Harpers Villas Care Centre Ltd

Harpers Villas Care Centre

Inspection report

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Date of inspection visit:
12 January 2017

Date of publication:
03 March 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Our inspection took place on 12 January 2017and was unannounced. We last inspected the service on 12 and 13 November 2015. We found the service required improvement in the areas of safety in respect of staffing levels and leadership in respect of feedback on the service. We found that improvements had been made.

Harper's Villas Care Centre provides accommodation for up to 26 people requiring personal care who may have dementia. At the time of the inspection there were 22 people living at the service.

There was 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 2008 and associated Regulations about how the service is run.

People were supported by a staff team who knew how to keep people safe from the risk of harm and abuse. Potential risks had been assessed and staff supported people in a way which reduced these risks. People were supported by sufficient numbers of staff who had been recruited safely. People received the medicines they needed to support their health.

Staff ensured people were consenting to their care before supporting them and the provider worked within the principles of the Mental Capacity Act 2005. The provider had consulted with the local authorities to ensure, where people's liberties were deprived in order to keep them safe, the appropriate legal process was followed.

People were provided with the appropriate support to eat and drink. People received food which was in line with their beliefs or health needs. Staff sought the assistance of outside healthcare professionals in order to keep people well.

People were treated with kindness and respect. People's privacy and dignity was promoted.

People's individual care needs and preferences were understood. Staff used appropriate care planning in order to deliver care which met people's individual needs. Records showed and people confirmed staff consulted them regarding their needs.

People and their relatives were provided with opportunities to give feedback on the service. The registered manager had systems and processes in place to monitor and audit the quality of care. Where appropriate, the provider took action to improve identified areas for development.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

We found there were enough staff to support people with their needs and people received their medicines as prescribed.

Staff were clear about their duty to report matters of potential abuse.

The provider had used safe recruitment practices to ensure staff were appropriate for their roles.

Is the service effective?

Good

The service was effective.

The provider ensured that people were consenting to the care they received.

People received sufficient quantities of food and drink, which met their needs and supported their wellbeing.

People received appointments with healthcare professionals in order to support their health.

Is the service caring?

Good

The service was caring.

People were treated with care and respect.

Staff promoted and respected people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

Staff demonstrated a good understanding of people's changing needs.

There was a complaints policy in place which enabled people to raise issues of concern.

Is the service well-led?

Good

The service was well-led.

The provider sought to gain people's feedback on the service.

Audits were carried out to assess the quality of the service and actions were taken where improvements were required.

Harpers Villas Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 12 January 2017 and was unannounced. The inspection was carried out by an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people and dementia. During the inspection we carried out observations of the support and care people received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at information we held about the service. This included statutory notifications which are notifications the provider must send to inform us about certain events, such as injuries. We also contacted the local authority and other relevant agencies for information they held about the service. We used this information to help us plan the inspection.

We spoke with ten people who used the service, two relatives. We also spoke with two care staff, the deputy manager, the registered manager, the provider's area manager and the provider. We looked at five people's care records, records relating to the management of the service, records relating to health and safety and two staff files.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the service. One person said, "I definitely feel safe". Another person told us, "Yes, I feel safe here". We found people were protected from risks associated with their care because the provider had completed risk assessments which provided updated guidance for staff in order to keep people safe. These risk assessments related to, for example, people's risk of falling, risk of malnutrition and risk of sustaining sore areas of skin. Staff we spoke with demonstrated they were aware of the different risks people were vulnerable to. We observed staff working in ways to minimise risks to people throughout the day. For example, staff supported people to mobilise around the service safely and in line with their documented risk assessments.

People were protected from the risk of abuse because staff understood how to identify and report it. Staff told us they had received training in safeguarding and were able to demonstrate knowledge of outside agencies they could report suspected abuse to. Staff we spoke with were able to describe the potential signs that someone may be suffering abuse, such as changes in behaviour. Staff were clear about their responsibilities to report any suspicions of abuse. Staff were aware of the provider's whistle-blowing policy. Staff told us they felt comfortable in approaching the management team with any concerns they had.

