Pathways Care Group Limited

Harmony House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 30 April 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 1 May 2015 and was announced. We last inspected the service on 7 May 2013 and found the provider was meeting all legal requirements we inspected against.

Harmony House is a care home managed by Pathways Care Group Limited and is registered to provide accommodation for people who require nursing or personal care. Any needs in relation to nursing care are met by the local community nursing services.

The service has two wings, one supporting people with mental health needs called Harmony; the other wing, South View, supports older people living with dementia or a learning disability. All rooms on South View are on the ground floor. The service is set in a mainly residential area with good access to shops and local amenities. A maximum of 37 people can live there and it has good access both into and outside of the property.

There was a registered manager in post at the time of the inspection however they work at a regional level within the organisation. There was a manager based at Harmony House who had responsibility for the day to day management of the service. They told us they were in the process of registering as a manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

10 people were living in South View and 14 in Harmony at the time of the inspection.

People told us they felt safe living at the service and were well looked after. Staff had attended training in safeguarding vulnerable adults and were able to explain the procedures they would follow if they felt someone was at risk of harm. There was also information on display around the service on how to safeguard people and who to contact. Senior care staff explained that they would raise concerns with the safeguarding team from the local authority if the manager was not available to do so for any reason.

Accidents and incidents were appropriately recorded and the information was analysed to identify any trends or to identify where changes to peoples care may be needed.

Risk assessments were in place which identified relevant risks and how they should be managed. Area's where people did not need staff support were recorded and we observed staff respected this and gave people the time they needed to maintain their independence. Staff were seen to explain to people what they were doing and why so people were actively involved in the support they received and understood what was happening and why.

Each person had a plan in place for if they went missing from the service which was specific to their needs. Personal emergency evacuation plans were also in place and staff knew how to evacuate the building both during the day and at night. These procedures were different due to the different staffing levels at night. A business continuity plan was in place in case there were emergencies in relation to the building, utilities, staffing crisis or extreme weather conditions.

There was a fire risk assessment and building plan alongside all appropriate checks of fire alerting and firefighting equipment. A range of health and safety risk assessments were in place which identified risks in relation to building safety and security, maintenance, control of substances hazardous to health (COSHH). These documents had all been reviewed appropriately and future review dates had been set.

People and staff told us they were able to meet people's needs with the current staffing levels. We saw that staffing levels had increased when new people had recently moved to the service. There had been appropriate recruitment which included pre-employment checks such as obtaining at least two references and completing a Disclosure and Barring Service check.

Medicines were managed safely and effectively. Care plans were in place for medicine administration and protocols for 'as and when required' medicines had been developed. Senior staff administered medicines and had been trained and competency checked. Regular audits of medicines took place and the senior care staff spoke to each other regularly about ordering and booking in medicines together so everything could be double checked.

Staff told us they were well trained and supported with regular supervisions and an annual appraisal. We saw a training matrix which had been completed in August 2014 which showed that some training was out of date and needed to be refreshed. We spoke with the manager about this who was able to show us the electronic system whereby staff were completing eLearning. This system showed that staff had completed the necessary training.

Team meetings were held regularly and the timing of these had been changed so day staff and night staff could have a meeting together.

The manager and the staff had a good understanding of the principles of the Mental Capacity Act 2005 (MCA) and appropriate applications had been made and authorised in relation to Deprivation of Liberty Safeguards (DoLS). Staff were able to explain the restrictions that authorised DoLS placed on people and how this impacted on the care they received.

People had been involved in planning their care and where they were able to do they had signed their care records and risk assessments. People had also given consent for staff to manage their medicines on their behalf and for photographs to be taken for identification purposes or to display around the service.

People said they enjoyed the food and there were different options for people to choose from. The chef had a good understanding of people's specific dietary requirements and prepared one person's food separate to everyone else's as they chose to have a vegan diet.

Summary of findings

Nutrition and hydration care plans and risk assessments were in place and where referrals had been made to dietitians and speech and language therapy in order to ensure people's individual needs could be met.

