The Regard Partnership Limited

Harbour

Inspection report

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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

This unannounced inspection took place on 26 and 27 November 2018. The inspection was prompted in part by the Care Quality Commission (CQC) receiving information from the provider and the local authority of a safeguarding concern. The information shared with CQC about an alleged incident indicated potential concerns about the management and staff culture within the home.

Harbour 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. Harbour is registered to provide personal care and support for up to six people who have a learning disability or autistic spectrum disorder. The home does not provide nursing care. At the time of the inspection there were six people living at the home.
The home did not have a registered manager in post at the time of the inspection. An interim manager had recently been appointed by the provider to oversee the running of the home. However, they were not present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered provider, 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 home is run.

The home had been developed and designed prior to Building the Right Support and Registering the Right Support guidance being published, we found it followed some of these values and principles. These values relate to people with learning disabilities living at the home being able to live an ordinary life.

Prior to our inspection an incident had occurred which raised concerns about the conduct of one staff member and the culture within the home. During this inspection we looked at the actions taken to minimise the risks of similar incidents taking place. We found the provider had not taken sufficient steps to ensure other people living at the home were protected from similar risks. There was insufficient management oversight to ensure people received the care and support they needed, in a respectful and dignified way that promoted their wellbeing and protected them from harm. Where staff displayed poor practice, this was not always known or challenged by senior staff which impacted on the culture of the home. This had led to one person not having the opportunity to access advocacy, advice and support when they had need it.

We looked at the home's quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality and safety of the services provided. Although some systems were working, others had not been effective, as they had not identified the concerns we found during this inspection. This meant the systems in place to manage risk could not be relied upon.

People were not always protected from the risk of avoidable harm. We found risks such as those associated with people's complex care needs, medicines and the environment had not always been assessed or managed safely. Where risks had been identified, guidance had not been provided to staff to mitigate these risks. Although systems were in place to identify and record accidents and incidents, we found staff were not

consistently recording accidents and incidents or taking sufficient action to prevent future reoccurrence.

People's needs were assessed prior to coming to live at the home. This formed the basis of a support plan, which was further developed after the person moved in and staff had gotten to know the person better. We found people were at risk of receiving care that did not meet their needs as support plans were not being regularly reviewed.

There was a staff training programme in place and staff confirmed they received regular training in a variety of topics. These included safeguarding, health and safety, fire awareness and medication. However, we found some improvements were needed to ensure that staff had the necessary skills and knowledge to meet people's needs.

We have made a recommendation in relation to training.

People mostly told us they were happy living at the home and liked the staff that supported them and a relative told us they did not have any concerns about people's safety. People were encouraged to share their views and people told us they were aware of how to make a complaint. Although they were not confident their concerns would be taken seriously.

We have made a recommendation in relation to the management of complaints.

Systems had failed to ensure that people's personal and confidential information was being held securely or confidential information was not being discussed openly.

The registered provider had not always notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities.

The management and staff structure provided clear lines of accountability and staff knew who they needed to go to if they required help or support. Throughout the inspection, we found the provider's locality manager to be open, honest and transparent. Whilst they had not been aware of all the concerns we identified they were aware of the need to improve.

People were protected by safe recruitment processes. Systems were in place to ensure staff were recruited safely, and were suitable to be supporting people who might potentially be vulnerable.

People's healthcare needs were monitored by staff and people said they had access to healthcare professionals according to their individual needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice.

People were encouraged and supported to maintain links with the community to help ensure they were not socially isolated. People's support plans contained information about people's hobbies and interests.

The home was clean, staff had access to personal protective equipment (PPE) and there was an on-going programme to redecorate and make other upgrades to the premises when needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 home were not always safe.

People were not consistently protected from the risk of harm or abuse.

Risks to people's safety were not always appropriately assessed or well managed.

People were not always protected from the risks associated with the management of medicines.

Recruitment practices were safe and there were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The home was not always effective.

Improvements were needed to ensure staff had the necessary skills and knowledge to meet people's assessed needs in a safe way.