During our last inspection we had found that staffing levels were not always adequate to meet the needs of people. During this inspection we found that, while staffing levels had not changed, there were fewer people living at the service. Most people we spoke with told us there were enough staff to support people. One person told us that they had a red emergency cord located in their room. They said that staff responded quickly when they pulled this cord. We observed staff responding in a timely way to alarms or requests from people. Two people told us it would be beneficial for there to be more staff on duty at any one time. However, they told us they had not been adversely affected by too few staff being present. Staff told us that the people currently living at the service had less complex needs and that, while they were busy, staffing levels were adequate.

People we spoke with told us they felt their personal items were safe and had never lost any items or money. They told us they could choose to lock their doors if they wished. We saw staff giving people their room keys in order to secure their doors.

We looked at the recruitment records of two staff members. We found appropriate pre-employment checks had been completed to ensure staff were suitable people to work at the service. We saw the provider obtained references and undertook checks with the Disclosure and Barring Service (DBS). The DBS checks help employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable people. This meant people were supported by staff who were appropriate people to deliver care.

People told us they received the medicines they needed to maintain their health. We found the provider has robust systems in place to ensure people received the medicines they needed to keep them well. We observed medicines being given to people. We saw that staff used appropriate procedures to ensure people

had taken their medicines and to record this. However, we observed one staff member giving a person powdered medicine which had to be dissolved into water. The staff member did not ensure the powders were appropriately mixed with the water. We raised this issue with the registered manager who agreed to address this issue with the member of staff.

Staff were aware of procedures for proving people with "as required" medicines, such as pain relief. We saw staff assisting a person, who had a headache, to take appropriate pain relief. We found that guidance in people's care records helped staff to know when and how to support people with "as required" medicines. This included how people might exhibit pain where they could not verbally express it. This meant that people received "as required" medicines as they needed them. Staff received appropriate training in medicines and their competency to administer medicines was checked by the provider.

Good

Is the service effective?

Our findings

Most people we spoke with told us that their needs were met, and when asked if they would like to change anything, said nothing needed changing. We looked at people's care records and found that people's needs were assessed and regularly reviewed to ensure their needs had not changed. Staff accurately reflected the changing needs of people, and how they might require different support from day to day. This included examples of where people's mobility might change or be affected by certain events, such as illness.

We spoke with staff about the induction process they had undertaken when they first started with the service. Staff described how they had received opportunities to get to know the service and understand the needs of people who lived there. We saw that staff files contained individual training tables which identified what training staff must undertake on an annual basis. Training subjects included areas which affected the wellbeing of people, such as diabetes awareness. We found that, although these records required updating, staff felt they received adequate training in order to care for people effectively. We observed staff put their training into practice while delivering care to people. For example, we observed several instances of staff helping people to mobilise around the service. We saw that this was done in a skilled and knowledgeable way.

We saw that staff ensured people were consenting to the care they received. We found that some people lacked capacity to make certain decisions. We spoke with the registered manager and staff about how they ensured people's rights were supported in respect of decisions about their care and day to day lives. We found that staff had a good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards and how these impacted on people. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the management team had liaised with the local authority regarding the need for DoLS applications for people living at the service. We saw that, where people were restricted, for example, from leaving the service alone, DoLS applications had been completed and sent to the local authority for assessment. We found the provider was also introducing improved Mental Capacity assessments to ensure that people living at the service had appropriate assessments of their capacity and were protected by individualised best interest decisions.

Most people gave neutral responses when asked about the food they received. People described it as "Alright" and "Ordinary". People we spoke with told us they were given enough food. One person said, "I always get enough food". One person we spoke with told us they had enjoyed their lunch and that, "It was plenty". The registered manager told us that people were given a choice of meals and these choices were respected. We found, from people's care records, that one person was vegetarian. Their records contained a

detailed description of what their foods needs were and how this supported their beliefs. We observed this person being served food which was in line with this guidance. Staff were able to accurately tell us about this person's dietary preferences.

Staff told us that one person was not eating well. We observed staff offering this person different choices of food to eat in order to encourage them. We saw this person eating a meal which was "off menu" which they appeared to enjoy. However, we did find that one person had been given food which they did not like and which staff were aware they would not choose. We raised this with the registered manager who agreed to address this with staff. Staff were knowledgeable about people's food requirements and were aided by clear guidance which was displayed in the kitchen. This meant that people received the nutrition they needed to keep them healthy.