Appointments and visits from health care professionals were recorded appropriately and this included contact with district nurses, opticians, chiropodists as well as doctors and community psychiatric nurses.

People had hospital passports which could be used as 'grab packs' containing vital information for medical staff should someone need to attend hospital as an emergency.

We observed that staff had positive and meaningful relationships with people based on kindness and respect. Staff were unrushed and were seen to spend time with people chatting or holding their hands to offer reassurance and company. Staff were very aware of people's right to confidentiality and treated them with respect, maintaining their dignity at all times by offering support in a discrete and compassionate way.

Care records were personalised and included information on people's life story and their background, as well as their current likes and dislikes, preferences and wishes. Documents supported staff to maintain people's independence and recognised that there were area's where people did not need staff support.

People told us there were activities available but also said, "The staff teach me new stuff." We saw photographs of group outings and events displayed around the service and staff were enthusiastic about fund raising so people could enjoy trips to the theatre or similar events. Staff supported people to maintain contact with their family and friends and we saw that one person had requested staff support them to send cards to their family on special occasions.

Pictorial information on how to complain was available throughout the service and we saw that complaints had been recorded and acted on appropriately with letters of apology sent to complainants as well as the results and outcomes of investigations.

An annual quality assurance questionnaire had been sent out to families, professionals and staff. The results of which were all positive with everyone believing a good service was provided. Staff felt it was a good place to work and they said they were well supported by the manager.

Audits were completed by the senior care staff, the manager and the area manager. We saw that action plans were in place and identified areas for improvement however they were not always signed off as complete. We spoke to the manager about this as we had seen that many actions had been completed, such as a new boiler being installed. The manager said for things that hadn't been done they kept reporting them and spoke to the area manager about it on their visits. They stated they would sign things off as complete when work was finished so there was an audit trail of actions completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood procedures for safeguarding people and were aware of whistleblowing. One staff member said, "I would stand up for people's rights no matter what."

Relevant risk assessments and emergency plans were in place.

People and staff told us there were enough staff to meet people's needs. We found appropriate recruitment procedures were in place and being followed.

Medicines were being managed in a safe and effective manner.

Is the service effective?

Good

The service was effective. Staff were trained and said they were well supported by the manager, receiving regular supervision and annual appraisal.

Staff understood how authorised Deprivation of Liberty Safeguards (DoLS) impacted on people's care and were proactive in following the principles of the Mental Capacity Act (2005).

People said they enjoyed the food and their health and nutritional needs were being met.

Is the service caring?

Good

The service was caring. We saw that staff had positive and caring relationships with people and were aware of maintaining people's individuality and dignity.

People were treated with kindness and respect and staff were quick to respond if someone was upset or anxious but they did not draw attention to this and cared for people in a discrete and appropriate manner.

Is the service responsive?

Good

The service was responsive. The staff were aware of the need to put the person at the centre of the care they received and were responsive to individual needs. They recognised that people had histories that were important to them and captured this in people's life stories.

Activities were arranged according to people's preferences and people told us they enjoyed outings and were learning new things.

Complaints and concerns were recorded appropriately and managed within specified timeframes.

Is the service well-led?

Good

The service was well led. The manager had an active presence around the service and was known to and well-liked by all people and staff.

The registered manager visited the home on a weekly basis and completed monthly audits of the service.

There were a range of quality assurance audits used and actions were recorded however they were not always signed off as completed but we did see that the majority of actions had been completed.

Harmony House

Detailed findings

Background to this inspection

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

The inspection took place on 30 April 2015 and 1 May 2015. Day one of the inspection was unannounced.

The inspection team included one adult social care inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events of incidents the provider is legally required to let us know about.

During the inspection we met with six people who lived at the service. We spoke with seven members of staff including the manager, care staff and senior care staff. The registered manager visited the service during the inspection. We contacted the local authority safeguarding team and commissioners of the service to gain their views. They had no concerns about the service.

We looked at four peoples care records and five staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We looked around the building and spent time with people in communal areas.

Good

Is the service safe?

