Care Quality Commission

Orchard Care Homes.com (3) Limited

Harmony House

Inspection report

The Bull Ring
Chilvers Colton
Nuneaton
CV10 7BG
Tel: 024 7632 0532

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Ratings

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

Overall summary

We inspected Harmony House on 18 March 2015 as an unannounced inspection. At our previous inspection in June 2014 we found there were breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008 related to Consent to care and treatment, Care and welfare of people who use services, Medicines, and Assessing and monitoring the quality of service provision. We asked the provider to send us an action plan to demonstrate how they would meet the legal requirements of the regulations, and the actions had been completed.

We found there was a breach in the legal requirements of Regulation 20 Records, of the Health and Social Care Act (Regulated Activities) Regulations 2008, which corresponds to Regulation 17 of the Regulations 2014. This was because care records did not consistently record how care was delivered to people, which put people at risk of receiving inconsistent care.

Harmony House is divided into two separate floors and provides personal and nursing care and accommodation for up to 57 older people, including people living with dementia. There were 45 people living at Harmony House when we inspected the service.

Summary of findings

A requirement of the service's registration is that they have a registered manager. 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 and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection.

There were enough staff available to safeguard the health, safety and welfare of people. Staff were given induction and training so that they had the skills they needed to meet the needs of people at the home. However, staff were not supported with regular supervision meetings.

We found that people were protected against the risk of abuse, because the provider took appropriate steps to recruit suitable staff. The provider had appropriate policies and procedures in place to report abuse, or allegations of abuse.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Where people could not make decisions for themselves people's rights were protected; decisions were made in their 'best interests' in consultation with health professionals.

People were supported to have food and drink that met their health needs and met their preference. People were supported to access healthcare professionals to maintain their health and wellbeing.

We saw care staff treated people in a caring manner, and respected people's privacy and dignity. Staff encouraged people to maintain their independence.

People made choices about who visited them at the home. This helped people maintain personal relationships with people in the community.

People knew how to make a complaint if they needed to. Complaints were fully investigated and analysed so that the provider could learn from them. Action was taken to improve the service following complaints.

People who used the service, and their relatives, were given the opportunity to share their views on the quality of the service. Quality assurance procedures were in place to identify where the service needed to make improvements, and where issues had been identified the manager took action to improve the service.

You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was safe.

People told us they felt safe. There were enough staff available to protect people from harm. People were protected from the risk of abuse, as staff knew how to safeguard people from abuse, and suitable staff were recruited to support people. Medicines were administered safely.

Good

Is the service effective?
The service was not consistently effective.

Staff were given induction and training so that they had the skills they needed to meet the needs of people at the home. However, staff were not supported to have regular supervision meetings. Where people could not make decisions for themselves people's rights were protected, decisions were made in their 'best interests' in consultation with health professionals.

Requires Improvement

Is the service caring?
The service was caring.

Staff treated people with respect and kindness. Staff knew people well, and respected people's privacy and dignity. Staff supported people to maintain their independence.

Good

Is the service responsive?
The service was not consistently responsive.

People were not supported to take part in interests and hobbies that met their preference. However, people were able to raise complaints and provide feedback about the service. We saw complaints were analysed to identify any trends and patterns, so that action could be taken to make improvements.

Requires Improvement

Is the service well-led?
The service was not consistently well led.

Care records were not always up to date, and did not always accurately describe the care people received. The manager had identified that improvements to record keeping were required and an improvement plan was in place to address this. Quality assurance procedures were in place, and where issues had been identified the manager had taken action to improve the service.

Requires Improvement

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.

This inspection took place on 18 March 2015 and was unannounced. The inspection was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We asked the provider to send to us a Provider's Information Return (PIR). The document allows the provider to give us key information about the service, what it does well and what improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection.

We reviewed the information we held about the service. We looked at information received from relatives, from local authority commissioners and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 14 people who lived at the home, five relatives, five members of staff, and the manager. We also spoke with three visiting health care professionals.

We observed care being delivered in communal areas and we observed how people were supported at lunch time.

We looked at a range of records about people's care including four care files. This was to assess whether the information needed about each person was available, and the care delivered met people's needs.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service.

We looked at personnel files for two members of staff to check that suitable recruitment procedures were in place, and that staff received appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at the home. One person told us, "Yes I feel safe. Staff are wonderful, and I receive excellent care."

