

Harmony Care Homes (2003) Limited

Highgate Road

Inspection report

91 Highgate Road
Walsall
West Midlands
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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 07 and 08 June 2017 and was unannounced. At our last inspection completed on 04 March 2015 we rated the service as being 'good' overall. We found the service had gone through a period of significant change since this inspection. The new management team had made improvements since their appointment. However, further improvement was required overall within the service.

Highgate Road is a residential home for up to six people with disabilities. At the time of our inspection there were six people living at the service. The service supports people with a range of needs including; learning disabilities, physical disabilities and complex needs. People currently living at the service range from young adults through to older people and most had complex needs.

There was a manager in post. The manager was not yet registered with CQC. They had applied to register and their registration was in the process of being reviewed at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by sufficient numbers of staff to keep them safe from harm but not to protect their dignity and provide person centred care. People were supported by a staff team who could recognise signs of potential abuse and knew how to report concerns. People were protected by staff who understood risks to them and knew how to protect them from the risk of harm from accident and injury. People were supported by a staff team who had been recruited safely for their roles. People received their medicines as prescribed.

People were supported by a staff team who had mixed skill levels and abilities. Some care staff required further training to support people effectively in all areas. The management team recognised this and were developing training and support available to staff members.

People were supported in line with the requirements of the Mental Capacity Act 2005 (MCA). However, issues with records meant that the new manager did not always have the required knowledge of previous restrictions authorised for people under the Deprivation of Liberty Safeguards (DoLS).

People were supported to have sufficient quantities to eat and drink. People's day to day health was maintained and they were supported to access healthcare professionals when required.

People were supported by a care staff team who were kind and caring towards them. Staff knew how to protect people's dignity. Staff knew people well and worked to encourage choices and promote independence. People were supported to maintain relationships that were important to them.

People's basic needs and preferences were met by care staff. Care staff had a good knowledge of people and care plans were in place that reflected people's needs and preferences. People were enabled to participate in activities and had access to the local community. People's feedback was sought and complaints were addressed appropriately.

People were supported by a staff and management team who were committed to providing a good service and making improvements to the care provided. Staff mostly felt supported by the management team and felt involved in how the service was run.

A new quality assurance and governance system had been introduced that was successfully identifying many areas for improvement required within the service. Action was taken by management to make required improvements. Further development of this system was required to ensure that all issues and areas of risk to people were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

People were supported by sufficient numbers of staff to keep them safe from harm but not to protect their dignity and provide person centred care.

People were supported by a staff team who understood how to protect them from abuse and harm such as injury.

People were supported by a staff team who had been recruited safely for their roles.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Some care staff required further training to support people effectively in all areas.

While people were supported in line with the requirements of the Mental Capacity Act 2005 (MCA), there were some issues around previously authorised restrictions to people's liberty.

People were supported to have sufficient quantities to eat and drink.

People's day to day health was maintained and they were supported to access healthcare professionals when required.

Is the service caring?

Good ●

The service was caring.

People were supported by a care staff team who were kind and caring towards them.

Staff knew how to protect people's dignity.

Staff knew people well and worked to encourage choices and

promote independence.

People were supported to maintain relationships that were important to them.

Is the service responsive?

Good ●

The service was responsive.

People's basic needs and preferences were met by care staff.

Care staff had a good knowledge of people and care plans were in place that reflected people's needs and preferences.

People were enabled to participate in activities and to access the community.

People's feedback was sought and complaints were addressed appropriately.

Is the service well-led?

Requires Improvement ●

The service was not yet consistently well-led.

Not all areas of improvement and risk to people were identified. However, a new quality assurance and governance system had been introduced that was beginning to identify improvements needed.

People were supported by a staff and management team who were committed to providing a good service and making improvements to the care provided. Staff mostly felt supported by the management team and felt involved in the service.