Our findings

People told us they felt safe living at Harmony House. We observed staff reassuring one person who was anxious that they were safe and another person told us, "I'm very happy here, I'm well looked after and safe, I've no complaints."

Information on safeguarding was available around the service and procedures and contact numbers were on display in the office.

There were individual safeguarding logs in people's files which gave a brief account of any concerns. The manager explained that the detailed log was in a separate file stored confidentially in the office but they felt it was important that staff had access to some basic information in case it was needed whilst they were out of the office. The manager's log contained information on the date and names of the people involved, whether it had been raised as an alert or managed internally. There was also information on the action taken and the outcome of the concern or alert with a review date, name and role of the responsible person and a signature.

Staff were able to explain what they would do if they thought a person was being harmed in any way. One said, "I would speak to the manager or CQC [Care Quality Commission] if I needed to." They went on to say, "I would keep the person safe and speak to them, reassure them."

Another staff member said, "I would report it." "Whistleblowing." "I have no problem with this; I would stand up for people no matter what."

Accident and incident forms were completed with a description of the incident, any behaviour prior to the incident and what the triggers for the incident may have been, the action taken and which staff were involved in supporting the person. The information was analysed to identify any trends or triggers and to amend care plans and risk assessments in response to any identified change.

Appropriate risk assessments were in place and identified the risk, the existing control measures and risk rating. There was also space to record any additional actions that needed to be taken to reduce or manage the risk.

Staff explained that most people had appointeeships to support them with the safe management of their finances. An appointee is someone who manages benefits on behalf of the person, for most people this is either a relative or the local authority. Care plans and risk assessments were in place to direct staff how to support people with finances and accessing money. We observed one transaction and saw staff checked and recorded the balance at the same time as recording the transaction. All transactions were recorded, double signed and receipts were kept.

Where people had mobility needs we saw specific care plans and risk assessments were in place which provided detail on the hoist and sling to be used and how staff should work together to enable safe and comfortable transfers for people. It was documented that staff were to explain what they were doing and why during transfers. We observed one person being transferred to their comfortable chair by two staff and saw that they followed the care plan appropriately offering explanations and reassurances of what they were doing.

A senior care staff member told us, "[Person] uses a hoist for transfers because they can't weight bear." They added, "The occupational therapist was involved in the initial assessments."

Plans were in place in case of emergencies. Each person had a 'missing persons form' which was to be shared with the police if needed. This included a photograph and description of the person, their next of kin, known places where they may go, a summary of their condition and any emergency contact numbers including the crisis team's phone number.

People had 'personal emergency evacuation plans' in place which included information on their mobility and sensory needs as well as any specialist equipment that might be needed to support an evacuation. There was also a description of a night time evacuation and a day time evacuation which took account of the different staffing levels during the night. These were stored in a red file with the business continuity plan. The contingency plan included key threats to the service such as loss of the building, utilities, staffing crisis, and extreme weather conditions. There were also possible causes for the threats listed along with action plans including detail on who to contact.

Emergency contact numbers for repairs and maintenance, crisis teams and on call staff were on display in the office as was a copy of the fire procedure.

A fire folder was in place which recorded a range of tests and servicing that had been completed on firefighting

Good

Is the service safe?

equipment, break glass boxes, emergency lighting, the fire alarm system and fire door maintenance. We saw that where any action had been needed this had been completed in a timely manner.

A building plan was in place and a fire risk assessment had been completed and identified all the people who may be at risk. Specific standards were recorded and the assessment identified whether they had been met and how. There was also space to record any necessary actions.

Relevant certificates were in place to ensure the safety of the building such as the electrical installation certificate; gas safety certificate; fire alarm inspection; emergency lighting certificates were all in place. Portable appliance testing had been completed and recorded appropriately.

An external company completed the maintenance and management of legionella checks including water temperature checks and testing, disinfection and maintenance of shower heads.

Appropriate health and safety risk assessments had been completed and covered things such as the building safety and security, slips trips and falls, fire, legionella prevention and contractor visits. We saw that these were all in date and future review dates had been specified.