People were protected against the risk of abuse. Care staff told us they completed regular training in safeguarding and whistleblowing. Staff were knowledgeable about the procedures for identifying and reporting any abuse, or potential abuse. Staff told us they were comfortable with raising any concerns they had with the manager, and were confident that they would be protected by the manager under whistleblowing procedures. One member of staff told us, "I have raised something internally before, and this was resolved by the manager." The provider notified us when they made referrals to the local authority safeguarding team and when an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken.

Staff told us and the records confirmed suitable recruitment procedures were in place which included checks into the character of staff before they started working at the home. This was to ensure they were safe to work with people.

There was a system in place to identify risks and protect people from harm. Each person had risk assessments completed for risks to their health or wellbeing. The assessments detailed the type of activity, the associated risk; who could be harmed; possible triggers; and guidance for staff to take. Risk assessments were up to date. For example, we saw one person was at risk of weight loss. We saw records detailed their dietary preferences, how they should be assisted to eat, and how often their weight should be monitored. This was to ensure the risk was minimised and staff knew how to respond if the person needed their support.

Risk assessments were in place to manage risks to the home. The risk assessments included risks such as fire and flood which could affect the running of the service. Emergency plans were in place to manage the identified risks, for example, what to do in the event of a fire. We saw fire alarm testing being undertaken to check equipment, as part of the risk management strategy. Plans detailed the actions for staff to take in an emergency. This meant there were clear instructions for staff to follow, so that the disruption to people's care and support was minimised.

We spoke to the manager about how the numbers of staff were determined at the home. We saw assessments of people's needs and abilities were used to create a dependencies score. For example, the more assistance a person needed with dressing and eating, the higher their dependency score. The manager explained the dependency scores were used to determine the numbers of care staff required at the home to care for people effectively and safely.

We saw the manager had identified a number of vacancies within the home by using the dependency tool, and was using agency staff to supplement the regular staff team. The manager explained that all agency staff were checked for their suitability before being employed. A recruitment campaign was underway to recruit additional permanent staff, because they could offer more consistency and continuity of care to people. We saw the manager was also recruiting to other key positions in the home, for example, a deputy manager and an activities co-ordinator. This was to improve management support at the home, and provide people with access to interests and hobbies that met their needs.

People we spoke with and their relatives told us there were enough staff available to care for people safely. One person said, "I think there are enough staff." One member of staff told us, "Everyone would like to have more staff if we could, but we work together and help each other to get things done, it's teamwork." We observed the support offered to people in the communal areas of the home. There were enough staff to meet people's needs throughout our inspection. Care staff responded promptly to people if they needed assistance, for example, we heard one person calling out for a member of staff from their room and a member of staff went straight away to assist the person.

We observed a medicine administration round. Staff told us, and records confirmed, staff were trained to administer medicines safely. Records showed people were given their regularly prescribed medicine at the right time of day. Medicines were stored safely. There was a protocol in place for administering medicines prescribed on an 'as required' (PRN) basis to protect people from receiving too little, or too much medicine. We saw people were asked whether

Good

Is the service safe?

they needed PRN medicine during each medicines administration round. Where people could not communicate their need for the medicine, there were protocols in place for staff to follow to determine whether people needed to receive the medicine.

Requires Improvement

Is the service effective?

Our findings

People told us staff had the skills they needed to support them effectively. One member of staff told us, "I had an induction which included basic skills, and shadowing another member of experienced staff for more than two weeks. We did extensive manual handling training where my competency was tested. Competency is also regularly checked to keep us up to date."

Staff told us that each member of staff also received an individual training programme tailored to their specific job role. For example, nurses received training in medication administration and other nursing skills. We saw staff had their skills checked through supervised observation after undergoing training, for example, in medication administration and manual handling techniques. The manager organised training courses on a range of topics and techniques so that staff had the skills they required to meet people's needs.

Staff told us the manager encouraged them to keep their training and skills up to date; however, the training was often done in their own time. We saw a staff training matrix recorded what training each member of staff had completed, and when training was due to be renewed. Training was delivered in a number of ways, including in-house training courses, and courses on-line. We saw the provider had recently introduced a new training system where staff could access training on-line at the home. This was to ensure that they had access to training courses if they did not have computer equipment at home, to keep their skills up to date.

Staff told us and records confirmed, staff did not always receive regular one to one supervision meetings and appraisals with their manager. Staff told us they didn't always feel supported because they did not have an opportunity to discuss their concerns, and their professional development through these meetings. One staff member told us, "I don't feel supported, I haven't had a supervision meeting with my manager for more than a year." The manager confirmed one to one supervision meetings were not held regularly with staff, but a plan was in place to implement regular supervision meetings. The meetings would provide an opportunity for staff to discuss personal development and training requirements and issues of concern. Regular meetings would also enable the manager to monitor the performance of staff, and discuss any areas for improvement.