Highgate Road

Detailed findings

Background to this inspection

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

This inspection took place on 07 and 08 June 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is someone who has experience of using, or is a relative or carer of someone who has used this type of service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We reviewed information submitted by the provider on their Provider Information Return (PIR). A PIR is a document the provider submits in advance of an inspection. They can advise us in the PIR of things they do well within the service and areas they have identified for improvement. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

Most people living at the service were not able to speak with us about their views around the care they received due to their complex needs. During the inspection we spoke with one person who lived at the service and communicated using non-verbal methods with four other people. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We spoke with the manager, operations manager and four members of care staff including a senior member of staff. We also spoke with one social care professional. We reviewed records relating to people's medicines, four people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance.

Is the service safe?

Our findings

One person told us there were not sufficient staff to ensure their needs were met. Most staff we spoke with also told us there were not enough staff. One staff member said, "[Staffing levels are] a real concern at the moment". They told us personal care and activities were the times when staffing levels were the most challenging as people needed either 1:1 or 2:1 support during these times. We saw there were sufficient numbers of staff to ensure people were kept safe. However, there were not sufficient numbers of staff to ensure people's needs were met in a person centred way due to the complexity of most people's support needs. For example; we saw people's dignity compromised due to staff not being available to support them when they coughed up phlegm. We saw people waiting for support with meals due to insufficient staff to provide the required 1:1 support at this time. We also saw some people with complex needs seated for periods without staff interaction or any other form of stimulation due to the unavailability of staff. We saw during the inspection that staff were also required to complete all domestic duties such as cooking and cleaning. This resulted in staff being unavailable to provide support to people while these duties were completed. We saw that staffing calculations did not allow for staff time spent completing domestic tasks. We spoke with the manager and the operations manager about the staffing levels in the service. They immediately made contact with the managing director to discuss our concerns and to review the staffing levels.

We looked at how the provider ensured staff were recruited safely for their roles in the service. We saw a range of pre-employment checks were completed prior to staff starting work. These included identity checks, references and Disclosure and Barring Service (DBS) checks. DBS checks allow an employer to review a potential staff member's criminal history to ensure they are suitable for employment. We saw current recruitment practices were safe. The operations manager had completed an audit of historic staff files and had identified areas where they felt further information or additional checks may be required. People were protected by recruitment practices that ensured appropriate staff members were employed to support them.

One person was able to communicate to us that they felt safe in the service. We saw they felt comfortable with the staff members who supported them. The person confirmed they could talk to staff and indicated to us who they would talk to if they felt worried. Staff we spoke with could describe signs of potential abuse and how they would report any concerns. Staff knew how to whistle-blow if required. Whistle-blowing is when staff raise concerns with an organisation outside of the service such as CQC, the local safeguarding authority or the police. Managers we spoke with also demonstrated a good understanding around how to protect people from potential abuse. We saw, where appropriate, referrals had been made to the local safeguarding authority. This enables investigations to be completed and plans to be put in place to protect people from further harm.

Staff we spoke with understood the key risks to people and how to keep them safe from harm. For example; staff described risks associated with people choking, changes in behaviours and seizures. They also described how they safely managed these risks. We saw risks were outlined in people's care plans and risk assessments along with guidance around how to keep people safe from potential harm. We saw where

accidents and incidents had arisen, these were recorded and reviewed by the manager. Where appropriate action was taken by the manager to ensure the risk of accidents arising in the future was reduced as far as practicable.

While people couldn't share their views with us around the support they received with their medicines, we saw people received their medicines as prescribed. Medicines were stored safely and we saw they were administered to people in a safe and appropriate way. We saw care staff administering medicines did so in a caring way and explained to people what they were taking and why. We checked the amount of medicine held in the service matched the amount outlined on people's medicines administration records (MAR). We saw for the people we checked the correct amount of medicine was held. We saw appropriate records were kept along with guidance where required for staff. For example; around how to administer emergency medicines for people's epilepsy.

Is the service effective?