A senior care staff member told us, "There are three waking night staff, one on each side and one who floats between the two. During the day three care staff work on South View and two on Harmony. Two of the day staff are seniors." We asked why there were fewer staff working on Harmony when more people lived there. Staff explained, "It's because the people living there are pretty independent, there's no moving and handling or anything so the staff ratio can be lower." They added, "Someone could go over if they were needed but this doesn't happen." One staff member said, "It would be beneficial to have an extra member of staff working the night shift in case someone needed to go to hospital but the manager and the seniors are on call for out of hours emergencies." The majority of staff told us they were able to meet people's needs. One staff member said, "Yes, there's enough staff, we all manage great."

The manager explained, "Social services specify what hours of one to one support are needed." They added, "We do have enough staff to deliver this at the minute." We saw that staffing levels had been increased to accommodate the needs of people who recently moved into the service, and the manager told us that another senior care staff member was being recruited.

Appropriate pre-employment checks had been completed including two references and the completion of an enhanced DBS check. We also saw that people were required to complete an application form and there were standard interview questions in place and a record of applicant's responses.

We observed a medicine administration round and saw that the senior staff member washed their hands and wore appropriate personal protective equipment. Bottles of medicines had when opened dates recorded on them, and boxed medicines had people's photograph on them for identification purposes. Boxed tablets were also stock checked to ensure the correct administration and balance remaining. The senior staff member supported people individually and knew that one person needed to take their medicine one tablet at a time and be prompted to swallow whilst someone else took them all together. Medicine administration records (MARs) were signed after people had taken their medicines. Body charts were used to guide staff with regard to the administration of topical medicines such as creams.

Temperature checks for the safe storage of medicines were recorded every day.

Medicine care plans were in place and recorded information such as the person needing to have their medicine in liquid format; that the person needed staff to tell them it was their medicine and to be patient and approach slowly.

Protocols for 'as and when required' medicines were in place and recorded the identified need for the medicine, the reason for the medicine, the desired outcomes and the actions and interventions needed such as people requesting their medicines or how staff would know if someone needed their medicine to be offered. Protocols and care plans instructed staff to seek information on previous times and doses given before administering any medicines. They also instructed staff to contact the persons GP if they felt any 'as and when required' medicines were being used more often than usual and to amend the care plan as needed.

Good

Is the service safe?

Medicine information sheets were available in people's medicines files for staff to refer to.

Senior care staff completed a medicine audit every Sunday, which included a check of controlled medicines. Controlled medicines have tighter legal controls around them to prevent them being obtained illegally, being misused or causing harm to people. This audit checked many things including the MAR charts for correct entries and a check of explanations for any refused or destroyed medicines

A senior care staff member said, "Seniors try to have a day together for a catch up on the role and responsibilities. We try to order medicine and book them in together so we can check everything is ok."

Good

Is the service effective?

Our findings

One staff member told us, "I am still new so still doing my training." They added, "I've started my NVQ and I've done my mandatory training." They added, "I haven't been trained in mental capacity yet but I've picked up little bits from reading the care plans." They told us, "I have an induction workbook and things I've done are ticked off, like fire safety, getting to know people, doing a fire evacuation."

One senior care staff member told us they had received training in, "Medicines, moving and handling, fire, infection control, food hygiene, health and safety, safeguarding, autism, mental capacity act, dementia, challenging behaviour, MAPA [management of actual and potential aggression] and had their NVQ levels 2 and 3 in health and social care."

Another staff member said, "I've done all the mandatory training as well as dementia and safeguarding. I welcome refresher training as it keeps you up to date."

We reviewed a training statistics log and training matrix which had been completed in August 2014. This showed that some training needed to be refreshed. We asked the manager about training and they explained that staff were completing on line eLearning. They showed us the completion statistics and we saw that the manager needed to print off many certificates and update the training log and matrix. We saw the manager completing this during the inspection.

