Larchwood Care Homes (North) Limited

Harmony House

Inspection report

The Bull Ring
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 10 and 11 January 2017. The visit was unannounced on 10 January 2017 and we informed the registered manager we would return on 11 January 2017.

Harmony House provides accommodation, nursing and personal care and support for up to 57 people living with physical frailty due to older age and complex health conditions. At the time of the inspection 37 people lived at the home. The home has two floors; on the days of our visit, the ground floor offered two residential care beds and 15 nursing beds. People on the first floor all required nursing care.

The home is required to have a registered manager in post. 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. At the time of this inspection the home had a registered manager who had been in post since March 2015 and registered with us since August 2015.

When we inspected the home in March 2015 we found a breach in the governance of the home and the legal requirements and regulations associated with the Health and Social Care Act 2008 were not being met. A requirement notice was served on the provider to tell us what action they would take to make improvements. At our last inspection in June 2016, we found improvements had not been made. We identified breaches in the management of medicines and the safe care and treatment of people. A continued breach in the governance of the home resulted in enforcement action being taken and we served a warning notice on the provider and the registered manager. The home was placed in 'special measures.' The special measures framework is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Services in special measures are inspected again within six months following the publication of the inspection report.

At this inspection we looked to see if the provider and registered manager had responded to make the required improvements in the standard of care to meet the regulations. Whilst we found that sufficient improvements had been made to remove the service from 'special measures,' we found further improvements were required. The requirements of the warning notice served had not been fully complied with. Further improvements in how the senior managers assured themselves that they were providing a safe service, that ensured people's health and welfare needs were fully met, were required. The registered manager showed us the service development plan that provided details of further planned improvements.

Systems in place to assess the quality of the service provided were not always effective and improvements had not been fully implemented. Checks undertaken by nurses, the deputy manager and registered manager to ensure the safe management of medicines and people's care and treatment was safe, had not identified potential areas of risk. Whilst some improvement had been made, further improvements were required.

Feedback was sought from people and their relatives but improvements were not always effectively made in the areas that mattered most to people. Staff did not always feel supported by management. Staff felt the 'culture and feel' of the home needed to improve so concerns could be openly raised with management and feedback given.

Nurses had been trained to use an electronic system when administering people's medicines and felt supported with this. However, further improvements were needed so that nurses had the information they needed to ensure 'when required' medicines given consistently to people and in ensuring storage of medicines was undertaken safely.

Risk assessments to minimise where people may be at risk of harm or injury and the required actions, had not always been taken. People's wound care records did not always contain the information needed for staff to prevent and manage the risks of skin damage.

People were supported by staff who were trained to know what abuse was and how to report any concerns.

People were supported to eat and drink and improvement had been made in the snacks offered to them between meals. Further improvement was required to ensure staff followed professional healthcare guidance from speech and language therapists when supporting people to eat. Care records showed healthcare professionals were involved in people's care and treatment, but further improvement was required to ensure records were detailed so that actions could be referred back to.

Nurses and care staff received training, however they did not always put this into practice or demonstrate their understanding of what they had learnt from the training.

Staff worked within the principles of the Mental Capacity Act (MCA) 2005 when supporting people. The registered manager understood their responsibilities and acted in accordance with the MCA. The requirements of the Deprivation of Liberty Safeguards were followed.

People were supported by some kind and compassionate staff who demonstrated a caring approach. However, this was not consistent with all staff.

Overall, staff responded to people's physical care needs. Planned activities took place but did not always meet people's needs and improvements were needed to prevent the risks of loneliness and people becoming socially isolated.

People and their relatives knew how to make a complaint if needed. Complaints were investigated and action taken to resolve issues but relatives felt improvements were not always sustained.

We found continued breaches in the regulation relating to the safe care and treatment of people and in the governance of the home. We met with the provider to discuss these on 26 January 2017.

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

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.

Nurses did not have the guidance they needed to give people's 'when required' medicines in a consistent way. Nurses did not always follow the provider's policy with medicines such as dating 'short-life' medicines when opened and when undertaking checks on the safe storage temperatures for some medicines.

Risks were not always effectively assessed, and actions to minimise harm or injury had not always been taken. People's care records did not always contain the information needed for staff to prevent and manage risks of skin damage.

Staff were trained to know what abuse was and how to report any concerns. Sufficient levels of staff were not always planned for, such as, covering times of absence.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements had been made to ensure drinks were accessible and appropriate snacks offered as required. However, improvement was required to ensure staff followed professional healthcare guidance when supporting people to eat. Care records showed healthcare professionals, such as GPs, involvement with people. Improvement was required in ensuring records were detailed so that actions could be checked when referrals or actions had been made.

Staff received training, some improvement was needed in staff learning from their training. Further relevant training was being sourced for staff to develop skills they needed.

Staff worked within the principles of the Mental Capacity Act (MCA) 2005 when supporting people. The registered manager understood their responsibilities and acted in accordance with the MCA. The requirements of the Deprivation of Liberty Safeguards were followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by some kind and compassionate staff who demonstrated a caring approach. However, this was not consistent with all staff.

Staff promoted people's privacy. Improvements were needed in ensuring people's dignity was maintained through consistent attention to personal appearance.

