Amicura Limited

Harmony House

Inspection report

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20 January 2022

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Harmony House is a residential care home providing personal and nursing care for up to 57 people over the age of 50. At the time of our inspection visit there were 43 people at the home.

Harmony House accommodates people in one building, split over two floors. Each floor had separate dining areas and bathroom facilities. People had en-suite facilities in their bedrooms. At the time of our inspection visit there was an outbreak of COVID-19. Those people who had tested positive for COVID-19 were co-horted (grouped together) on the ground floor of the home.

People's experience of using this service and what we found
Procedures to ensure risks to people's health were managed effectively required improvement. On the first day of our inspection the provider did not have a system in place to check the COVID-19 vaccination status of health professionals and contractors visiting the home, as required by law since 11 November 2021. However, by the second day of our inspection they had put a system in place in response to our feedback.

Staff understood their responsibility to protect people from abuse and avoidable harm. However, we found the provider had not always notified us of relevant information regarding a recent safeguarding concern. This is currently being re-investigated.

People, staff and relatives told us there were enough staff to meet the needs of people using the service. Medicines were managed safely. The home was clean and was adapted to meet people's needs.

People received food and nutrition that met their needs, and were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Overall, people were referred to external health professionals when concerns were identified about their health or wellbeing

Staff were caring. People's privacy and dignity was respected.

People told us their care could be more personalised, as they were not always supported to bathe as often as they wished. Improvements were required to ensure people continued to have visitors in accordance with government guidance.

The provider's systems and processes were not used effectively to review and maintain oversight of the quality of care being provided. There was no registered manager at the service. Leadership and support to the management team was required to ensure the home was managed effectively.

Staff and the management team were committed to the people living at the home and feedback from our inspection was welcomed. The provider told us action would be taken to address all the areas which

required improvement.

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

Why we inspected
This was a responsive inspection. The provider had reported an outbreak of COVID-19 at the home which involved more than twenty per cent of the people who lived there. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. During the first day of our inspection visit we identified concerns in the other key questions. We therefore opened our inspection to look at all five key areas.

Rating at last inspection
This service was registered with us in April 2021 and this is the first inspection of the service under this provider. The overall rating for the service is requires improvement.

We have found evidence that the provider needs to make improvements.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to regulation 9, person-centred care, regulation 13, safeguarding and regulation 17, good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will work with the local authority to monitor progress. We will also request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Harmony House

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team comprised of six inspectors. Two inspectors visited on 14 January 2022. On the second day of our inspection, on 20 January 2022, three inspectors visited the home. Two inspectors made phone calls to relatives and staff to support the inspection visit.

Service and service type
Harmony House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission at the time of our visit. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service had an outbreak of Covid-19, and we needed to be sure the service could accommodate our inspection team in a safe environment. The first day of our inspection visit was on 14 January 2022. We returned to continue our inspection on 20 January 2022.

What we did before 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. We asked Healthwatch for any intelligence they had about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and eight relatives about their experience of the care provided. We spoke with ten members of staff including the area manager, the manager, the care manager, nurses, an activities co-ordinator, care staff and facilities staff.

We reviewed a range of records. This included five people's care records, daily records and medicines records. We looked at three 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.