A senior care staff member said, "The manager does supervisions every three months and we have an annual appraisal. We are well supported." One staff member said they had, "Regular supervision and an appraisal with the manager." Another told us "I have regular supervision and there's always the seniors to go to if I'm unsure of anything, or peer support from colleagues. The staff are skilled so we are learning from each other."

One staff member said, "There's loads of support. [person] is a fantastic manager, you can go to them for anything, they're really good." Another said, "I haven't had an appraisal yet but I'm due my probation meeting after six months so it's coming up soon."

We viewed supervision records and saw that they were held regularly and included discussion on people supported, safeguarding, health and safety, record keeping, training, hours worked and leave and sickness.

Team meetings were held on a regular basis and the agenda included medicine administration and recording, safeguarding, knowledge and confidence, health and safety, infection control, residents meetings with staff, care plans and Care Quality Commission updates. We saw that the minutes of the team meeting reflected that staff had been praised for their knowledge of safeguarding.

One staff member said, "There's regular team meetings, we've tried mornings and afternoons to find the most appropriate time for night staff to attend. The last meeting was at 7pm to get the day and night staff together."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We saw that DoLS authorisations were in place where needed and had been managed appropriately. Staff were able to describe the reason for the DoLS authorisation and the impact it had on people's care. Corresponding care plan's had been written. One person's care plan needed to be updated in relation to an authorised DoLS that came into effect one week prior to the inspection. We asked the manager about this and they said, "There is a note in the office to alert staff to the change but It'll be done straight away." We saw this note and saw that staff were aware of the change and were able to explain what the recent DoLS authorisation meant in relation to this persons support.

Appointments with Independent Mental Capacity Advocates (IMCA) and best interest assessors were recorded appropriately. IMCA's are appointed to represent people where there is no one independent of the services being provided, such as a family member or friend, who is able to represent the person. A best interest assessor is an authorised and trained person who decides whether a deprivation of liberty is occurring, or is likely to occur, and, if so, whether a DoLS is in the best interests of the person being assessed.

Where people had the capacity to do so they had signed documents giving agreement that they had read the care plans and agreed with the plan of care. People also gave

consent for staff to administer medicines and to have a photograph taken which could be used for identification purposes. We saw that lots of these documents were in pictorial format and were easy to read.

Care plans documented people's history in relation to any behaviour that may challenge and any triggers that may result in the behaviour. For example, boredom and lack of structure; or needing medical interventions. Specific actions were recorded that staff needed to follow to reduce the likelihood of any incidents as well as what action they should take if any behaviour did happen.

Staff had completed behaviour charts for any incidents which included information on the behaviour and the environment at the time. Social workers had been informed and the service were working closely with the specialist behaviour team who visited the service every week to share information with the staff and to highlight any triggers for behaviours. We were told that the community learning disability team also held weekly meetings at the service to update and share information.

There was a policy on restraint which stated, 'Restraint represents bad practice and should be avoided wherever possible.' Staff confirmed that they did not use any methods of restraint when supporting people. Staff did say they had received training in the management of aggressive and potentially aggressive behaviour.

One person told us, "The food is adequate, I indulge every day, its good." Another said, "The food is really good."

We spoke with the chef who told us they had been trained in food hygiene and health and safety as well as having a qualification in food cookery. They explained there was a choice of two hot meals for people or they could have sandwiches. People could have a cooked breakfast and snacks were available for people overnight should they be hungry. There was a board in the kitchen which detailed any special dietary requirements people had and the chef knew who these instructions related to.

Dining room tables were set nicely, with napkins, condiments and glasses. People were supported to the dining room about 15 minutes before the meal was served and were offered a choice of juice whilst they waited. The chef served each person individually asking what they wanted. There were sufficient staff to support people if needed but many people were independent and enjoyed their meal socialising with staff and others.

Staff said there was an option for people to have meals in the lounge or in their rooms if they preferred to do so. Some people did not want to eat lunch at the same time as everyone else so their meals were plated, covered and labelled with the date, time and heating instructions. Thermometers were available for staff to check the correct temperature of food before serving.

We saw menus were displayed and included information on any allergens.