People's health care needs were monitored and referrals made when necessary.

The principles of the Mental Capacity Act 2005 had been followed in relation to obtaining consent and best interests decisions.

Systems for ensuring staff received supervision and support were in place.

Is the service caring?

Requires Improvement

The home was not consistently caring.

People did not always receive respectful and responsive care.

People and their families told us staff were kind and caring.

Staff displayed caring attitudes towards people and spoke about people with kindness.

People were offered choices in how they wished their needs to be met.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Requires Improvement

The home was not always responsive.

People were at risk of not having their care needs met in a consistent way that respected their preferences.

Systems to monitor and review people's care records were not always effective.

Information about how to raise concerns was available but people told us they were not confident their concerns would be taken seriously.

People were occupied and stimulated and there was a programme of activities and social events.

Is the service well-led?

Requires Improvement

The home was not always well led.

Quality assurance systems in place were not being used effectively or undertaken robustly enough to identify the issues seen during the inspection.

Records were not always well maintained.

Confidential information was not stored securely and in accordance with the General Data Protection Regulations (GDPR).

The provider had not notified the CQC of incidents at the home as required by law.

Harbour

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 was 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 unannounced comprehensive inspection took place on 26 and 27 November 2018. The inspection was prompted in part by CQC receiving information from the provider and the local authority of a safeguarding concern. The information shared with CQC about an alleged incident, indicated potential concerns about the management and staff culture within the home. This inspection examined those concerns. The inspection team consisted of one adult social care 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 home.

This home had also been selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team also included a dental inspector who looked in detail at how well the service supported people with their oral health. This included support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Prior to the inspection, we reviewed the information we held about the home. This included statutory notifications we had received. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law.

During the inspection, we met and spoke with five people living at the home, nine members of staff, as well as the provider's locality manager and regional director who had responsibility of overseeing the running of the home. We asked the local authority who commissioned with the home for their views on the care and support provided by the home and we received feedback from five healthcare professionals and the local authority's quality assurance and improvement team (QAIT) who had recently visited. Following the inspection, we received feedback from one relative.

To help us assess and understand how people's care needs were being met, we reviewed three people's care records. We looked at the medicines administration records and systems for administering people's medicines. We also looked at records relating to the management of the home; these included three staff recruitment files, training records, and systems for monitoring the quality of the services provided.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of harm or abuse because systems in place to manage risks were not always effective. We found safeguarding concerns were not managed appropriately and some risks, such as those associated with people's complex care needs and/or the environment had not been identified or insufficient action had been taken to mitigate those risks.

People were not always protected from the risk of abuse. Prior to our inspection CQC were informed of an incident that raised concerns about the conduct of one staff member and the culture within the home. This incident is currently being investigated by the local authority's safeguarding team. During this inspection we looked at the actions taken by staff at the time of the incident as well as steps taken by the registered manager to minimise the risks of similar incidents taking place. We found although staff received training in safeguarding adults, some staff only had a limited understanding of abuse or the action they should take when they suspected someone was at risk of abuse. For example, following the incident in October 2018 some staff had not taken appropriate action to protect people in accordance with home's policies and procedures or the training they had received.

When concerns were raised by a relative, records showed the registered manager referred the concern to the local authority's safeguarding team and senior staff had carried out an internal investigation. However, we found the investigation had been of a poor quality and had failed to identify or address all the concerns. We asked a senior staff member who had been involved in this process, if they had received any training or guidance prior to carrying formal meetings with staff. They told us they had not. We discussed what we found with the provider's locality manager who agreed the investigation had not been as comprehensive as they would have expected and assured us this would be looked at again by an experienced manager.

Following the incident in October 2018, records showed the registered manager had discussed the safeguarding concern with staff and put up posters reminding staff to report any concerns they might have. However, upon reviewing people's records and talking with staff we found another incident which had not been appropriately reported. Although staff had reported the incident, senior staff had not recognised the incident as an allegation of abuse or a matter that needed to be referred to the local authority or reported to CQC. We discussed what we found with the provider's locality manager who reported the incident retrospectively. This meant the provider could not be assured that lessons had been learnt or sufficient action would be taken to keep people safe from harm.