On the second day of our inspection visit we identified an incident, following which a person using the service may have been harmed. This incident is subject to a police investigation and as a result at this inspection we did not examine the circumstances of the incident. However, the information shared with CQC about the incident, indicated potential concerns about the management of risk and safeguarding investigations. When the investigation is concluded we will consider any further action we may take.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. The provider used risk assessment tools to assess the level of risks in different aspects of people's care. For example, in relation to falls, skin damage and mobility. Risk assessments and risk management plans required regular updates to ensure people received safe care. However, we found risk management plans were not always kept up to date and we therefore could not be assured people always received safe and consistent care.
- One person had been assessed as needing a certain level of supervision and restriction in their movements, to protect other people at the home. We found staff were not following the agreed restrictions, and the risk to others was not being appropriately managed. The manager told us they would review the risk assessments, to ensure the level of supervision required was clear.
- One person had bed rails and a bed rail risk assessment had been completed on 12 February 2020. There was no evidence this had been reviewed every month in line with the provider's policies and procedures to ensure the level of risk had not changed.
- The provider used the National Early Warning Score to identify any deterioration in people's health. One person's score in December 2021 indicated that the nurse should reassess the person. There was no evidence a reassessment had been carried out.
- Care plans to minimise risks sometimes contained conflicting information. For example, in one person's care plan it indicated they needed a large size sling for transfer but later in the care plan it said they needed a medium size sling.
- Some catheter care plans provided guidance for staff on how to monitor and care for the catheter safely and staff had good knowledge about potential risks relating to catheter care. However, one person's care records had two catheter care plans and conflicting information about how often the catheter should be changed.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected against the risk of abuse. We found a recent safeguarding incident that had been reported to the local authority safeguarding team and CQC, did not contain all the relevant information regarding the incident. The manager and provider had not shared information in a way that ensured relevant agencies could effectively investigate the safeguarding concern. We spoke to the manager and provider, and the local authority safeguarding team, who are continuing to investigate the concern.
- Staff told us they were confident identifying potential safeguarding concerns and knew how to report these to management. However, one staff member had not raised concerns with the manager regarding the potential abuse of a service user. As part of our inspection we alerted the manager to the concern for

investigation. The manager has reminded staff on how to report safeguarding concerns and the provider's whistleblowing procedures.

This was a breach of regulation 13 Safeguarding, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person told us they felt safe in the home because, "Nobody can get in if they haven't got the codes." Another person said they felt safe because of the way staff treated them and explained, "The way they [staff] treat you, they don't boss us around. Anything we need help with, they do it."

Preventing and controlling infection
● The provider had not always ensured infection outbreaks could be effectively prevented or managed. On the first day of our inspection the provider did not have a system in place to check the COVID-19 vaccination status of visiting health professionals or contractors working in the home, as required since 11 November 2021. On the second day of our inspection, the provider had implemented a system to check the vaccination status of people visiting the home following our feedback. We have signposted the provider to the regulation and guidance to develop their approach.
● The home was clean and free from any unpleasant odours. Staff understood their responsibilities regarding good infection control procedures.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● There were enough care and nursing staff to care for people safely. People cared for in bed had call bells to hand and told us they did not have to wait long when they called staff for assistance. One person told us, "I do use it (the call bell), it depends where they are [staff] and what they are doing, but I have never waited too long. They [staff] come as quick as they can." Another person told us, "Oh yes, (they [staff] do come quickly) and they check on us anyway."
● Staff told us they had no concerns about staffing levels, there were enough staff to support people safely.
● The manager explained they had experienced workforce challenges, due to the skills and competency of potential staff. A vacancy for an activities co-ordinator took more than three months to recruit a suitable staff member. The new activities co-ordinator started work in the service in January 2022.
● There had been staff pressures due to COVID-19 related sickness. Where staff rotas were not able to be covered by permanent staff the provider was using agency staff. These staffing pressures had meant a reduction in group activity sessions for people, but not in providing safe care.
● Records showed the provider's assessed numbers of care staff, based on their dependency tool, had been maintained. Staffing levels were reviewed on a monthly basis and altered according to people's needs.
● The recruitment process continued to ensure staff were suitable for their roles by conducting relevant pre-employment checks. These included COVID-19 vaccination as a condition of deployment checks and an enhanced Disclosure and Barring Service [DBS] check. The DBS helps employers make safer recruitment decisions so only suitable people work with those who are vulnerable.

Learning lessons when things go wrong
● The provider and manager had missed opportunities to learn lessons when things went wrong in

investigations and through audits.

Using medicines safely

● People received their medicines as prescribed. Staff who administered medicines received specialised training in how to administer medicines safely. Medicines were administered using an electronic monitoring system which instructed staff on when to administer medicines, and in what dosage.

