Harmony Care Homes (2003) Limited

Harmony Care - Little Bloxwich Community Hub

Inspection report

Stoney Lane
Walsall
West Midlands
WS3 3DW

Date of inspection visit:
16 December 2019

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26 February 2020

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?	**Inadequate**

Summary of findings

Overall summary

About the service
Harmony Care- Little Bloxwich Community Hub is a domiciliary care service providing personal care to 72 people across Staffordshire and Walsall at the time of the inspection. People were supported within their own homes, flats or supporting living accommodation.

People's experience of using this service and what we found
People were not supported to receive their medicines safely and staff were not always recording the support they had given people with their medicines.

People were not supported to remain safe. The provider had failed to ensure all potential incidents of safeguarding had been reported and investigated to reduce the risk of reoccurrence.

People were not supported in a timely way by a regular staff team who knew them well. People felt rushed and had to wait for their support.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests as people's capacity had not always been assessed.

People were not supported by a staff team who had up to date training and were always recruited safely. The provider had failed to consistently act upon people's complaints to drive improvements at the service.

People were not always supported to eat and drink in a safe way. People were not all supported in a caring way which respected their dignity as people had to wait for care.

People did not have care plans which contained clear guidance for staff to support them to meet their needs. People did not have regular reviews of their care to ensure their support met their changing needs.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people's needs had not been reviewed to ensure staff offered support in line with these and in a way which people preferred.

The provider had failed to ensure quality assurance tools were in place and effective at identifying, implementing and sustaining improvements at the service. The provider had not ensured people were able to give feedback about their care and lessons were learned when things went wrong.

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

Rating at last inspection
Since the last inspection the service has changed its name. We have used the service's previous rating to inform our planning at this inspection. The last rating for this service was requires improvement (published 07 September 2018). Since this rating was awarded the service has moved premises. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about people receiving safe care, staff training and there not being sufficient staff to meet people's needs. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to people receiving safe care and treatment; people's capacity being assessed and best interest decisions being recorded; safeguarding incidents not all being reported to the local authority safeguarding team; people's care calls being late and missed; complaints not being recorded and acted upon to drive improvement and the governance at the service.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Harmony Care - Little Bloxwich Community Hub

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. We checked 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 inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, there was a manager at the service who was in the process of registering at the time of our inspection.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 16 December 2019 and ended on 22 December 2019. We visited the office location on 16 December 2019.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with nine people who used the service and two relatives about their experience of the care provided. We spoke with twelve members of staff including the provider, quality manager, operations director, the manager, care coordinators and care workers. We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who support the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people were not always safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The provider had failed to ensure staff understood their responsibilities to safeguard the people they supported. Whilst staff received safeguarding training, were knowledgeable about how to identify the signs of abuse and were aware of how to report issues, they had not reported all incidents of concern to the management team For example, where only one staff member had attended a person who required two people to support them to move safely, this had not always been reported to the manager and actions taken to reduce future risk. We saw on occasions staff had moved a person on their own or with an untrained family member. This placed people at risk of harm.
- The provider had failed to ensure effective systems were in place to monitor incidents of potential safeguarding, investigate and report all concerns to the local safeguarding team, to reduce future risks to people. Whilst the manager had a system in place by the time of our inspection and was reviewing accidents and incidents, this system was newly implemented and we could assured this improvement would be embedded into practice and improvements sustained.
- The management team had failed to report to the local safeguarding team or investigate all potential safeguarding concerns. For example, an incident of unexplained bruising and an incident of staff giving a person the wrong diet causing them to choke was not reported or investigated by the management team. As no action had been taken following these incidents people were placed at continued risk of harm.

Systems were either not in place or robust enough to demonstrate safeguarding concerns were consistently reported to the Local Authority Safeguarding team, investigated and future risks of harm to people were reduced. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People did not always feel safe as the provider had failed to have effective systems in place to investigate and act on concerns they had raised with them about staff not attending their care calls on time and acting in a caring and respectful way.