People who had specific dietary requirements were catered for, including one person who chose a vegan diet. The chef explained that their food was prepared separately to the other foods to avoid cross contamination.

Nutrition and hydration care plans and risk assessments were in place and included any specific nutritional or medical needs people had, such as diet controlled diabetes. People had access to specialist support such as dietitians and speech and language therapists and this was well documented and advice transferred into care and support plans for staff to follow. Mealtime information sheets gave instruction on any specific care needs people had in relation to food and drink and also recorded any equipment people needed, what position they needed to be in and what support they needed.

We saw relevant records relating to people having appointments with doctors, dentists, chiropodists, opticians, district nurses and community psychiatric nurses. Outcomes of the appointments were recorded appropriately.

As well as routine appointments with healthcare professionals people had been referred to dietitians and occupational health in relation to ensuring their individual needs were met.

People had hospital passports which were used as grab packs of vital information should someone be admitted into hospital. For example, they included information on risks such as choking; peoples medical background; one person's stated that they needed their medicine to be in liquid format as they were unable to take tablets. There was also information on people's communication needs and how people showed that they were worried or anxious.

Good

Is the service effective?

Physical health and wellbeing plans were in place. One person's included detailed information on how to care for the person if they experienced a seizure. It also included information that the person may become distressed if they needed to have a medical intervention of any sought.

Good

Is the service caring?

Our findings

One person said, “Staff are good, belters in here like.” Belter is a colloquial term for someone who is admirable or outstanding. This person went on to say, “It’s good living here, I’m doing well.” Another person said, “It’s a lovely home.”

One person we spoke with said, “It’s home from home, the staff are lovely, the food’s lovely, they take us out when they can, go to appointments and hospital with us.” Another said, “She [the manager] has been a good lass to me, she always helps me.”

People had positive relationships with all staff and spent time with people freely engaging in conversations with the care staff, the chef and the manager alike. We saw that people were enjoying a laugh and joke with the chef whilst asking what was for lunch. The chef explained that they were also trained as a member of the care staff team so people knew them well.

Staff handovers were completed for every shift change in both written and verbal format. They included information on people’s day; their general well-being, any medicine concerns, their sleep patterns or other concerns. We observed that staff spoke about people in a respectful manner and ensured information was handed over in a confidential space to maintain privacy and dignity.

A recent residents meeting had been held and had been used for people to share any issues or concerns they may have. We asked the manager about the meetings and were told, “We are planning to hold them as resident and relatives meetings in South View. In Harmony it can be difficult as people tend to do their own thing and will come and see us if they have any worries or concerns.” The manager explained that they were looking to hold the meetings during an evening time as they felt this may be a better time and opportunity to get people together.

We observed that people who lived in the Harmony wing of the building often popped in to see the manager and shared any thoughts or feedback or concerns with them in a very open way. The manger was responsive to these conversations and welcomed the opportunity to speak with people.

There was information on advocacy available, including IMCA’s. IMCA’s are independent mental capacity advocates and support people who do not have any family to act as their representative.

Staff treated people with dignity and respect and were careful not to share any confidential or sensitive information about people in public settings. We observed that staff spent time chatting with people and were very quick to respond when someone appeared distressed or anxious or in need of some support. Staff explained to people what was happening and allowed people the time they needed to process the information. One staff member said, “It’s about having a common sense approach. Standing up for people’s rights and making a difference.”

There was a ‘Wall of Achievement’ in Harmony House which celebrated people’s success such as moving on to live independently, looking after the gardens, successfully completing arts and craft courses. People we spoke with were proud of their achievements and were happy for their stories and photographs to be shared on the wall.

The manager explained, and we saw, that everyone had personalised bedrooms. The manager said, “We have tried to copy [person’s name] bedroom from where they used to live to replicate it due to them having tunnel vision and needing consistency.”

We also observed that people who lived in Harmony were very caring and compassionate about people who lived in South View and often asked how people were. People had also been involved, with the staff in organising fund raising events for South View for people who were living with dementia and they had also held similar events for a local women’s refuge resulting in photographs in the local paper.

Good

Is the service responsive?