We saw staff had undertaken assessments of people's risk of malnutrition. We found that appropriate referrals to dieticians had been made where people's risk was considered to be higher. This meant that people's risk around malnutrition was monitored and acted upon where needed.

People were given adequate liquids to drink. We saw that staff recorded people's hydration needs, how much they had drunk throughout the day and where fluids were refused and needed to be encouraged. However, we saw that choices in drinks were not always given. We found that some staff offered choice, but some staff did not check with people what they wanted. Staff told us this was because they already knew people's preferences. This did not take into consideration instances where people might prefer a change from time to time. We raised this issue with the registered manager who agreed to raise this with staff.

People had access to external healthcare professionals in order to maintain their wellbeing. We looked at records which detailed visits and appointments people had with outside health agencies. We saw that people did receive the appointments they needed. For example, once person had diabetic care needs. We saw this person received foot care from a podiatrist and retinal eye checks with the local NHS Trust. We found that people were registered with local GPs and received visits from them when they needed them. We saw that some people received regular visits from the District Nurse Service to receive support with various aspects of healthcare such as insulin injections.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us that staff were compassionate and caring. One person told us, "All the staff are brilliant". Another person said, "They are very nice and cheerful to talk to". A further person described how staff were, "Willing to do anything". We looked at recent surveys which had been completed by people and their relatives. The surveys, which we chose at random, were complimentary about staff and showed that people would recommend the service to others.

We observed the way in which staff supported people throughout the day. We saw that staff interacted positively with people and took time to ensure they were comfortable and not in need of assistance. We spoke with staff and the registered manager about the cultural needs of people living at the service. The registered manager described how one person liked to sit with her in the office area for quiet prayer and contemplation time. Staff were aware of people's spiritual needs describing how one person liked to attend a place of worship.
Staff reacted to ensure people were comfortable. We saw that one person was experiencing discomfort. Staff acted in order to relieve this person's pain by assisting them to stand. We spoke with the manager who was able to reflect on this as being the best method to comfort this person. We saw that staff's actions were effective in supporting this person in this aspect.

People's beliefs, likes and wishes were explored within care records and guidance in these records reflected what staff and people told us about their preferences. Each record contained a comprehensive history of each person. We saw that each person had an assigned member of staff who would meet with them regularly to ensure their needs were continuing to be met.
A relative described how a person had been readmitted to the service from hospital late at night. They told us the manager had attended the service specially to ensure their relative was comfortable and settled back in.

People and their relatives told us staff communicated with them regularly to ensure they were aware of any matters affecting people's care. One relative told us how staff had kept them updated following an incident involving two people. They said they had been notified of the matter on the same day. This meant that staff communicated in a timely and transparent way with people about issues effecting their care and wellbeing.

We found that one person had been assigned an Independent Mental Capacity Advocate (IMCA). The Mental Capacity Act 2005 introduced the role of the IMCA. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions. This includes making decisions about where they live and aspects of medical treatment. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. This meant the person had an advocate who could speak up on their behalf. This person's care records contained guidance on the role of the IMCA to ensure staff supported this important line of communication for this person.

Staff respected people's dignity and privacy. We saw that staff were mindful about the security of people's

records. People's care records were stored in a staffed office and kept securely when not. People's doors were lockable, and unless assessed as being unable to have access to their door keys in their best interests, were able to keep their doors locked. We saw staff respecting people's privacy by knocking on people's doors and awaiting a response before entering.

We saw people being assisted to mobilise around the home by use of a hoist. We saw that staff ensured people remained appropriately covered during the use of the hoist. People we saw were well presented and staff sought to maintain people's dignity throughout the day.

We saw, from care records, that staff had discussed people's preferences, should they die at the service. This included spiritual arrangements. This meant that the provider would know what the person's preferences were and to respect these on death. The registered manager showed knowledge of the spiritual preferences of the different cultures of people who used the service. At the time of our visit no one living at the service was receiving palliative or end of life care. We found from staff training records that staff received end of life care training.

Good

Is the service responsive?

Our findings

People and their relatives were involved in the planning of their care and support. One person told us how staff had reacted to their request for a specific room. They said they had preferred a room with a bay window and, as soon as one of these rooms had become available, staff had ensured they were moved into it. They told us, "I would not change it for the world". We observed this room was well furnished, personalised and comfortable. A relative told us they had been involved in care decisions and staff listened to them. Another relative told us, "They are good at answering questions". We saw care records were written in a person centred way and observed that staff followed the guidance in care records. Care records were regularly reviewed. This meant that people received personalised care which met their changing needs.