Staff had a supportive and caring approach toward relatives of people receiving end of life care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff responded to people's requests and prioritised people's needs above other tasks, however, this was not always consistent. Planned activities took place but did not always meet people's needs and improvement was needed to prevent the risks of loneliness and people becoming socially isolated.

People and their relatives knew how to make a complaint if needed. Complaints were investigated and action taken to resolve issues but relatives felt improvements were not always sustained.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A service development plan identified where improvement in the delivery of the service was required and recorded actions and progress of improvements with target dates. Further improvement was required to ensure quality monitoring processes, such as audits and spot checks were always effective. This would mean appropriate action could be taken to improve and minimise risks to people's health and wellbeing.

Staff enjoyed working at the home, however, did not always feel supported in their role or that their concerns were acted upon. Improvement was needed in planning staffing effectively. The regional manager planned to ensure people, relatives and staff had more opportunities to make their views known and to ensure improvements focused on areas identified and a positive and supportive culture developed.

Harmony House

Detailed findings

Background to this inspection

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

The inspection took place on 10 and 11 January 2017. The inspection visit was unannounced on 10 January 2017 and we told the registered manager we would return on 11 January 2017. The inspection team consisted of three inspectors, an inspection manager and a pharmacist inspector on the first day. On the second day, two inspectors and an inspection manager returned to continue the inspection.

The provider had previously completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to this inspection, a request for a new PIR was not made. Since our last inspection in June 2016, the provider had been sending us weekly action plans telling us about the improvements they had made. During this inspection, we gave the registered manager an opportunity to supply us with information, which we then took into account during our inspection visit.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. We reviewed feedback sent to us from relatives who had 'shared their experiences' with us. Some of these people had shared concerns with us about the home, such as examples of poor care being given to people. The local authority shared a complaint with us that was being investigated.

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent time with these people and observed the care and support they were given by staff. We observed nursing staff administering people's medicines to them.

We spoke with nine people who lived at the home and nine relatives or friends, who told us about their

experiences of using the service. We spoke with staff on duty including two nurses, an agency nurse, ten care staff, the cook, the duty manager, the registered manager and two regional managers.

We reviewed a range of records; these included eight care records, daily progress logs, three wound care management plans and 15 medicine administration electronic records. We looked at quality assurance audits and the results of the provider's quality monitoring system to see what actions were taken from people's feedback. We looked at the provider's service improvement plan to see what further improvements were planned for.

Requires Improvement

Is the service safe?

Our findings

At our inspection in June 2016, we identified breaches in the regulations regarding the safe management of medicines and the safe care and treatment of people. The provider did not take always protect people against potential risks or take action to mitigate such risks. In June 2016, we rated the area of safe as 'requires improvement' and sent a requirement notice to the provider. This meant the provider had to send us an action plan to inform us how they intended to make the required improvements to the service people received. The provider sent us an action plan as requested. At this inspection, we checked whether the provider had implemented improvements to meet the regulations. We found some improvements had been made but further improvements, in managing medicines, were required. We found people did not always receive safe care and treatment because risks were not always effectively managed. This meant there was a continued breach in the regulation relating to the safe care and treatment of people.

In June 2016, we identified that assessments to minimise the risks of people falling had been completed, however, actions to reduce the risk of harm or injury were not detailed which meant staff did not have the information to refer to if needed. At this inspection, we found insufficient improvement had been made. For example, one person's assessment recorded they were at 'high risk' of falls. However, there was no detailed information recorded on this person's assessment to tell staff how to reduce the risk of this person having a fall. Records showed that since our last inspection, this person had nine falls; with and without sustaining injuries to themselves. We observed this person was left unobserved by staff for twenty-five minutes in the communal dining area; after lunchtime. We saw this person became anxious asking others, who lived at the home, to assist them because they wanted to leave the dining room. They became frustrated in waiting for staff and began to bang the table to get staff attention. This meant actions to reduce the risks of injury or harm were not always taken by staff, who did not always have the information they needed to know how to maintain people's safety.

The registered manager informed us that some people were being treated for pressure areas on their skin. However, we looked at three people's wound management plans and found these were not sufficiently detailed. For example one person's pressure care plan recorded to change their dressing 'when required,' this did not promote consistency in the management of their skin care or healing their sore skin. A nurse had recorded one person's skin sore as a 'scab,' however, ten days later a different nurse recorded a 'grade three necrotic area' which described a serious deterioration of this person's skin. We discussed this with the registered manager and they agreed it was not clear how the person's skin had deteriorated in this time or the steps taken to prevent this.

Another person's initial assessment said they required special 'boots' to be worn in bed to protect their feet. These were not made available to them on their admission and three weeks following this, they had sore skin on their feet. The registered manager told us the required feet protecting 'boots' were ordered by them three months after the admission of this person and there was a delay in the delivery. Timely action had not been taken to prevent skin damage to this person's feet.