Our findings

We saw most staff had the required skills to support people effectively. We saw all staff were well intentioned and worked hard to provide effective care to people. However, on occasion gaps in their skills meant they did not always recognise when they were not providing effective care. For example, we saw staff lacked knowledge around how to fully engage and involve people in certain activities. We also saw staff did not always have the skills to recognise when people's body language indicated they may require additional support. We saw one person sitting without interaction for 45 minutes. They appeared to be unhappy and were rocking and playing with a seat strap during this time. The manager confirmed sensory equipment was available for staff to use to support the person. However, care staff present did not have the skills to recognise this person required this support.

Some staff told us they did not feel all staff members had sufficient skills to support people effectively. For example; they felt staff did not always recognise when people needed support and needed to develop their skills in understanding non verbal communication. This reflected what we saw. Staff told us they received regular training however they felt some training delivered online did not always provide them with the required skills. We found the manager and operations manager had recognised that improvements were required to training and development. They told us and we saw from quality assurance documents and action plans that plans were in progress to improve training and staff skills in specific areas. We saw that actions had been completed already in the months leading up to the inspection. For example; we saw due to a number of errors with medication in the past, staff had been required to complete further medicines training. We also saw improvements had been made to the way staff member's competency was assessed in relation to medication administration. We saw gaps in training had been identified and steps were being taken to address these gaps. We saw staff received regular supervision meetings with their line manager. The management team had also developed a programme of supervision for care staff including observations, spot checks, formal one to one meetings and team meetings. We saw an appropriate induction was in place for new staff members and care staff were required to complete the Care Certificate. The Care Certificate is a nationally recognised standard for the skills and competency of care staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Most staff we spoke with had a good understanding of the MCA and how to apply this during their day to day work. Staff knew that where people were not able to make their own decisions or provide consent due to their capacity they should make decisions in their 'best interests'. Staff told us if people refused care they

would encourage them as far as possible and report concerns to their managers. They also told us they would ensure they had considered other issues that might be contributing to someone's refusal; such as poor health, distress and pain to ensure these could be resolved. We saw care staff were acting in people's best interests and where appropriate applications had been made to deprive people of their liberty. We saw while the basic principles of the MCA were being followed decisions were not always being recorded in line with the requirements of the Act. For example; records reflected a 'generic' assessment of people's capacity rather than considering their abilities around specific decisions. We also found while the new manager had ensured appropriate DoLS applications had been submitted, they were not always certain where prior DoLS applications had been authorised. As a result, they could not be certain that any authorised restrictions were being followed in line with any conditions outlined. The manager was taking steps to confirm which DoLS had been authorised and to obtain copies from the appropriate authorising bodies. Where people's had representatives who stated they were financial appointees, evidence of their legal ability to act on behalf of people had not been checked and recorded.

We found staff were aware of people's health needs and people were supported to see healthcare professionals when needed. We saw during the inspection staff were implementing temporary instructions from someone's doctor around increased fluids as they had been unwell. We also saw another person attending a medical appointment. We saw from communication records that people received regular appointments with professionals such as their doctor, dentist, psychiatrist or nurse. We did however find where specific instructions had been recommended by healthcare professionals, care staff were not always recording support given. The manager was also not monitoring to ensure these actions had been completed and couldn't be assured that staff were following the instructions from health care professionals.

People were supported to have sufficient amounts to eat and drink. Staff were able to describe people's individual needs where they have special dietary requirements. For example; where people had diabetes or required a soft diet. We saw where appropriate healthcare professionals such as speech and language therapists (SALT) were involved. This ensured appropriate guidance was in place to enable staff to manage risks such as choking safely. We saw most people required one to one support when eating. Staff supported people appropriately and ensured risks were managed. We found people had limited involvement in choosing their food although staff did try to provide food options based on their prior experience of what people enjoyed to eat. We found some cultural needs were met; for example, Halal meat was sourced due to one person's religious beliefs.

Is the service caring?