Staffing and recruitment

- People were not supported by regular staff. One person told us, "I don't know who is coming I think it would be nice if I had the same ones, but there are lots of different ones some I only see once. Of course, I would like to know who is walking into my house."
- The provider had failed to ensure there were sufficient staff to support people in a timely way in line with their needs. For example, people told us staff were consistently late for their care calls and did not stay for the duration of their allocated time. One person told us, "I have a care call in a morning, it should be at 10.30

but it never is. One of the [staff] always comes at 09.30 and some of them come two hours late. They never let you know." Another person told us, "I should have a 45 minutes call in a morning this should include a shower. If I am lucky I get 15 minutes."

● There was no effective system in place to monitor whether staff attended people's care calls or the time staff arrived and spent at people's care calls. One relative told us, "They (staff) are not very good, we never know who is coming to get [my relative] up and half the time I have to struggle myself to do it." Whilst there was a new system in place from one week prior to our inspection, the manager told us this was not fully working at the time of the inspection and was not yet embedded into practice. This meant the provider could not be assured staff were attending people's care calls on time and supporting them for their allotted time. This placed people at risk of harm as people had to wait for personal care, support with diet and medicines.

Systems were either not in place or robust enough to ensure there were sufficient staff to enable people to receive their required care and care was consistent and timely from a regular staff team. 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.

● We saw one staff member had commenced employment prior to checks on their suitability being completed. This placed people at risk of harm of not being supported by suitably safe staff. Despite this, we saw other people were recruited safely. The manager told us they were in the process of completing checks on all staff's recruitment records to ensure they were now being completed. We will check this at our next inspection.

Assessing risk, safety monitoring and management

● Although people had personalised risk assessments in place for known risks they did not always contain up to date guidance for staff following periods of illness or incidents. For example, one person did not have a risk assessment in place despite being at risk of their skin becoming sore. Whilst staff who knew this person well were providing care to reduce this risk, newer staff were not.

● Where people did have risk assessments these were not consistently reviewed and updated. For example, one person's risk assessment contained contradictory guidance around how to support them with their dietary needs. This meant new staff working with this person would not have clear guidance around how to meet their needs. This placed people at risk of not receiving the appropriate care.

Using medicines safely

● Medicines were not managed safely. We saw staff were administering creams to people without there being any guidance on how and when to administer these on their medicines charts. For example, we saw two people did not have medicines charts in place for staff to record the support they had been given with creams.

● Whilst people told us staff provided support with their medicines records did not support this as staff had not consistently recorded the support they had given. For example, we saw multiple missed signatures on people's medicines records. These had been identified by medicines audits, however, no action had been taken in response to concerns raised. This placed people at risk of prolonged harm from their medicines not being administered as prescribed.

● People did not consistently have detailed guidance for staff where they were prescribed medicines 'as required'. For example, we saw and the manager confirmed, only one person using the service had this guidance in place. This placed people at risk of not receiving their as required medicines as they were prescribed.

Learning lessons when things go wrong

● The provider could not be assured lessons were learned when things went wrong. For example, accidents and incidents had not all been reviewed by management team and actions were not always taken to reduce the risk of reoccurrence. For example, following staff giving a person inappropriate diet causing them to choke the management team had not completed an investigation to ensure lessons could be learned. Whilst we saw the new manager had made positive changes to reviewing accidents and incidents these were newly implemented and we could therefore not be assured any changes would be sustained. We have reflected this within the 'well led' domain of the report.

Systems were either not in place or robust enough to demonstrate people's medicines and safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff understood how to reduce the risk of infection. For example, staff used protective personal equipment including aprons and gloves when they were supporting people.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● The provider had failed to ensure the principles of the MCA were followed as people did not always have their capacity assessed and best interests' decisions recorded as required. For example, records showed a person did not have a capacity assessment or best interest decision recorded for having a restraint on their mobility equipment despite the management team telling us the person did not have capacity.
● Staff had training on the MCA however had not identified where people may lack capacity and require assessment to ensure their care was being offered in their best interests. For example, one person did not have decision specific capacity assessments and best interests decisions recorded for their finances and medicines. Staff told us this person did not have capacity yet a family member was making decisions on behalf of this person without the legal power to do so. This placed the person at risk of not receiving care in line with their wishes and best interests.

People did not consistently have their capacity assessed and best interests decisions recorded in line with the MCA. This placed people at risk of not receiving care in line with their wishes and best interests. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, records showed people had consented to their care and staff sought consent prior to delivering care and people were encouraged by staff to make day to day choices.