Our findings

Initial assessments were completed prior to people moving into the service. Assessments covered a range of support needs including, medicines, risk factors, personal preferences, nutrition, cultural beliefs, communication, relationships, coping strategies and expectations.

Some people had one page profile's in place which included what was important to the person such as, 'Don't rush me; I like to have your attention and to shake hands as you pass me.' The document also included things people liked and admired about the person, and how best to support them, such as the need for two staff to support with moving and handling. A one page profile is an example of a person centred thinking tool which supports staff to get to know the person and their likes and dislikes rather than just seeing the person as someone who needs care and support. We asked why not everyone had a one page profile and staff said, "They are being completed with everyone, just some haven't been done yet."

People's life stories were in their care records and included quotes such as, "Love knocked on my door." It also gave history on where the person worked, and what they enjoyed doing. One person had won awards for their gardening and had been 'honoured to receive an award from the Queen.' People's life history included many photographs of things that were important and of value to people.

Care plans were written in person centred ways from the perspective of the individual and were structured into, 'Why I need support, the aims, the objectives and the interventions required.' Care plans were signed by the person where they had capacity to do so. People's individual preferences were recorded along with acknowledgement of areas where people maintained independent skills that did not need staff support.

Care plans included specific information on how the person wanted and needed to be supported by staff and they had been reviewed on a monthly basis. Records included a summary of events that had occurred over the month.

There was information on 'How to communicate with me.' We saw one person's file included information on autism to indicate that the person thought in a linear and literal way. It also told staff how to identify if the person was upset or worried. This specified for staff to 'Be verbal with me, to speak to me as an equal. I will take what is said literally.'

What's important to me recorded information on 'How I move around, my personal care etc.' It specified where people needed support and how this should be delivered as well as areas where people were independent. This document also recorded the things the person liked and didn't like.

People had hospital passports which included information on what medical staff needed to know about the person, such as what was important to them and what their likes and dislikes were. The 'must know' information included a record of risks such as choking and swallowing and a list of current medicines.

When asked about social activities one person said, "The staff teach me new stuff, I go to reading and writing lessons, I'm doing well." Another person said, "We go out for pub lunches and for walks, it's really good." They added, "It's really lovely here, the staff are really good."

People had documented information on the activities they enjoyed and on their family contact. We saw that one person's favourite pastime was singing. It also included information that staff sent cards to family members on the person's behalf for special occasions and at Christmas time.

Staff explained that they organised days out with people depending upon where they want to go. They added, "People living in Harmony tend to do their own things like going to Newcastle, to the gym, one person enjoys doing weights, some people like to play pool or draughts and others go to arts for wellbeing." Staff told us they had been to the Tyneside theatre as people had wanted to go there. They also said they, "Arranged vintage teas and celebrations for people, entertainers come in, we do war events with people and have different activities and decorations up. It depends what people want to do."

There were photographs on display around the home of events that had been held including St Georges Day and a display of birthday celebrations.

A copy of the complaints procedure was in people's file and we saw that there were appropriate timeframes for acknowledging and investigating concerns and complaints.

Good

Is the service responsive?

Documents called 'service user guides to complaints' were on display around the home as was pictorial information on how to complain. Compliments forms were also available around the home.

A complaints log was in place which included information on the response to the complaint, any action plans that had been put in place, who was responsible and the date the outcome had been achieved. We saw that letters of apology had been sent to complainants which also detailed the outcome of the investigation and action taken to rectify it. Complaints had been responded to in a timely manner.

Quality assurance questionnaires had been sent to family and friends, other professionals and to the staff team. The findings of the quality assurance questionnaires sent to family and friends was on display and we saw that overall the service had been rated as good or excellent. Actions plans had not been developed based on these findings but there was a shared ethos around service improvement. With staff and the manager agreeing that it was important for people to be part of the local community and to have the opportunity to 'give something back'. This was being done by staff and people organising promotion events such as summer fayres to raise money for activities for people but also to raise awareness in the community. Staff said they had also held garden parties and barbeques in order to break down barriers and promote active engagement.