Our findings

While people were not able to share their views about the care staff, we saw people were treated in a kind and caring way by staff. The provider information return (PIR) submitted in advance of the inspection stated, 'Positive relationships are evident at our service'. We saw this reflected during our inspection. We saw people appeared to be relaxed in the company of care staff and saw examples of people's faces lighting up when they saw staff. A visiting social care professional also told us she had seen people respond in a positive way when care staff entered their room. They also told us they too had seen staff interacting with people in a kind and caring way. Staff we spoke with were passionate about supporting people well and demonstrated to us they had a positive approach with people. One staff member told us, "When I go home I feel good about myself as I've helped other people". We saw some positive examples of caring support given by staff and people using the service. For example; we saw a member of staff when supporting someone with their thickened fluids focussing on the person, explaining what they were doing and what the person needed to do. We saw further examples; including a staff member gently wiping away food residue from someone's mouth. We saw a caring culture was supported by the management of the service. We saw people recognised the manager and responded positively to them. We also saw care plans contained information such as, 'I have a lovely smile and I always find the funny side of a situation'. This showed us people were valued and respected as individuals.

People's individual choices were respected and we saw people spent their time in different ways during the inspection. We saw from care records that people went to bed and got up at different times. We saw one person had chosen to have a lie in on the first day of the inspection and received their breakfast at a flexible time when they had woken up. We also saw people had choice over their surroundings and saw bedrooms were personalised to reflect people's individual preferences. Staff recognised the importance of offering choices to people. One staff member told us, "Everyone is individual". We saw communication passports were present in care plans which outlined to staff people's individual methods of communication. We saw some improvement could be made to staff skills and practice to ensure people were enabled to proactively make an increased number of choices. However, the manager had recognised this prior to the inspection and had already taken steps to make improvements. For example; we saw in staff meeting minutes discussions had taken place around ensuring people were fully involved in choosing the films they went to see and where they ate. The manager told us about further work they planned to complete to ensure people's choices were promoted as far as practicably possible.

We saw staff worked hard to respect people, to protect their dignity and promote independence. One person indicated to us that staff knocked on their door before they entered their bedroom. We also saw staff knocking the door prior to entering this person's room. Staff were able to describe how they took steps to protect people's dignity. One staff member told us how a person could remove their clothes during seizures so they took steps to ensure they were covered up. Other staff members told us how they tried to encourage people to do as much for themselves as possible. A staff member told us, "Even when we're out we'll try to involve them in activities. If we go to the [park] we'll put bread in their hands to feed the ducks". We saw care plans promoted independence where possible. For example, one care plan outlined how a person could wash their own hair if staff put the correct amount of shampoo into their hands. We did see some examples

where insufficient staffing levels meant care staff could not respond to people's needs as quickly as required to protect their dignity or to promote independence.

People were supported to maintain relationships with people that were important to them, for example family members. We saw relatives could visit without any restrictions. The management team were keen to develop engagement with family members to enable them to be more involved in the lives of people living at the service.

Is the service responsive?

Our findings

People received care and support that met their basic needs and preferences. Staff we spoke with knew people well and were able to describe their individual needs. A visiting health and social care professional told us care staff understood people's needs well. They said, "They know [person's name] really well and could answer my questions really well, I'm really quite impressed". We saw care plans had recently been updated into an improved format. The new care plans contained clear information that described people's preferences and individual support needs. We found systems were in place for communicating any changes in people's needs. For example; there were communication diaries and handover meetings between care staff at the beginning and end of each shift.

People's religious and cultural beliefs were respected and taken into account. We saw culturally appropriate food had been sourced for one person although the person did express they would like to eat this food more regularly. We also saw that care staff were trying to organise a celebration to mark the religious festival of Eid.

People were enabled to access activities and leisure opportunities. We found two staff members were able to drive a mini bus owned by the provider which enabled people to access the community. People were supported to visit the shops, go bowling, eat out, visit farms, go to the cinema and a range of other activities. We saw during the inspection people were going out with staff to access the community and complete activities. We found staff were completing activities with people within the service. However, staffing levels and staff skills did not always ensure people were able to fully participate. The manager had recognised the need for improved activities and stimulation for people. The provider's PIR outlined actions required in this area and plans were already in progress to make improvements in this area. For example; additional staff training was planned, staff were being engaged in discussions around enhancing activities and plans were being made to support people to go on holiday during the summer months.