We reviewed how the provider was meeting the requirements of The Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). These set out principles to ensure decisions are made in people's best interests when they are unable to make decisions for themselves. The manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Records confirmed people received mental capacity assessments if they could not make decisions for themselves. We saw that where people could not make decisions for themselves, decisions were made in their 'best interests' in consultation with health professionals.

Staff told us they completed training on MCA and DoLS and were able to tell us the action they would take if a person's capacity to make decisions changed, or if they suspected this. Staff gave us examples of when they had applied the principles of the MCA to protect people's rights. For example, asking for people's consent, and making decisions for people in consultation with other staff, professionals and relatives if people could not make decisions themselves. We saw staff asked for people's consent before they assisted them during the day.

Records confirmed the manager reviewed each person's care needs to ensure people were not unlawfully deprived of their liberties. No one at the home had a DoLS in place at the time of our inspection. The manager had assessed each person at the home to see whether a DoLS was required, and their assessments were waiting to be reviewed by the local authority responsible for authorising DoLS. This meant the manager understood their responsibility to comply with the requirements of the Act.

We observed people having their lunchtime meal. People told us they enjoyed their meal. We saw dining tables were laid with table cloths and flowers to help the room seem more inviting to people. Some people ate their meal in the dining room, and other people were assisted to eat and drink in their room. We saw some people being assisted to eat their meal. People ate at their own pace, and staff waited for clear signals that people had finished their main meal before offering them dessert.

Requires Improvement

Is the service effective?

Staff supported people who needed assistance to cut up their food, or made sure people had any specialised equipment they needed, without being prompted. This helped people to maintain their dignity, and demonstrated dining room staff knew people well. We saw people used plate guards and adapted tools to help them eat their own meals without assistance from staff which helped to maintain their independence. People were offered drinks throughout the day. Staff offered people a choice of drinks, such as tea, water and milk. Staff waited for a response from people regarding their preference before preparing their drink. One staff member said, "We encourage people to have as much fluid as they can, as this makes sure people are hydrated."

The provider catered for people with specialist diets, for example, offering a choice of gluten free and dairy free food. We saw the kitchen also prepared food for people on a 'soft' diet, and for people with diabetes. We saw that people were offered a choice of meal. There were menus on display around the home, so that people could see the daily meal choices. During our inspection we saw a member of staff asking people whether they had enjoyed their meal, and future meal options they would like. People were offered nutrition that met their health needs, and their preferences.

Staff explained how they handed over key information to staff coming in on the next shift, so that staff were kept up to date with changes to people's health. We observed the daily handover, and saw this was conducted verbally, and a daily handover sheet was prepared. Information was shared about changes in people's health or care needs, or any special arrangements for the day. We were able to view the daily handover file and saw this was kept up to date so staff who missed the meeting could review the information.

We looked at the health records of people who used the service. We saw each person was supported to attend regular health checks. We saw that care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, we saw people were able to see their GP, speech and language therapist, mental health practitioner and dentist where a need had been identified. On the day of our visit three health professionals visited people at the home. One visiting health professional told us, "We are asked to attend people when there are health concerns, for example, we are asked to attend people with mobility problems, and to assist with reviewing dressings for wounds." One health professional told us, "Staff come and speak to me and want to work together to support people."

Good

Is the service caring?

Our findings

People and their relatives told us staff treated them with respect and kindness. One person said, “Oh yes they are smashing, I have wonderful care.” Another person said, “This is as good as you can get.” One relative told us, “Staff are wonderful, they have a good attitude and are exceptionally good.” One person told us, “They are looking after us really well, they are caring for us.” A visiting professional told us, “[Name] is very good, professional and caring.”

Staff responded to people in a caring manner. For example, we saw one person started to cough and looked anxious. A member of staff quickly responded, assisted the person by patting their back, and spoke to them in a kind and reassuring manner. The person was calmed. We saw the member of staff continued to monitor the person to make sure they remained comfortable.

Staff we spoke with knew people’s preferred name, and spoke with people in a respectful and caring way. A visiting health professional told us, “Staff understand people and know people well.” We saw staff knew how to respond to people who were anxious and distressed due to their complex needs. For example, one person called out to staff. A member of staff went over immediately and spoke to the person softly and quietly, they used the information they knew about the person to engage them in a conversation. They stayed with the person until they were reassured, and then offered the person a milkshake. We saw from the person’s care plan that they liked to have milkshake, which also helped to calm them. The person remained calm, and staff monitored them until they had drunk their milkshake to make sure they were no longer anxious.