● Medicines were stored safely and securely. Medicines were monitored to ensure they were stored at the correct temperatures, so they remained effective.

● Some people required medicines to be administered on an "as required" basis. There were protocols (plans) for the administration of these medicines.

Good

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the effectiveness of people's care, treatment and support achieved good outcomes for people.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us they enjoyed the food. One person commented, "Very good. They [staff] give you a choice of two meals. You never feel hungry." Another person said, "They [staff] come along and refill my drinks, the food is spot on. I've no complaints at all." At lunch time the food looked hot and portions were generous.
- Care plans included information about whether people required specialist diets such as fortified for people who needed extra calories, diabetic, or pureed for people at risk of choking. People had daily fluid targets based on their weight and their intake was monitored through food and fluid charts.
- Food and drinks were provided in between meals and there were snack stations for people to help themselves. Staff had good knowledge of supporting people with specialist diets. One nurse said, "We monitor people's fluid intake and if their target hasn't been met, we discuss this at handover and people are reminded to push fluids. If their target hasn't been met for 3 days, we refer back to the dietician and the GP."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The manager told us they assessed people's needs before they moved to the home to ensure staff had the skills and competencies to meet those needs effectively.
- Where people needed support with the management of health conditions, guidance from the National Institute for Health and Care Excellence (NICE) was being reviewed and followed.

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Mental capacity assessments were carried out for those identified as needing them and applications made to the authorising body for anyone identified as potentially being deprived of their liberty.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Overall, people were referred to external health professionals when concerns were identified about their health or wellbeing. This included dieticians, GPs and tissue viability nurses.

● Twice daily handovers ensured key information about people's health and well-being or any concerns was shared amongst the staff team.

Staff support: induction, training, skills and experience

● Staff did not always receive effective induction. On the first day of our inspection we found one staff member had been working at the service for four days and had not begun their induction training. However, the staff member was working under supervision.This was due to staff shortages, because of the outbreak of COVID-19. Following our inspection visit the staff member received their induction.

● Staff were given training considered mandatory by the provider and completed The Care Certificate. The Care Certificate is a nationally recognised set of training standards for health and care workers.

● Staff received supervision and were encouraged to complete further qualifications in health and social care. One staff member said, "I had supervision about 3 months ago. We identified that I needed PEG training which I've done now. They were putting me down to do an NVQ."

Adapting service, design, decoration to meet people's needs

●Some areas of the home were tired and in need of refurbishment, such as the corridors on the first floor. The lounge on the first floor was being used to store three wheelchairs and scale seat at the time of our inspection and was not inviting for people to relax in. The manager told us a planned refurbishment of the home had been delayed due to the COVID-19 pandemic.

● People were able to personalise their rooms with items of their choosing.

Good

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- All the relatives we spoke with told us the staff were caring. We observed positive interactions between people and staff and staff regularly checked on people's wellbeing. For example, one person became a little upset. A staff member immediately responded to identify the cause of the distress and acted quickly to reassure the person.
- People were positive about the caring attitude of the staff team. One person told us, "I would rather be at home with my family, but this is my other family here." Another person said, "I love it, I wouldn't want to be anywhere else. They (staff) treat you with respect and you can have a good laugh with them."
- One relative described how staff used their knowledge of their family member to form a relationship with them. They told us, "The staff are very caring and understanding. They empathise with the person. [Name] has a dry sense of humour and the staff recognise that and use humour to communicate." Another relative commented, "Staff are very good, we have a laugh together."

Supporting people to express their views and be involved in making decisions about their care

- Relatives told us people were supported to discuss their care needs as far as they were able to. One relative told us, "Staff are very respectful to [Name]. She's always been involved in decision making." Another said, "They [staff] speak to her at length to get her opinions."
- Overall, relatives confirmed they were involved and kept updated about their family member's health and welfare and if there were any changes with their care and support needs. One relative told us, "Staff are very good at talking to me and answering my questions." Another person said, "People must think I'm unhappy because I'm in bed, but I'm really not because I'm well looked after."
- However, two relatives told us they had not been contacted when their family member became ill. They said this had been some months ago and they thought the situation had improved since then.