People were listened to and encouraged to share their views about the service. We saw feedback was obtained through staff surveys and any complaints raised by people had been addressed and responded to with appropriate action taken. For example; one person had expressed that not all staff knocked their door and said hello to them. We saw that the provider had acted upon this concern and this person was now happy with this aspect of their support. Another person was looking forward to starting a college course in September as a result of the feedback given to staff. We also saw formal written complaints had been recorded in a complaint log. These complaints had been responded to and an appropriate response provided.

Is the service well-led?

Our findings

The service was required by law to have a registered manager in post. A manager was in post at the service and had applied to become registered with CQC. Since our last inspection, the service had gone through a period of significant change. Staff told us they had been managed by multiple managers in the 18 months leading up to the inspection. They told us this had impacted on the stability of the service and had caused some confusion amongst staff regarding expectations of them and certain systems and processes. The management of the service acknowledged there had been a period of disruption to people using the service and the staff team. They had already made significant improvements within the service. They were committed to providing the stability and management required to ensure a good quality of service was provided to people. The provider's PIR outlined the steps being taken to stabilise the management team, to obtain the views of people using the service and to make any required improvements.

We saw a new quality assurance and audit system had been introduced into the service. This system had successfully identified many areas for improvement. We saw action plans were put in place where improvements were identified and we saw steps were taken to make positive changes needed. For example; we saw that improvements had been recognised as needed within areas such as staff skills, training and the provision of activities and steps were being taken to make these improvements. We saw issues such as care staff not following instructions relating to someone's nutritional needs and the speed at which staff reported a broken wheelchair were identified and addressed. We saw where external audits had been completed; for example by the local authority around medicines management, the manager had been receptive to feedback provided and had made improvements based on recommendations made. The provider information return (PIR) submitted in advance of the inspection also outlined a number of recognised improvements. It outlined a number of initiatives that were being introduced that we saw during our inspection. For example; medicines training updates and the introduction of a keyworker system.

We did however identify that there were still some improvements needed to the quality assurance and monitoring systems in addition to the accuracy of some records. For example; we found systems were not in place to sufficiently monitor specific instructions given by healthcare professionals. One person was required to stand for a period each day, they required increased fluids and enhanced dental care. The manager was not able to confirm these actions had taken place in line with the instructions given. We also saw some instructions in care plans were not accurate and reflective of support given. For example; one person's care plan outlined they should be taken to hospital when their stomach became swollen. Staff told us this was an unrealistic instruction and we found their hospital passport outlined a different instruction. We found the management team were aware of their responsibilities to submit statutory notifications to CQC. However, they had not recognised certain specific issues as requiring a notification. A notification is legally required to inform CQC of significant events such as serious injury or allegations of abuse. We spoke to the manager and operations manager about these issues and they began to take steps to make improvements immediately during the inspection.

While people could not share their views around the management of the service, we saw people recognised the manager and responded positively to them. We saw people's feedback was obtained where possible,

concerns were addressed and improvements made as a result of the feedback given. We saw the management team were looking at ways to increase family engagement with the service which would further enable views to be sought about the care people received.

Most staff we spoke with told us they were happy with the support received by the manager and were motivated in their roles. One staff member said, "If I've got a problem I've only got to go into [the manager]. That's a weight off my shoulders as I have worked at places where I've felt alone". They also told us the staff team were very supportive of them. Another staff member said, "My manager is wonderful and does what she can to help". We saw the management team were taking action to engage staff more in decisions made in the service. For example; we saw from records and staff told us they were being involved in decisions around amending staff shift patterns and activities for people. Staff told us they felt some areas of the service were tired and in need of decoration. This had been recognised by the manager who had shared these views with the managing director. They were awaiting authorisation for some improvements to the environment at the time of the inspection.

We saw the manager had appropriate support in place from the senior management team and provider. The operations manager had developed a mentoring scheme in order to provide additional support to the manager as they developed in the role and became registered with CQC.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found that the management team had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary. The management team were committed to improving the quality of service provided to people living at the service.