Staff respected people’s privacy and dignity. Staff knocked on people’s doors before entering, and announced themselves when they entered people’s rooms. Staff spoke to people in respectful positive ways, and asked their permission before performing support tasks.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People told us they could have visitors when they liked. This helped people maintain links with family and friends.

Requires Improvement

Is the service responsive?

Our findings

We asked people if staff responded to their individual needs. One relative told us, "Staff are good with [Name], they do things whenever we ask. Our lives are made easier by the support we are receiving here."

We saw that people's personal preferences were recorded on their care plans. For example, we saw one person liked puzzle books, and liked to have the puzzle information read to them. Staff we spoke with knew the person's preferences. We saw another person liked to have snacks between meals. Staff knew their preference, and we saw the person was offered snacks and drinks between meals.

People's preferences regarding how they spent their time were not always met. We saw there were posters displayed around the home offering people support to attend events and activities. However, people told us that although the events and activities were advertised, they did not always take place. One relative told us, "The home doesn't do very much in activities, this is our main concern." Another person told us, "There is nothing going on, and nothing to look forward to. It is the same every day." Another person said, "I would love staff to have more time to chat, as there are no activities."

People told us they weren't given the support they wanted to maintain their individual interests. One relative told us, "My relative has a memory box, they used to use this with the activities co-ordinator, but there is no-one in this role now." The manager told us, "The care staff provide some activities when the activities co-ordinator is not available." They added, "We currently have a vacancy for an activities co-ordinator."

We saw there was information about how to make a complaint available in the reception area of the home. The complaints policy and procedures were explained in the service user guide that each person received when they moved to the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One person said, The manager is accessible, I have not concerns, if I did I would tell them."

In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. For example, one complaint record we reviewed showed the manager had invited the complainant in to the service to meet with them. The complaint, and action taken to resolve it, had been reviewed by the organisation's quality officer to make sure the complaint had been responded to adequately. We saw complaints were analysed to identify any trends and patterns, so that action could be taken to improve.

Requires Improvement

Is the service well-led?

Our findings

Record keeping was not always up to date at the service. For example, on one person's medication administration record the staff member responsible for administering medication had not recorded whether the person had received their medicine. We asked staff to check whether the person had received their medicine. Staff were unable to tell us, because an accurate record of stock medicines was not available to check against. This meant all medicines at the home could not be accounted for.

Some people had their food and fluid intakes recorded if they were at risk of poor nutrition. This was to ensure they were eating and drinking enough to maintain their health. However, we found these records were not consistently completed by staff. One member of staff told us, "The charts aren't always filled in." For example, one person's records did not document the amount of food and fluid they needed each day, and staff did not consistently record how much food and fluid the person had consumed. Staff were unable to tell us how much food and fluid the person needed each day. The lack of recording put the person at risk, as not all the staff knew how much food and fluid was needed to maintain the person's health.

Records did not always demonstrate that people were receiving the care they needed at the right time, and in accordance with their care plans. The information was not consistently recorded about the care people received. For example, one person needed to be moved every two hours as they had limited mobility, and were at risk of developing damage to their skin. We saw the person had a chart in place to record when they were moved by staff. However, the charts were not up to date as they showed the person had not been moved for several hours on the day of our inspection. We asked a member of staff if the person had been moved, and they told us they had been moved, but could not be sure how often this was taking place. They said, "The re-positioning charts aren't always filled in."

In one person's care record we saw information was not recorded consistently to provide clear information for staff on how the person should be cared for. For example, a visiting professional told us the person was required to wear a splint on their arm. This information was not recorded in the care file. On the day of our inspection we saw the person was not wearing the splint. Staff we spoke with were unable to explain why the person was not wearing the splint.

Records were not always reviewed in a timely way to make ensure people received the care and treatment they needed. For example, one person had paperwork showing they should not be resuscitated if they suffered from cardio pulmonary arrest (DNARCPR). The decision had been made by health professionals more than a year ago. Records did not show whether the person, or their relatives, had been involved in the decision regarding the DNARCPR. The manager confirmed a review of the decision had not taken place so were unaware if the person's circumstances or wishes may have changed.

We found this was a breach in the legal requirements of Regulation 20 Records, of the Health and Social Care Act (Regulated Activities) Regulations 2008, which corresponds to Regulation 17 of the Regulations 2014.