Photographs of people's sore skin were not consistently taken by nurses to assess progress and healing of

skin wounds. We discussed this with the registered manager who agreed that photographs, for example, from August 2016, had not been taken or were not available on records which meant tracking progress or deterioration of a person's sore skin was not always possible. The registered manager informed us that nurses had received some skin care awareness training from sales representatives promoting their products but had not undertaken in depth tissue viability training from a specialist skin care professional.

This was a continued breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had special mattresses on their bed and staff had the information to refer to if needed to check what setting the air flow should be set at for individuals based on their body weight. Care staff told us they would alert the nurse if they had any concerns about a person's skin and some care staff had completed skin care awareness training. One staff member told us, "We have to turn people in their beds every few hours so they don't get pressure sores and we sign the turn chart to say we've done it. If a person's skin is red or sore, we tell the nurse and ask them to check it." The registered manager informed us further training would be sourced for care staff and nurses so that they had the skills they needed to prevent and manage people's risks of damage to their skin.

The registered manager told us about changes in their system of managing people's medicines, which involved a move to using an electronic Proactive Care System (PCS) during November 2016. Nurses told us they had felt supported in being trained to use the new PCS. One nurse said, "I was a bit worried with it all being electronic, but now I prefer it to the paper based charts we had before. I feel there is less room for error."

Medicines were stored securely in designated clinical rooms, and nurses monitored the temperatures of the rooms. Some medicines required refrigerator storage and were kept within two refrigerators in the clinical rooms. Nurses had frequently recorded temperatures above the maximum range in both refrigerators and had not taken any action to report this. This meant there was a risk of people being administered medicine that was no longer effective and nursing staff had not recognised this.

We found medicines, with a limited shelf life, such as liquids did not have opening dates recorded, which meant the medicine might not have been effective when administered to people. The regional manager told us, "Nurses should always date any bottles of liquid medicine when they are opened."

Nurses used the PCS to keep electronic records of stocks of people's medicines. The PCS showed nursing staff when stock was low and, through the PCS, nurses could reorder repeat medicine supplies and prevent missed doses as a result of stock running out. However, we found one person's medication had been ordered at the pharmacy but had not yet been delivered to the home. This medicine had been unavailable to this person for five days. There was no evidence that nurses or managers had taken action to obtain the prescription sooner or seek alternatives for this person. This meant the medicine to help this person's anxiety was not available to them. We discussed this with the registered manager and regional manager who told us they were unaware of this and would take action to ensure the medicine was made available. On the second day of our inspection, the regional manager informed us a supply had been obtained for this person.

Some people were prescribed 'time critical' medicines due to their health conditions and nurses gave these medicines to people at the correct time intervals.

Some people had their prescribed medicine through skin patches and nurses used 'patch application record

charts' to record where, on the person's body, they applied the patches. This record enabled nurses to safely rotate the sites of application in accordance with the manufacturer's guidance. We were told care staff administered most of people's prescribed topical preparations, such as creams and completed a separate topical administration chart. However, these did not always record creams had been applied because there were gaps in dates on some people's charts.

We found some people's medicines were not always administered in a safe way if they were prescribed on a 'when required' basis. Improvements had not been made since our last inspection in June 2016 to ensure guidance was available to nurses so that 'when required' medicines were given to people in a consistent way. The PCS did not have sufficient detail to enable decisions to be made, such as when using medicines to help manage a person's anxiety or distress. We discussed this with the registered manager and they agreed there were not sufficient guidelines for nurses around how to administer these medicines safely, which had potentially resulted in the people being over medicated.

We received mixed feedback from people and relatives when we asked them if they felt there were enough staff on shift. Some people felt there were enough staff and that things had improved. One person told us, "I think things have got a bit better here."

Some relatives felt staff had little or no time to spend with their family member to talk with them or spend any time in social interaction. Our observations supported this, we found that care was task focused and there was limited time for staff to engage people in social interaction or conversation.

One nurse told us, "For the number of people we are currently caring for on the first floor, if we have one nurse and six carers that is just enough and better than things were. If the ten currently empty beds were filled, it would be better to have at least seven carers and the nurse."

Care staff told us when the expected levels of staff were on duty on each floor they were able to meet people's physical needs. Staff told us there were numerous occasions when staffing levels were not sufficient. For example, staff said unexpected absences were not always covered and it then became difficult to cope in meeting people's needs in a safe way. One staff member told us, "It's not just occasionally that we don't have enough staff, but nearly half the time." Another staff member told us, "The shift rota is not always followed, where it says staff are working is not always what actually happens."

The registered manager informed us on the first day of our inspection that the care shifts for the day were fully staffed. However, staff told us differently and said three care staff were spending part of their shift on a scheduled training update and a further carer had not arrived for their shift. Staff felt this added pressure to them on the shift, one staff member said, "It's not as safe for people because they have to wait, it means they don't get the care at the time they should get it, such as being turned, (repositioned in bed)." We discussed how the training was planned with the registered manager and regional manager. The regional manager told us, "It would have been my expectation that staff are not pulled off the floor for training but attend, for example, on the morning and then are on shift in the afternoon." This had not been done by the registered manager and impacted on people and staff remaining to cover the shift in a negative way on the first day of our inspection.