Good

Is the service well-led?

Our findings

There was a manager registered with CQC but they had moved into a more regional role within the organisation. The manager who was managing Harmony House on a day to day basis told us, "I'm currently completing my registration with CQC." They explained that they were responsible for the management of the service and staff. In terms of responsibilities with CQC they had completed notifications appropriately and had submitted a provider information return as requested.

We heard mixed messages from staff. One staff member said, "It's a good company to work for, there's not a lot of communication back from the organisation in terms of things like training but the [registered manager] is supportive and comes once a week." Another staff member said, "There is limited contact with the organisation, one director will visit but the area manager visits and we are well supported by the manager." Another told us they felt, "The organisation itself doesn't respond quickly and they could offer more support but the manager is really good and we are supported by them."

The results of the staff survey showed that staff thought the service was 'very good' and was 'a good place to work.' One staff member said, "It's a good place to be, I'm well supported."

The manager had a visible presence in the service and staff said they felt well supported by the manager. The manager had regular contact with the area manager for support and said a manager from another home was also really supportive and helpful.

Regular team meetings had been held and the manager had gone to lengths to ensure day staff and night staff were able to attend and share their views together as one team. The minutes of the last meeting were displayed on the wall in the staff office for everyone to read.

The manager said everyone was involved in making improvements to the service provided in particular in ensuring the service and the people living there had an active and were accepted as contributing, valued members of the local community.

A quality assurance questionnaire had been sent to family and friends and professionals in the past six months and the outcomes and findings were on display in the service.

Overall, the service was rated as very good in relation to a good mix of people; the professionalism of the service; the activities on offer and the support provided. No improvements had been identified in response to the questionnaire but the manager explained that all staff were now involved in training particularly in relation to autism and dementia. One staff member told us, "There's no improvements or changes needed here."

Some improvements to the environment had been identified and were being progressed by the manager; this included some redecoration work and general maintenance. It was noted that some of the comfortable chairs in South View were very dated and in need of replacement. The manager had previously identified that a more effective system was needed in relation to communication around the maintenance of the service and this was being developed.

A range of audits were being completed in order to monitor and improve the quality of the service provided for people.

A health and safety audit was completed on a monthly basis. We saw that various actions had been recorded such as a new boiler being fitted. Areas noted for redecoration had been recorded over two months. When asked about this the manager said, "I do keep reporting it and it will get done, the lounges have been recently redecorated. If I need to I can buy the paint and the maintenance man will do it."

Monthly infection control audits of the main kitchen and the skills kitchen were completed. Comments recorded included that clinical rooms did not have elbow controlled taps for hand hygiene; there was no wall mounted hand gel dispensers; waste bins were not foot operated. Although audits were completed regularly and comments were noted we saw limited evidence of any action plans. The manager did say that things were raised with the area manager during audit visits and we saw that where the manager was able to action things this had been completed.

Medicines audits were completed on a weekly basis by the senior care staff and were checked by the manager on a monthly basis.

The area manager completed a monthly audit which included observations from walking around the home, a summary of items discussed and actions completed as well as information on falls and any statutory notifications that had been completed. Other areas audited included care

Good

Is the service well-led?

plans, nutrition, safeguarding and premises safety. We saw that required actions were recorded such as ensuring evaluations and assessments were up to date; ensuring handwritten entries on medicine administration records were counter signed. All actions recorded who was responsible for completing the work and when by. During the course of the inspection we saw that the necessary action had been taken however there was not always a record of the date that the work had been completed. We spoke to the manager about this who said, "I'll make sure this is recorded moving forward."

The manager explained there was a new process of completing a manager's report every Friday which covered things like accidents and incidents, staffing, referrals, training needs, complaints, safeguarding. We could not assess how effective this system was in monitoring and improving quality as it had only been in place for three weeks at the time of the inspection.

Relevant policies and procedures were in place and we saw they were current and had a planned review date recorded on them. A quality assurance policy was in place which directed managers towards, 'Continuous self-assessment and regular monitoring review and audits.'