Failure to protect people from abusive practices and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always stored or managed safely. We found the home did not have a robust system in place to ensure that people or unauthorised staff could not access people's medicines. For example, medicines which were required to be kept refrigerated were kept within a fridge in the main office. On the first day of the inspection we found the office had been left unattended and the fridge did not have a lock to prevent unauthorised access.

Records relating to the management of people's medicines were not accurate. Although the provider had clear procedures in place for recording what medicine had been received or given to a person, we found staff were not always following these guidelines. Records relating to the management of people's medicines were not consistently completed. For example, medication administration records for one person showed that staff had not booked medication in correctly when it had been received or carried forward stock held by the home. Records for another person, who had returned to the home following an overnight stay, had not been completed properly and stock balance sheets for a third person were inaccurate and confusing. For example, staff had recorded for one person's medicine, stock received/carried forward 37, number used 36 number remaining 24. This meant staff were unable to tell how much medicine they should have in stock or if people were receiving their medicine as prescribed, as the records were not accurate and could not be relied upon.

People were not always protected from the risks associated with their complex care needs. We found risks associated with people's medicines and behaviour had not always been identified or guidance provided to staff to mitigate these risks. For example, staff told us that one person was not able to manage their medicines independently due to a risk of overdosing. Records showed this person regularly spent time away from the home and staff were giving this person their medicines to take with them. There was no risk assessment in place to show that the risks associated with giving this person four or five days' supply of medication had been considered. We discussed what we found with the provider's locality manager who agreed that systems in place did not adequately mitigate the risks. On the second day of the inspection the provider's locality manager informed us they had put in place a risk assessment.

Records for another person showed they regularly displayed aggressive behaviour towards other people living at the home. Although this person did have in place a positive behavioural support plan, we found the risks assessment lacked detail and did not fully identify the risk to other people living at the home or visitors and had not been reviewed following a number of recent incidents. On the second day of the inspection this person's positive behavioural support plan had been update.

People were not always protected from the risk of harm as they were living in an environment that may not be safe. Whilst some premises checks had been completed, risks to people's health, safety, and wellbeing had not always been identified, assessed, or mitigated. Records showed staff carried out weekly window safety checks. This involved checking that window restrictors were in place and fitted correctly. However, we found these records were not correct. For example, staff were recording the office window had in place, a properly fitted window restrictor. When we checked we found the window had been fitted with a standard bolt which could be easily removed. We asked a senior staff member to recheck all the windows in the home, they told us that two first floor windows were not properly restricted as window restrictors could be easily overridden. We brought this to the attention of the provider's locality manager who arranged for the windows to be looked at.

We reviewed the home's fire safety precautions. Records showed routine checks on fire and premises safety were taking place. However, we found the provider did not have in place an adequate Fire Risk Assessment or fire evacuation procedure, which is a legal requirement under The Fire Safety Order. Staff told us the home's fire alarm system was connected to three self-contained adjoining flats and a staff office/sleep in room. Which was part of a separate supported living service (The Quays), owned and run by the same provider. Senior staff explained that part of their responsibilities was to alert and provide support to the people and staff who lived at The Quays should the fire alarm sound as the only fire control panel was located in the main house (Harbour). Due to the nature of the environment this meant staff had to leave the home to alert staff in the adjacent service both during the day and night. The home's fire evacuation procedure did not contain any information about the Quays or guide staff as to the actions they should take

in order to help protect people living at the Quays or the impact this might have on people living at the Harbour.

We looked at people's personal emergency evacuation plans (PEEP). The purpose of a PEEP is to ensure staff know how to assist each person to leave the building safely in the event of an emergency. We found all six people needed assistance to leave the home in the event of an emergency. PEEPs lacked detail and did not give staff clear guidance about how to support people to evacuate the building at night given the reduced number of staff or the additional support provided to The Quay. This meant the provider did not have suitable management arrangements in place to ensure people's safety should a fire occur.