We saw people engaging in activities positively with staff. We observed activities being undertaken on a group and one to one basis. People's records contained details of hobbies people had enjoyed prior to living at the service. Staff we spoke with were able to accurately reflect the activities people liked to take part in.

We saw that people, or their representatives, had signed important care records. This was to show their knowledge and involvement with these records, in addition to their consent of the contents. We saw the service assigned a key member of staff to each person. We saw evidence of regular meetings between these key members of staff and people. These conversations included any improvements or changes the person wanted. People told us the provider did not hold regular residents' meetings and there were fewer "formal" ways to feedback to the provider, but felt that they were provided with other avenues to feed back to the registered manager and provider about the service. We saw there was clearly displayed compliments and complaints information in the main foyer of the service.

We saw the registered manager had gathered surveys from people and their relatives over the course of the year. A relative confirmed they had received a survey during December 2016. We sampled these surveys and found that people were positive about the service provision. We saw that, where improvements were identified for the service, the provider had taken action to implement actions in connection with these. This included areas such as the laundry service.

We found the provider had a process to capture complaints and actions to address concerns. None of the people or relatives we spoke with told us they had cause to raise a complaint. People we spoke with told us they felt satisfied that, if they raised a concern, it would be taken seriously. We did see the provider had recorded some matters of concern. These records showed how the provider and registered manager had sought to address issues raised in order to reduce the risk of a reoccurrence and improve the service.

Good

Is the service well-led?

Our findings

During the last inspection we found that people were not always offered the opportunity to comment on the service in a formal way in order to improve the experience of the service for people. Although it was still the case that the provider did not hold formal residents' meeting we found people were presented with other opportunities to provide feedback. People we spoke with told us they felt they were listened to by the management team. We saw instances of feedback gathering by the provider in the form of staff meeting with people, access to a clear compliments and complaints process and surveys. We saw evidence of the registered manager and provider reacting to any concerns raised. Most people and relatives we spoke with were happy with the service provided and had confidence in the management team.

Most people, relatives and staff were positive about the management team and how the service was run. People and their relatives knew the registered manager and expressed confidence in them and their staff. Relatives described the registered manager as communicative and we observed her greeting relatives to the service as they arrived for visits. One person told us, "[The registered manager] always asks how I am". One relative told us, "They [the registered manager] are good at answering questions" and "If the manager is too busy she will always come back to you later".

Staff were positive about the culture the management team had created at the service. One member of staff described how they frequently approached the management team on an "ad hoc" basis with suggestions for improving the service. They gave us examples of how the management team had taken on board their suggestions and actioned them, such as the laundry process.

Staff told us they felt supported by the registered manager. They told us they had one to one meetings with supervisors where their performance and training and development needs were discussed. We saw, from staff records, the management team addressed performance issues directly with staff. We saw that, where staff had not carried out their duties in an appropriate way, for example medicines procedures, a member of the management team would meet with them and discuss how they could improve. Staff we spoke with said they enjoyed their roles and enjoyed coming to work at the service. One staff member told us how they gained satisfaction from "helping people" at the service.

We saw the registered manager and deputy manager were visible within the service. People reacted positively to the management team and appeared to be comfortable in their presence. There was a registered manager in post. Registered persons are required to notify CQC of certain changes, events or incidents at the service. We had received appropriate notifications from the provider. The registered manager and area manager held records of reportable matters. They were able to discuss these matters in respect of liaison with appropriate external agencies, such as the local authority. We saw these records were well organised and showed that matters had been progressed appropriately. This showed that the registered manager was aware of, and fulfilled their responsibilities in terms of the law.

We found that the management team carried out audits and reviews of the quality of care. Records were regularly reviewed to check they had been completed and updated as necessary. We saw the management

team had carried out specific care record audits to ensure that records were of a high quality and consistent with procedure. We saw other audits, such as those in respect of the environment and equipment, had been carried out, areas for development had been identified and action taken. Staff told us they received constructive feedback on any areas for improvement from members of the management team, such as medicines procedures. This was supported by records which we saw.