The registered manager informed us they used a dependency assessment tool to inform staffing levels. They told us, "The assessment does not always take into account everything so I do tweak it, because some people's care and support might take staff longer." On the second day of our inspection, we observed sufficient staff on shift to meet people's physical needs in a safe way.

Most staff told us they had been working at the home for several years. One staff member said, "I've been here years now, but I do recall that before I started working with people, they did checks, like getting references and my criminal record check." This meant that the provider's recruitment process involved checks being made to ensure staff were of good character. The registered manager informed they were in the process of recruiting a new care staff member but they had not yet started work, so we did not make checks on newly appointed staff on this inspection.

We asked staff how they would deal with emergencies that might arise from time to time. Care staff told us they would press the emergency buzzer and get the nurse. Nursing staff were confident they knew how they would deal with emergencies, such as a fire, accidents or incidents that might arise. One nurse told us, "I am confident with any clinical incidents that might need action. For example, one person had accidently pulled out their PEG tube and I safely re-inserted it for them. If a person has a fall, I will assess them for any injuries. We'll call 999 if needed." Some people had ppercutaneous endoscopic gastrostomy (PEG) feeding tubes so their nutritional needs were met. A PEG tube is a tube passed into a person's stomach through their abdomen, to provide a means of feeding when oral intake is not adequate.

People felt safe living at the home. One person told us, "I feel safe here in my bedroom. If anything worried me, I'd tell my relatives." Staff were trained in safeguarding people from abuse and told us they would report any concerns to the registered manager. Some care staff found it difficult to give us examples of what might constitute abuse which meant they might not always know when it was important to report an issue. Posters were displayed to remind staff what abuse was and how to report it.

We identified an example of where care staff had recorded some bruising on a person's body and had completed a body map, noting 'unexplained bruising'. The registered manager was unable to show us evidence of any investigation into this which meant that potential safeguarding concerns had not been investigated in line with their responsibilities in ensuring people received safe care and treatment.

Relatives told us they felt improvements had been made in the cleanliness of the home. During our inspection visit, the home looked clean and there were no offensive odours. Staff understood the importance of using personal protective clothing, such as gloves and aprons, and we saw these were worn when needed.

Requires Improvement

Is the service effective?

Our findings

At our inspection in June 2016, we identified improvements were needed in the effectiveness of the service provided to people. At this inspection we received mixed feedback from people and found whilst some improvements had been made, further improvements were still required.

People told us they had enough to eat and drink and we saw drinks were accessible. A few people told us they enjoyed the food and if they did not like the menu choice, they could ask for something different. For example, one person told us, "The kitchen staff know I like a prawn cocktail and will do that for me if there is nothing on the menu I like, that's lovely." However, some people did not always enjoy their food and did not experience being offered alternatives. One person told us, "The food quality could be better, I'm just given the two options on the menu to choose from."

Care staff did not always feel the food looked appetising when served to people and told us choices were limited. One staff member told us, "There are always two choices for people who do not require pureed food, but there is no real choice for people that have puree meals. Like today, the main choice is meatballs or stroganoff, so people on a puree diet get a puree meatballs for lunch and a puree stroganoff for teatime." The cook confirmed this to us, however said that if they were made aware of a person not liking a particular food, they would do something different for them. The cook made efforts to present puree foods in an appetising way by blending food items separately but told us 'food shape moulds' would help achieve this. However, these had not yet been purchased.

The cook informed us they had no budget restrictions placed on them as to what they ordered and showed us well stocked cupboards. The cook said, "Since your last inspection, no one has ever said we need to cut back on what we order, I order what I need and it is delivered."

People had Malnutrition Universal Screening Tool (MUST) assessments. (MUST) is a management plan for people who are malnourished or at risk of malnutrition. The cook told us they minimised the risks of malnutrition by adding extra calories to milk and porridge and offered high calorie snacks, such as full fat yogurts or smoothie milk drinks, to people between meals. The cook told us, "Improvements have been made to the snacks on the tea trolley, there is a range of snacks now and it includes soft food items for people." On both days of our inspection we saw snacks were offered to people, however, two care staff members told us there had been a few occasions that the tea trolley and snacks had not been offered to people because there had not been enough staff. We discussed this with the registered manager and they told us they had not been made aware of this.

Some people had special diets, such as gluten free or based on their cultural preference. The cook had this information available to them and we saw these people's needs were met. However, we saw the cook's information on which people required a puree diet was not up to date. The cook told us they had not been informed about any changes which posed a potential risk to people being given the wrong consistency of food that was safe for them.

At our previous inspection in June 2016, we found that staff did not always check or follow the guidance given by healthcare professionals. At this inspection, we found improvements had not been made. For example, one person had been reassessed by a speech and language therapist, (SALT), in October 2016 as being able to have a 'fork mashable' diet, however, they were served a pureed meal. We discussed this with staff, who told us the person required a 'pureed meal.' We pointed out the dietician information in this person's care plan and also an 'information sheet' stuck to the wall in this person's bedroom, where staff supported them with their meal. Staff told us they had not been 'aware' of this change.