Staff support: induction, training, skills and experience
● The provider had failed to ensure staff received training to support them in their role in line with their own policies as records showed a significant amount of staff training was out of date. For example, we saw eight staff required their food hygiene training updating, four of these staff were over a year out of date with this

training. This meant the provider had not followed their own systems to ensure people were supported by suitably trained staff to meet there needs.

As reported in 'Safe', this placed people at risk of harm. 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 an induction and shadowing to help them meet people's needs. One staff member told us, "I shadowed another staff member for a week." They went on to tell us this helped with their confidence.
● Staff received supervision and appraisals where they discussed their progress.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● Whilst one person had choked following staff giving them an inappropriate diet. We saw other people were supported in a safe way to eat and drink with a variety of dietary requirements such as diabetic diets.
● People were supported to access healthcare professionals and improve their diet where they wished. For example, people accessed speech and language therapists and dieticians. One person told us how staff had supported them to lose weight and become healthier.

Staff working with other agencies to provide consistent, effective, timely care
● Professionals told us the service made timely referrals to ensure people received support with their health and social care needs. For example, we saw people had been referred to physiotherapists and occupational therapists.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to and during them receiving support.
● People's sexuality, gender, culture and religion were considered as part of the assessment process and was recorded within their care plans.
● People had oral health care plans, if required, which gave staff clear guidance around how to support people to maintain their oral health care needs.

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.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● People told us they and where they wished, their relatives were supported to make decisions regarding their care. However, we saw these were not always respected. For example, one person told us they wished to go to bed early and had requested an earlier care call however staff continued to visit at a later time.
● We received negative feedback about communication at the service. One staff member told us, "I have raised concerns but nothing gets done. Communication is not brilliant." Despite this, we saw the manager was working to improve communication and planned to hold open days for people, their relatives and staff to discuss improvements at the service. We will check this at the next inspection.
● The management team were in the process of reviewing all people's care plans. Newly completed care plans directed staff to support people to make choices. For example, one care plan explored the person's preferences but advised carers to ask the person what they would like to eat. We will check care plans reflect people's choices at the next inspection.

Respecting and promoting people's privacy, dignity and independence
● The provider had not ensured the deployment of staff supported people to receive care in a timely way by a regular staff team. One person told us, "We never know who is coming and at what time. I have told them up the office I am sick of it. It makes absolutely no difference." Another person told us, "When I am still in bed at 11.30am, I ring [the office] and say no one (staff) has come, [the office] make you feel bad for asking, they just make excuses."
● People did not consistently receive support that promoted their dignity. This was because people told us they had to wait for support. For example, one person told us they had to wait up to two hours for their care call.
● People were supported to maintain their privacy. For example, staff told us they closed doors and curtains whilst providing personal care.
● People were encouraged to maintain their independence. For example, we saw people were encouraged to maintain their skills. One staff member told us, "When I take [person's name] shopping I leave them to it. I can give them examples of deals but I let them pay themselves and push the trolley."

Ensuring people are well treated and supported; respecting equality and diversity
● We received mixed feedback about staff and their approach to people. For example, one person told us, "Staff are perfect. They are nice and help me and stuff."
● Staff completed equality and diversity training and people's religious, cultural and social needs were considered during care planning and delivery. For example, people with specific religious dietary needs were

supported in line with these.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

● People and their relatives felt able to complain, however told us they did not feel confident action was always taken to address their concerns. For example, one person told us, "I can't tell you the amount of time that I have complained to the office they just do nothing about it. They don't even answer me half the time. They said someone will ring me back, they never do." Another person told us they did not feel comfortable to complain as, "I think the staff would take it out on me if they found out as I said most of them are not nice."

● The provider had a complaints policy in place and we saw formal complaints had been responded to in line with this. Despite this, there was no process in place to record and address informal comments and grievances. Following our inspection, the manager implemented a process of recording comments and grievances and actions taken to improve people's experience of care.

Complaints, comments and grievances were not consistently recorded and action taken to address people's concerns. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's needs and preferences were included in personalised care plans. For example, one person's care plan explored their preferences for washing and care staff. However, people told us their wishes were not always respected as staff did not know them well or have time to meet these. For example, the time of calls and preferences for personal care.

