The provider subsequently forwarded us an action plan setting their proposals for improvement.

At our December 2012 inspection we spoke to the manager about these issues. We found that since our last visit, the service had reviewed how they manage restraints and that there had been progress and change on all areas of the action plan they had submitted to us.

We found that policies, procedures and recording of restraints had been reviewed and improved. There had been some delays in ensuring that all staff had received training about the new forms and procedures but this process had now been completed. The management had reviewed how and why some people become upset and looked at alternative methods of intervening to lessen people's anxieties (root cause analysis) before they became upset. We were told and saw records for one person where this had lessened the number of incidents of behaviour that challenged the service.

We asked for and received information about the summary of incidents to see if outcomes for people that lived in one of the houses were improving. We found across the home there had been a marked lessening of physical restraint in favour of de-escalation and breakaway techniques. There was a monthly analysis of all interventions where consideration of changes to people's care plans were made to lessen incidents. This meant that the service was regularly assessing the best means of dealing with challenging behaviour.

We had received information before our visit that an inappropriate restraint had been used. This had been independently raised with the service before our visit and it had been
investigated by the service. The provider may wish to note that this allegation had not been referred to the local safeguarding authority and we had not been notified as required.

We spoke to care staff who confirmed that they were familiar with the new changes in relation to the recording and reviewing of incidents. They told us that new forms had been introduced and that incidents were now reviewed and analysed on a monthly basis. We checked training records and confirmed that most care staff has received training in relation to safeguarding vulnerable adults, the use of restraint and dealing with challenging behaviour. This meant that staff had the knowledge and appropriate training to deal with incidents of behaviour that challenged the service.

We found that since our last inspection of this care home that improvements had been made in relation to this outcome and that our concerns from the previous inspection in August 2012 had been rectified.
Records

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our inspection in December 2012 we visited two of Primrose Hill Farm's seven residential houses and talked to house manager's regarding record keeping.

At one house, we examined three care plans and found the information recorded was legible and easy to understand. Each individual care plan was detailed and covered every aspect of people's lives. They included relevant information regarding medical needs, interests and dietary preferences. We saw that where necessary, risk assessments were in place to enable people to access social and educational activities safely.

We found that people's religion and ethnicity were recorded on care records and this reflected in how care was offered. We noted that care plans were checked and reviewed by the house manager which meant that care needs were regularly being assessed and changed if appropriate.

At this house we checked records for personal care and saw that they were current and up to date and that people were showering, bathing and receiving personal care regularly.

When we visited the other residential house, we found that there was no permanent house manager in post. We were told that this person had left prior to our visit and had not yet been replaced. We were introduced to the person who was in charge of this house on 'temporary' basis, a person who was a full time manager from one of the other provider’s care homes.

We subsequently examined care plans of two people who lived in the house. We found that both care plans were lacking in detail and some of the risk assessments and care records had not been updated on a regular basis.

Although some records were very good (providing instructions to staff) regarding specific health conditions, we found that completion of care plans in this house was generally inconsistent. For example we could not see any entries on care plans which related to people's likes and food preferences. However when we spoke to care staff about the
people who lived there, we found that they knew what food people liked (and disliked) and had also made special arrangements to provide people from ethnic backgrounds with a wide variety of (preferred) meals.

We checked bathing and showering records and saw that they had not been completed to show that either person had been assisted with personal care for more than two weeks. We spoke to the manager about this who assured us that both people's personal care needs had been attended to and that these omissions were recording errors. This meant that people were not always protected from the risks of unsafe and inappropriate care arising from a lack of proper information about them because verbal decisions and communications about care and support were not always documented within personal records effectively and promptly.

The manager told us that due to the absence of a permanent manager at this house that they had recently arranged for an internal review of care to be conducted by a senior member of staff. This review had been completed and had also identified shortfalls with record keeping at this house. We were told that these problems were being addressed as a priority and that the appointment of a house manager (who had been recruited and was about to join) would ensure a significant improvement.

During our inspection of both houses, we found that records were kept securely and could be located promptly when needed.
This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
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<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Records</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>People were not always protected from the risks of unsafe and inappropriate care arising from a lack of proper information about them because verbal decisions and communications about care and support were not always documented within personal records effectively and promptly.</td>
</tr>
<tr>
<td></td>
<td>Contrary to Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010.</td>
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</tbody>
</table>

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 26 February 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✔ Met this standard

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
### Glossary of terms we use in this report (continued)

**(Registered) Provider**

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

**Regulations**

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

**Responsive inspection**

This is carried out at any time in relation to identified concerns.

**Routine inspection**

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

**Themed inspection**

This is targeted to look at specific standards, sectors or types of care.