Another person's guidance said staff should encourage them to have, "up to three teaspoons of pureed food." This guidance was in addition to this person having nutrition though their percutaneous endoscopic gastrostomy (PEG). However, this guidance was not always followed because one staff member told us, "I can see from [person's name] they are enjoying the food, so I give them more." Care staff had not been given the training to assess if this was safe for this person or that a referral back to SALT may be needed before changes were made to guidance given.

People told us that staff informed their doctor if they were unwell. One person told us, "I've got a bad chest at the moment and have some antibiotics." Care staff said they would raise any concerns about people to the nurse in charge and nurses told us they would contact a person's GP if needed.

The registered manager said they felt improvements had been made in making timely and effective referrals to healthcare professionals when needed. However, some relatives disagreed with this and felt they had to put 'pressure' on the registered manager before referrals were made. One relative told us, "My family member was losing weight and this concerned us. Only after raising this several times was a referral made and a prescription for supplements given." Another relative said they had requested a longer bed for their family member but had been told by the deputy manager this was not needed. We discussed this with the deputy and registered manager, who gave us conflicting information; that the bed had been extended and the bed could not be extended. There were no records available to clarify whether action had or had not been taken and improvement was required so that actions, if taken, could be referred back to.

We received mixed feedback when we asked people and their relatives if they felt most staff had the skills they needed for their role. One person told us, "They seem to know what they are doing." Some relatives told us they had to remind staff about information they had shared and felt some staff did not always demonstrate the skills they needed. One relative told us, "I have told staff that my family member is prone to urine infections and shows certain behaviours when they have an infection, but despite our information, staff haven't always recognised this."

The registered manager told us most staff had completed the training they needed, however acknowledged there were a few gaps where staff either needed to update their knowledge or they needed to source training for staff. For example, from a clinical practitioner to give training in tissue viability (skin care) training. Despite staff's training, we saw not all staff demonstrated they had learnt from their training, for example in how to support people effectively and ensure care records were completed as required.

The Mental Capacity Act 2005 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. Staff worked within the principles of the Act and management understood their responsibilities.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. On this inspection visit, we found improvement had been made and the registered manager and provider were acting in line with the requirements of the Act. The registered manager informed us that 12 people were deprived of their liberty and they applied to the supervisory body, for the authority to deprive a further eight people, of their liberty, because their care plans included restrictions to their liberty. For example, they could not go out independently, because they did not recognise risks to their safety outside of the home.

Requires Improvement

Is the service caring?

Our findings

At our inspection in June 2016, we identified improvement was needed to ensure staff consistently took a caring approach toward people. At this inspection we continued to receive mixed responses when we asked people if staff were caring. We observed most staff had a caring approach to people, however, this was not consistent.

People told us most of the staff were kind and thoughtful, but did not always have time to spend with them. One person told us, "They are nice girls (staff), I get what I need. If they can't do something, then they'll get another carer." Another person said, "Most of them are caring and do what they need to do, it could be worse." A further person agreed and said, "Most staff have a kind approach but some have a stroppy attitude."

Most relatives felt staff 'did their best'. One relative said, "There are some really kind staff here, they go the extra mile for my family member." However, another relative said, "I don't think staff care."

During our inspection visit we observed some positive caring interactions. For example, one care staff member knelt down next to one person and said, "You are getting hot. Shall I take you to your chair in your bedroom?" However, we also found some staff did not always have a caring approach toward people. For example, we saw one person did not have a call bell and asked two staff members if this person should have one. Each staff member separately told us, "I don't know' and made no effort to check, despite them working on the first floor with this person. We asked a third staff member who told us, "I think they should have one, I'll go and check." This third staff member returned to us and explained this person was unable to use a call bell so did not have one. They demonstrated a caring approach because they checked on behalf of this person.

During lunchtime we observed support offered by staff to one person in the dining room. Two care staff separately approached this person, however the interactions did not demonstrate a caring approach. One staff member stood next to this person and told them to 'sit up properly' and then walked away, which was not supportive or respectful toward this person. Another staff member again stood next to this person and helped them put food onto their fork, whilst also talking with another staff member before moving onto another task leaving this person with their lunch. The third staff member who approached this person, sat next to them before asking them, "Would you like me to help you?" This person replied, "Yes, please," the staff member supported the person in a caring way so they could enjoy their lunch.

People did not always receive person centred care. Care staff told us they were 'allowed' to read people's care plans, but said they did not have the time to do so. None of the care staff we spoke with had read people's care plans. This meant care staff members were often only able to tell us about the physical aspects of caring for people they supported showing their approach was task led. However, care staff told us they would like to spend more time with people so that care was more person centred. One care staff member said, "Most of the time we only get to talk with a person during personal care, it would be better for them if we had other time to chat with them as well."

Staff described caring and supportive approaches to people's relatives when people reached end of life care. One staff member told us, "Relatives can visit at any time and some have stayed all night." A nurse told us, "There have been a number of expected deaths recently due to people's frailty or health deterioration; we always try to be as sensitive as possible to their needs and support their relatives." The registered manager added, "Relatives can stay with their loved one as long as they wish, we try to be as caring as we can toward them and the person at such difficult times."

People's bedrooms were personalised which helped them feel as if it was their home. People's rooms contained their personal mementos and photos, relatives told us they could bring in items they felt would make bedrooms more 'homely' One relative said, "We've brought a small fridge for my relative's bedroom. It helps keeps their drinks and snacks cool."