● The manager was in the process of reviewing all people's care as people had not hade regular reviews of their care. For example, one person told us, "I have never had any meetings or anything like that in the last year. I don't know if I have any care plans." As this process was newly established and not embedded within the service the provider could not be assured all people would continue to receive timely and effective reviews of their care ongoing.

Meeting people's communication needs

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 was not consistently meeting their responsibilities under AIS as we saw people had not been consistently supported to access information in a format which supported their understanding. For

example, people's care surveys were completed by staff as these were not in an accessible format. People told us this made them reluctant to give feedback about their care as they were not anonymous. We raised this with the manager who told us they were developing a more accessible survey for people. We will check this at our next inspection.

End of life care and support

● No one was receiving end of life care at the time of our inspection. Despite this, the manager was aware of the importance of people being involved in planning their end of life care.

Inadequate

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider had failed to ensure they were meeting the regulations for staffing, safe care and treatment, safeguarding, complaints, compliance with the MCA and good governance.
- Systems were not effectively monitoring and assessing the quality of the service, driving improvements and ensuring compliance with the regulations. For example, whist audits on medicines and people's daily notes were being completed by the senior management team, these had not been reviewed to ensure the required improvements were actioned.
- Quality assurance tools had failed to identify all the concerns we found at this inspection. For example, audits on daily notes had not identified where staff were administering creams without a medicine administration record being in place.
- Quality assurance tools had failed to identify where people did not have capacity assessments and best interests' decisions completed where appropriate.
- Quality assurance tools had not identified where people did not have protocols for 'as required' medicines in place.
- The provider had failed to ensure there was an effective system in place to monitor staff training and ensure this remained up to date.
- The provider had not ensured people received consistent and timely care by regular staff. Changes had been made the week prior to our inspection. However, the system was newly implemented so we could not assess its effectiveness.

Quality assurance systems and tools were not effective at identifying and driving improvements at the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection the management team had sent notifications to the Care Quality Commission (CQC) and relevant authorities as required.

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

- Whilst duty of candour requirements were understood by the management team we could not be assured they were consistently met as staff were not always reporting incidents to the management team. For example, staff had not always reported where only one staff member had supported a person who required

two people to support them safely.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had sought feedback from people and their families during reviews, however, there was no effective system in place to ensure people were reviewed regularly. We also saw where people had raised concerns about their care, these were not always acted on. For example, one person had raised that staff did not always wash them when they requested this. We saw no action had been taken in response to this.

● The provider also sought feedback from people and their families with quality surveys. However, these were completed by the staff who visited people's homes. We saw people had reported they did not always feel comfortable with this process as they did not feel able to be as open about improvements which were required in their care and we saw no action had been taken in response to these concerns.

● The provider had failed to ensure staff had regular staff meetings. Despite this, the manager told us they had staff meetings planned for the future to improve communication at the service. We will check this at our next inspection.

● The manager told us they would be making improvements to the way they obtained feedback from people and their families. However, as these were not in place at the time of the inspection we were unable to establish the effectiveness of these.

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

● We received mixed feedback about the management team. Whilst the majority of staff gave positive feedback about the manager including, "[The manager] is very approachable. You can go to them and they get things sorted." Some people and staff told us they were not aware the service had a new manager and one relative told us, "I don't know who the manager is, I have spoken to the office staff but no one has said if a new manager has started." Another person told us, "I don't know who is in charge. It's a terrible company and I would not recommend it at all. The office isn't very well organised."

● The management team worked with us during the inspection to address areas of immediate concern we have raised. Whilst we saw the manager was making improvements at the service, these were newly implemented and our concerns were widespread.

Working in partnership with others

● Professionals spoke positively about how the manager had worked alongside them to ensure people received health and social care support.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not consistently have their capacity assessed and best interests decisions completed and recorded.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure all incidents of potential safeguarding were reported to the local authority safeguarding team, investigated and lessons learnt to reduce the risk of reoccurrence.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to record and act on people and their family's concerns to drive improvements at the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure regular staff attended people's homes in a timely way to meet their needs.