The manager had identified that care records needed to be improved through audit procedures. Up to date care records would assist staff in delivering consistent, good quality care. The manager explained a 'keyworker' system had been introduced to improve record keeping at the home. 'Keyworkers' were designated members of staff assigned to each person who lived at the home, to quality assure care delivery for each person. They would be responsible for people's care records to make sure things were not overlooked, and that care records were kept up to date. The manager also had a plan in place to make improvements to record keeping through a care record audit planned in February 2015.

We asked people if they felt the home was well led, and if the manager was available to meet with them. Most people told us the home was well led, and that systems had improved since the appointment of the registered manager a few months ago. One person said, "One of the senior members of staff is great." They added, "I hear them talking to the staff and supporting them, they really lead their team." One visiting professional told us, 'I'm quite happy with the management of this home." Another visiting professional told us, "The quality at the home has improved recently."

Requires Improvement

Is the service well-led?

Staff told us they enjoyed working at the service, and that they were able to speak to the manager if they needed to. One staff member told us, "I like working here, it's busy, but a nice place." Another staff member said, "I think it's a good place to work, the staff work as a team to support each other." Staff told us they had an opportunity to raise any concerns they had, or provide feedback and ideas about how the service could be improved in team meetings. One member of staff told us, "We have regular staff meetings." We saw a recent suggestion had been made in a staff meeting to introduce a 'keyworker' system at the home and that this had been implemented by the manager.

The manager was accessible to staff, people and their relatives, because they worked at the home each day. One relative told us, "There aren't enough channels for relatives to voice their views about the service. We have arranged a monthly meeting with the manager due to this, and its working well." The manager told us they planned to implement a weekly time for people and their relative's to 'drop in' and see the manager for a clinic session.

We saw meetings took place to gather views from people, and to involve people in the running of the service. We saw relatives meetings were advertised around the home. Meeting dates were monthly, and included different times of the day and different days of the week, to accommodate people's personal schedules to make the meetings as accessible as possible. We saw that the meetings were recorded. Items that were discussed at recent meetings included staff vacancies. We saw that relatives had been informed of the progress of the recruitment.

The manager told us that the service ran annual quality assurance surveys of people who lived at the home and their relatives. We saw people were also able to give feedback using a comments book in reception. Records showed people had provided feedback and an action plan had been produced to drive improvements. For example, a suggestion had been made that people should be involved in interviewing new staff. Information in the PIR confirmed people were to be involved in the recruitment of staff in the future, to increase involvement of people at the service.

One visiting professional told us that communication at the home could be improved. This was because the nursing staff, the care staff, and the manager didn't always co-ordinate to provide joined up care for people at the home. For example, on the day of their visit they were scheduled to see three people who used the service. The nursing staff were unaware of their visit, and two people were unavailable for their appointments. This meant the visiting professional needed to visit the home another day to see people, which would delay their access to health care. They said "Things have improved, but the nursing staff need to be better informed." We asked the manager if there was a person responsible at the home to liaise with the manager, care staff, and nursing staff regarding people's nursing needs. The manager told us the home did not currently have a 'clinical lead', but that this was being considered in the on-going recruitment campaign.

The service was part of a larger organisation. We saw that the area manager from the organisation frequently visited the service. This was to support the manager in audits and quality assurance procedures. The manager told us the wider organisation was supportive of the service, and offered regular feedback and assistance to them to support them in their role. We saw the manager attended monthly meetings with other managers who worked at the organisation. The manager told us this was to provide opportunities to support each other, and to share information and learning about the running of the home.

The service completed regular audits of different aspects of its service. This was to highlight any issues in the quality of the service, and to drive forward improvements. For example, we saw a recent audit has been completed on infection control procedures, and that all identified actions resulting from the audit had been implemented. The infection control audit had identified some areas of the home would benefit from re-painting, and we saw some painting was taking place, and a re-decoration plan had been approved by the provider.

The manager conducted a daily check of the service in a 'walk around', and recorded their observations. This daily check of the service contributed to audits and the monitoring of staff performance. For example, we saw that random checks were performed on specialist equipment, the premises, and the implementation of actions identified in previous improvement plans. In this way the manager checked that changes to the service had been implemented by staff, and the service continued to improve.

Records we looked at showed that staff recorded every time an accident or incident occurred. We saw the manager analysed the incidents to identify patterns or trends. The analysis provided information about whether processes or

Requires Improvement

Is the service well-led?

procedures needed to be changed, or care plans needed to be updated to reduce the risk of future events occurring. We saw that a recent incident had been investigated and procedures had been altered, following an analysis by the manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(c) HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance An accurate, complete and contemporaneous record in respect of each service user was not maintained.