Respecting and promoting people's privacy, dignity and independence

- People told us staff supported their dignity when receiving personal care. One person told us, "When you are in my position, there is a lot of personal help you need. So, you have to rely on them to be kind to you and treat you with respect, and they do."
- One person told us staff worked at their pace and explained, "I never feel rushed. I don't feel pushed or bossed around or that they need me to do things quicker." One relative told us, "They (staff) spend a lot of time talking to [Name]."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

● Care plans gave some information about people's preferred routines. However, we received some feedback that people did not always receive a shower as often as they would like. One person thought they could only have a shower when their name was on the rota. A staff member told us people could have showers whenever they liked. However, another person told us although they asked to have a shower, "I haven't had a shower since 25 November 2021. I wash myself in bed, I don't feel clean though."

● The provider was not facilitating visits for people living in the home in accordance with the current government guidance. People who had tested positive for COVID-19 were isolated to one floor of the home. On the first day of our inspection visit, on the floor of the home where no-one had a positive COVID-19 test, people were not allowed to receive visitors. The provider had not made provision for essential care givers to visit their relatives. These restrictions had been placed on people.

● One person was distressed during our visit and told us, "My husband and son usually come to see me 2-3 times a week for a few hours at a time. They've not been in since the lockdown. It's awful. I just sit here and cry sometimes." A relative told us their regular visits had been stopped since the COVID-19 outbreak. They said, "No one can go in at the moment… when the outbreak is over, I'll visit again", they added their relative would much rather they were able to continue to visit the home. Prior to our inspection visit the provider had not informed relatives about how essential care givers could still visit their relatives during COVID-19 outbreaks.

After our inspection the provider told us they would open the home up to visitors again. They explained they had initially closed the home to visiting based on the advice of Public Health England (PHE).

This was a breach of regulation 9 Person-Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 carer's.

● People's communication needs were highlighted in their care plan so staff understood what support people needed to aid their understanding of their care and support needs.

● However, we found the information in care plans was not always translated into everyday practice. For example, one person told us their hearing aids had not worked for several months and this had not been addressed by staff. This person was profoundly deaf and had not been supported to have replacement

hearing aids fitted. The manager informed us they would take action to assess the person's hearing needs following our visit.
● Care plans were not written in a format that would make them accessible for people to read and understand themselves.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The service had received some concerns that people were not being supported to maintain their hobbies and interests or to keep active. The provider recognised this was an area for improvement and had recruited a new member of staff to fill this role and support people's wellbeing.
● The new activities co-ordinator had only commenced employment the week of our inspection visit and had spent their first days meeting and talking with people to understand what activities they would like to engage with.
● Whilst the new activities co-ordinator recognised many people were very frail or unwell and, "Just want to hold your hand and talk to you", they had already started to introduce some craft activities, virtual tours of museums and zoos and musical events. The activities co-ordinator explained, "I have tried to test the waters for what the residents would and wouldn't go for. They have given me some ideas such as cards and dominoes and it is something I plan to revisit as a conversation topic every few weeks."

End of life care and support
● People had advanced care plans which recorded where they wanted to receive their end of life care and how they wanted their end of live care to be met.
● Clinical and care staff were due to attend a course facilitated by the local hospice which focused on enhancing life when cure was no longer an option. The course centred on patient wellbeing and involving them in in decisions about their care