Staff gave us examples of how they tried to involve people in day to day decisions about their care. For example, one person told us, "Staff do ask me if I want to get out of bed, like today I did so I could go to the singing." However, we heard one person say they would like to go outside for some fresh air, however, staff who had not over heard this, did not offer this person a choice of where they wanted to go, but informed the person they would 'take them back to their bedroom'. This meant there were some inconsistencies in how staff involved people in making decisions and whether choices were given to people by staff.

Most people were supported to maintain their dignity related to their appearance. People's clothing was clean and their beds were clean and tidy. However, we saw a few people had long fingernails with dirt embedded underneath. Their care notes recorded staff had supported them with washing and personal care. This meant some aspects of people's care were either overlooked or not attended to in a caring way to support people with their appearance and dignity.

We observed staff promoted people's privacy and dignity. For example, a few people removed their bedclothes which left their body uncovered. We saw the deputy manager gently pull a sheet back over one person's legs so the person's dignity was maintained. Other staff members closed bedroom doors when personal care was given.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in June 2016, we identified improvement was needed in how staff responded to people's needs and rated this domain as 'inadequate.' At this inspection we continued to receive mixed responses when we asked people if they felt staff met their individual needs. We observed occasions when staff delivered personalised care and met people's support needs, showing some improvements had been made. However, we identified occasions when staff did not always meet people's individual needs and found further improvements were needed.

A few people said they enjoyed the planned group activities in the home. Some people told us staff had asked them if they wanted to join a group 'sing along' on the ground floor on the second day of our inspection and one person later said, "I enjoyed the singing." However, some people were unable to comfortably get out of bed or did not always have a suitable wheelchair or armchair they could use. This meant some people either chose not to or were unable to join in planned group activities. Overall, people did not feel their individual social and activity needs were met and one person said, "There is nothing to do." Some relatives told us their biggest concern for their family member was 'loneliness' and one person told us they were 'lonely.'

The registered manager told us they allocated 42 hours a week to activities and as well as group activities, the activities staff member offered one to one sessions with people cared for in bed; due to their frailty or health conditions. The registered manager said, "People have individual activity care plans." One relative told us, "My family member is cared for in their bedroom and is meant to have one to one activities but it doesn't seem to happen." This person's daily progress log showed two entries, over seven days, had been made recording an offer of one to one activity. One entry recorded the person was 'asleep' and no record of a further offer was made to them that day.

Despite people having 'social interaction' care plans, we found no assessment had been completed to determine how risks of social isolation were minimised for people who were cared for in their bedrooms.

Care staff told us they were not encouraged by managers to spend time with people unless this was to complete a physical task, such as personal care. One staff member said, "The other day I saw one person was very upset in their bedroom, I sat with them and read a card to them to offer them reassurance. The deputy manager saw me and told me to get on with tasks." The regional manager told us they felt it was important for staff to take the time to have a cup of tea with people, for example, and this was a social activity. However, this had not been effectively communicated with staff because they felt if they responded to people in this way, which most felt would be a positive caring response, they may be 'told off' by managers. We discussed this with the registered manager who told us they felt it important that staff did spend time with people, but they were aware that the deputy manager had, on occasions, needed to remind staff not to spend time chatting amongst themselves.

Some people were able to use a call bell to gain staff attention if needed. We saw improvement had been made in the accessibility of these to people. Most people told us improvement had been made and staff

responded when they pressed their bell. One person told us, "Staff do come, even if they have to tell me to wait a bit." However, another person said, "It can vary, sometimes I have to wait." Throughout our inspection visit, we observed staff responded to people's call bells in a timely way and prioritised responding to people's needs over other tasks.

People and relatives told us they were involved in their initial assessment of need and care records showed this. However, people and relatives had inconsistent experiences of being involved in planning and reviewing their care once they lived at the home. Some relatives told us they were invited and attended reviews with staff and reviewing officers from the local authority or healthcare. However, one relative told us, "In four years, I have never been invited to a care review." People's care records did not always reflect how they or their relatives had been involved in their care plan.

The registered manager told us they tried to offer people and their relatives the opportunity to express their views by holding 'resident and relatives' meetings. Some people told us they were aware of the meetings but said they did not attend these because they were cared for in bed. One person said, "I leave things to my relatives." Most relatives told us they did not attend the meeting, though were aware of them. One relative told us, "If I need to say anything, I'll go and speak with the manager. I have done so in the past and think that works best for us." The registered manager informed us they had held a resident and relative meeting during December 2016, and this was attended by six relatives. The registered manager added that most issues raised were about individual's care that was addressed with relatives.

Some relatives told us they had raised concerns and complaints to the registered manager. Some issues had been about a lack of hygiene and cleanliness in their family member's bedroom and the home overall. Most relatives felt cleanliness had improved recently and their issues had been addressed and resolved. Of the 13 concerns raised, since our last inspection in June 2016, some issues were around 'poor care.' Relatives told us whilst things were addressed, improvements were not always sustained. For example, staff not always ensuring a person's table was left close enough for them to reach.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the home in June 2016 we identified a continued breach in the regulation relating to good governance of the home. We found planned improvements; following our previous inspection in March 2015 had not been fully implemented with insufficient improvements made. We found a number of examples during the first two days of our inspection which had not been identified by the registered manager or the provider from their own audit processes which meant the provider's audits to monitor the quality of the service provided were still ineffective. We served a warning notice on the provider and the registered manager and placed the home in 'Special Measures' and the home was rated 'inadequate.'

The registered manager informed us there had been several changes to their regional manager for the service since our last inspection in June 2016. The previous regional manager had left in September 2016 and a further two regional manager had supported the service since. On the first day of our inspection, the interim regional manager told us, "I have only been covering this service for three weeks and am in the process of introducing this service to another new regional manager who will be taking this over from me." The registered manager told us, "The different regional managers have each been supportive; it's just been a lot of changes. Each regional manager has been good, but it will be better to have some consistency with the new person starting this month. They will be regional manager for about five services and we will have regular meetings with them."

During this inspection we found sufficient improvements, and development plans for further improvements, were in place to remove the service from 'special measures.' The registered manager told us, "Improvements have been made since your last inspection (July 2016) but there is always room for further improvement and we are working on those areas. For example, the care plans are still 'work in progress,' this is partly because we received the paperwork later than expected and also because some staff need to improve on their care planning documentation."

We checked to see if the requirements of the warning notice served had been met. We found insufficient improvements had been made as although systems and processes were in place to monitor the quality of the service, these were not always effective. Where action to bring about improvements were needed or evaluation of whether actions taken were effective in making the required improvements, this had not always been identified by the provider's own quality assurance systems.

The PCS electronic audit system did not cover all aspects of the safe management of medicines. The registered manager informed us their last medicine audit had been completed during October 2016. We found this had not identified nurses had recorded a medicine fridge temperature that exceeded the maximum refrigerator temperature on 91 occasions between March and December 2016. As a result of the ineffective audit, there was an increased risk of medicines been given to people, when they were no longer effective. The registered manager told us immediate action would be taken to address this.

We found improvements had not been made for people that had medicines 'when required' (PRN). We discussed this with the registered manager on the first day of our inspection, and they told us, "Since the

PCS, we have gone 'paperless'. We did write the PRN guidance, but this was archived since we introduced the electronic system." This meant the registered manager had not identified that nurses, including agency nurses who did not know people well, needed the PRN guidance so that people's 'when required' medicines were given to them in a consistent way. On the second day of our inspection visit the registered manager showed us guidance had been written in response to our feedback to them. However, the registered manager had not identified that the newly written guidance did not provide staff with the detailed guidance they needed so that medicines could be given in a consistent way. We discussed this with the registered manager who told us further information would be added to people's 'when required' medicine guidance.

Whilst accidents and incidents were recorded and analysis took place, the registered manager had not ensured their identified actions to minimise the risk of harm or injury were followed by staff. The registered manager showed us their most recent monthly overview which recorded for one person the action taken to reduce their risk of further falls was 'continued observation'. However, during our inspection visit we saw this did not happen and the person was unobserved by staff for twenty five minutes. This meant that actions recorded were, in practice, not always happening because either the staffing levels did not permit this or staff were not always aware of what action to take.

We found there was a lack of oversight by the registered manager and senior managers to check that delegated tasks were undertaken effectively. For example, checks on staff had not identified they did not always follow guidance provided to them by healthcare professionals.

Quality assurance systems had not identified that nurses did not always have the training they needed to effectively prevent people's skin from becoming damaged. Checks on care records had not identified that nurses were not effectively making records so that progress or deterioration of people's skin damage could effectively be managed.

Following our last inspection in June 2016, the provider had invited people to give feedback on the quality of the service. Analysis of people's feedback had taken place and this, along with a summary of actions taken and planned for, was displayed in the home. Issues people, relatives and staff told us about during this inspection visit were the same or similar to those identified as requiring improvement from the provider's August 2016 survey. For example, 43% of people's visitors felt there were insufficient activities for people. Planned action for improvement had not been fully effective because people and their relatives told us this was still an area that required improvement. Feedback that had been sought from people, relatives and staff had not effectively been acted on to make improvements.

This was a continued breach of Regulation 17 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the service development plan was completed by regional managers with input from them. This plan listed some improvements were 'completed', some 'not on target' and some 'not started.' The registered manager explained some of the actions 'not started' were issues recently identified to them. For example, an infection prevention and control inspection undertaken by the Clinical Commissioning Group, in November 2016 and a food hygiene inspection undertaken in December 2016, identified some areas that required improvement not previously identified.

The registered manager informed us the service development plan was a 'live' electronic record on the provider's system. They said that they updated the service development plan to show when actions had been completed by them or that they were waiting, for example, for contractors to fulfil requests. They gave us an example of waiting for a part for one lift to be repaired that had been out of use since October 2016.

The registered manager told us the service development plan electronic record was looked at weekly by senior manager responsible for the Larchwood homes. This meant senior managers could access the progress on actions and also those outstanding actions at the home.