Improving care quality in response to complaints or concerns
● People told us they would be able to talk to the manager if they had any issues. One person told us, "I would go straight to the manager. I couldn't tell you her name, but we all know the manager." Another said, "I would go to the manager, [Name of manager]. I see her most days."
● One relative told us they had raised a concern about communication which had been acted upon. They explained, "I have asked them to tell me what's going on more and they have." Another said, "I haven't made a complaint, I wouldn't because if something was bothering me, I would speak to manager and they would listen."
● Records demonstrated complaints were investigated and responded to. The provider had introduced a new form to demonstrate any lessons learned from complaints, any resulting changes to policies or practice and how this had been communicated to staff.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider understood their role in terms of regulatory requirements. For example, notifying CQC of events, such as safeguarding's and serious incidents as required by law. However, improvements were required in the way the provider notified CQC of incidents. We identified during a review of incidents a recent safeguarding event was not referred accurately to CQC and the local authority safeguarding team, to enable a full and transparent investigation of the incident to take place. Key information based on the original recording of the concern was omitted from the information sent to CQC. The provider's governance systems had failed to identify this omission.
● Effective systems were not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the home and others. The provider's systems had failed to ensure people's risk management plans were always followed. The provider's systems had failed to ensure care records were kept up to date. The manager told us care records were all under review.
● Systems had not been implemented effectively to ensure the risk of infection of COVID-19 was effectively prevented or managed. Not all staff were part of the provider's testing systems, to ensure they had a negative COVID-19 test result, ensuring safe working. Systems to check the vaccination status of visitors required review; and was immediately updated following our inspection visit.
● One member of staff told us they had raised concerns about the accuracy of care records, but nothing had been done to investigate this further. Another staff member told us they had raised concerns before at Harmony House; but felt nervous of doing this again as they were concerned about losing their job. The manager told us they were aware of some dissatisfaction from staff regarding a particular member of staff, however, they had failed to investigate this. The manager had failed to ensure staff observations and checks had been undertaken in response to the concerns raised.
● Improvements were required to ensure an environment was created where there was an open culture at all levels. Relatives told us communication around government guidance to minimise the risks of COVID-19 had been poor. For example, relatives had not been informed as to the role of essential care giver (ECG) and how this could facilitate visiting and supporting their family member. The manager acted to inform relatives after the first day of our inspection but comments included, "I would have considered doing this (being an

ECG), even in an outbreak" and, "I would have gone in to see him."

● The provider had failed to have effective governance systems and processes to monitor the quality and safety of the service. The lack of effective systems meant the provider had failed to identify the concerns that we found during our inspection visit.
● The manager explained they did not have sufficient time to undertake all the management tasks; the lack of a clinical lead was impacting on their time to undertake their new role. In addition, there had been an outbreak of COVID-19 at the home, which had affected management team levels at the home.
● The manager intended to apply to become the registered manager at Harmony House. However, they were yet to receive the training they needed to operate in this role effectively. The manager told us the provider visited the home regularly, however, the provider's systems and processes were not used effectively to review and maintain oversight of the quality of care being provided.

This was a breach of regulation 17 Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider understood their responsibility to be open and honest when things had gone wrong.
● Relatives told us they were rung regularly and provided with an update about how their family members were during the most recent outbreak of COVID-19.
● There was not a registered manager at the service. The manager had been in their post for approximately three months at the time of our visit and had previously been the home's deputy manager. The management team had undergone a number of changes in the months leading up to our inspection, this included the change in manager, the removal of the post of deputy manager and also a vacancy in the clinical lead role.
● Staff told us the manager was approachable. One nurse told us, "The manager trying to do well, in the circumstances she was left in. I feel I can go to her if needed."
● The provider had an employee of the month scheme to recognise staff who had achieved high standards of care in their practice.
● There was a 'you said, we did' board in the reception area to inform people and relatives their voices had been heard and actions implemented in response.

Working in partnership with others; continuous learning and improving care
● The provider was committed to making improvements at Harmony House. Feedback from our inspection was welcomed and assurance was provided that action would be taken to address all of the areas which required improvement.
● The provider confirmed the manager was provided with updates to government guidance.
● The provider planned a programme of refurbishment at the home in the near future.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 3b. The provider had failed in designing care or treatment with a view to achieving service users' preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 2. The provider had failed to ensure systems and processes were operated effectively to prevent abuse of service users.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 2a &b. The provider had failed to ensure systems and processes were established and operated effectively to ensure compliance with the regulations. Procedures had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Procedures had failed to securely an accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

We issued the provider with a warning notice.