At our last inspection found the management of medicines was not safe. At this inspection we found some improvements had been made. For example, checks were undertaken to ensure nurses administered medicines to people in a safe way. The registered manager told us the provider had, in discussion with them, implemented an electronic Proactive Care System (PCS) during November 2016. The registered manager said they used this to complete a daily audit of medicines. The PCS system enabled the managers to undertake daily monitoring of medicines so that errors identified could be rectified in a timely way. The registered manager told us, "The focus, since November, has been on nurses following the correct administration processes which has been undertaken by the use of the daily and weekly reports. We have a weekly report that is generated by the PCS company to identify things, such as, staff not following the correct processes and we then support nurses to use the PCS correctly."

On the first day of our inspection visit, an agency nurse had been booked to cover a shift. This agency nurse had not worked at the home previously and was not familiar with the PCS of administering medicines. Their shift had been booked from 2pm which was the time the nurse they were receiving handover from was due to end their shift. Plans to ensure the agency nurse was confident in using the PCS, had not been put in place. We discussed this with the registered manager and regional manager. The registered manager told us the agency nurse had been booked the previous weekend to cover this shift. The regional manager told us they would have expected greater planning, by the registered manager, for the agency nurse's shift to have been booked with a 'few hours' overlap so that they could be shown how to safely use the PCS. As a result of the lack of planning for the agency nurse's support needs with the PCS, the deputy manager had to manage both medicine rounds for each floor on the shift, taking them away from where they should have been working.

An infection control audit that had been completed by North Warwickshire Clinical Commissioning Group (CCG) in November 2016. The CCG infection prevention and control lead gave the service a score of 84%. This score meant 'partial compliance' and some actions were identified where improvements were needed. For example, there was a lack of robust cleaning schedules in place for equipment, some of which was found to be dirty. The need for the service to have an identified lead staff member to undertake regular infection prevention and control audits of the home, was identified. The registered manager informed us they had identified a nurse to take on the lead role at the end of November 2016. This staff member was yet to commence tasks, such as audits, linked to their lead role at the time of our inspection.

The registered manager told us that some actions had been completed, following the CCG infection prevention and control audit, and further actions were planned for. The service development plan confirmed this to us. However, there had been no infection prevention and control audit had been completed by the registered manager during December 2016. This meant there was no check on whether improvements made were being sustained and whether any further actions; not identified to the provider by the CCG, to improve were required. The registered manager informed us they were currently sourcing training for the nurse taking on the lead role so they could effectively undertake audits.

Improvements had been made in supporting people to eat and drink sufficient to their needs, but further improvements were required. Fluid monitoring charts had been improved and now included a target amount based on individual need. Care staff completed fluid entries throughout the shift. We were told night staff should total the amount; however, this was not always completed. For some charts that had been totalled and a comment had been entered 'target not met,' we found no evidence, on those we looked at,

that the record was effectively monitored by the nurse, deputy manager or registered manager or that actions were taken when targets were not met.

The registered manager completed a monthly audit of people's weight or body mass index. The registered manager told us, "If people are losing weight, this might be due to their physical deterioration in health. However, we always refer to a dietician and they might prescribe supplements and the snacks offered to people on the tea trolley has improved." However, we found improvement was needed to checks undertaken on whether people received their supplements as prescribed. For example, one person was prescribed two supplements daily but records showed that out of six days, this person was recorded as having had the two supplements on only three days. There was no evidence of any reason or actions taken as a result. This person had lost weight since their admission to the home and whilst this was being monitored, their daily supplement intake was not always checked by the nurse.

Staff did not always feel supported by the management and some felt there was a 'blame culture' rather than an 'open culture' where learning and support could take place. Staff felt they could approach the registered manager but felt they did not always receive feedback on issues raised. Most staff told us they felt the deputy manager was not approachable and said they often felt 'intimidated' by them. Staff gave us examples of being 'put down' by the deputy manager and one staff member said, "The deputy manager can be a bit sharp at times and upset staff."

Overall, staff did not feel positive about their supervision meetings because they felt things did not change or they did not receive feedback. Staff meetings took place, however minutes from these did not show any staff involvement in the meeting. One staff member told us, "Nine times out of ten, no one speaks up when asked for their opinion at a staff meeting because we don't feel anything will be done. Manager's don't come back and give us any feedback." There was no action plan from the areas identified as requiring improvement in the staff meeting. However, the registered manager told us they now completed a daily recorded walk around the home to, for example, observe care practices and spot check care records. We found the registered manager's spot checks had not identified some of the issues that we observed during our inspection visit. For example, care practice observations had not identified healthcare professional's guidance was not always followed by staff.

The registered manager said a further feedback survey was due to be sent to people during February 2017 and a full analysis of this would take place so that further improvements, if needed, could be made.

Following our inspection visit, we met with the provider on 26 January 2017 and highlighted some issues of concern to them that we had identified. The provider told us about planned management changes at Harmony House. The provider informed us that the new regional manager was taking immediate action to make improvements and would send us updated reports on the progress of these improvements. The provider told us they would voluntarily continue to restrict admissions to the home whilst necessary improvements were made.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always effectively assessed, and actions to minimise harm or injury had not always been taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring processes were not always effective.