We discussed with the provider's locality manager the impact this might have on people's safety especially during the night when there were only one waking and one sleeping night staff on duty. Following this inspection, the locality manager confirmed they had arranged for the home's fire evacuation procedure to be updated and had bought two-way radios to enable staff downstairs to be alerted without the need for staff to leave the building.

Where accident or incidents had occurred, staff were not taking appropriate action to prevent or reduce future re-occurrence. For example, we found staff had recorded in the home communication book that a needle, which had been used in the management of a person health condition, had been found in the back of the house vehicle. Staff were instructed to check the car daily, however no action had been taken to identify when, how or why this had happened. When we reviewed this person's care plan and associated risk assessments we found the records had not been reviewed or updated following this incident.

The provider failed to take sufficient action to ensure care and treatment was provided in a safe way and that risks arising from people's medicines, complex health care needs or the environment were being mitigated or managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able told us they were happy living at the home and felt safe, however one person told they did not feel safe, they told us they found it difficult to relax due to the behaviour of other people living at the home. A relative told us they did not have any concerns about their family members safety.

People were protected by safe recruitment processes. Systems were in place to ensure staff were recruited safely, and were suitable to be supporting people who might potentially be vulnerable. We looked at three staff files, which showed a full recruitment process had been followed which included obtaining disclosure and barring service (police) checks.

Other risks to people's health and safety were well managed. People had a variety of needs relating to their learning disability and/or physical health. People's support plans contained individualised information about how to keep people safe at home and in the community. Staff knew the risks associated with people's care and how to manage and minimise these risks.

The home was clean, staff had access to personal protective equipment (PPE) to reduce the risk of cross contamination and the spread of infection. There was an on-going programme to redecorate and make other upgrades to the premises when needed. Systems were in place to ensure equipment was regularly serviced and repaired as necessary by appropriately, skilled contractors.

Requires Improvement

Is the service effective?

Our findings

The home did not always provide people with effective care and support. Some of the people who lived at the home told us they did not have confidence in the staff that supported them. One person said, "Some of the staff understand mental health and some don't." A healthcare professional told us staff did not always follow behavioural support plans without being prompted to do so. While another said, "At times staff have shown a lack of understanding and awareness of how to promote good positive outcomes for people."

We looked at the training, induction and supervision records for staff. The locality manager told us all new staff undertook a thorough induction and staff new to care were supported to undertake the Care Certificate. This is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high-quality care and support. The induction process included a period of working alongside more experienced staff until they had developed their skills sufficiently to support people living at the home. Staff we spoke with told us they had good access to training when they needed it. One member of staff said, "The training we get is really good. I have recently completed training in autism, acquired brain injury and mental health." The locality manager told us staff were able to request training using an online system/app and the registered manager was able to track staff training in real time.

However, we found some staff demonstrated a lack of understanding in a number of areas for example, health and safety, safeguarding, medicines, infection control and risk management. Following the inspection, we were provided with a copy of the home's training matrix. The training matrix identified significant gaps in the training staff had received. For example, staff needed their training to be completed/updated in several key areas which included, MCA & DoLS, mental health awareness, communication and data protection. We also noted that some staff had acted as a responsible adult but did not have in place safeguarding children's training. We discussed what we found with the locality and interim manager who told us staff training had been identified as an area that needed to be improved and this was part of the home's service improvement plan.

We recommend the provider undertake a review of the effectiveness of their training programme to ensure it provides staff with the necessary skills to enable them to carry out their duties.

Records and discussions with staff showed staff continued to receive regular support and supervision. These meetings provided staff with the opportunity to discuss their work, receive feedback on their practice and identify any further training needs they might have. Staff told us they felt supported by the previous registered manager and interim manager. One member of staff said, "[Interim manager's name] is a good manager I can tell them anything." Another said, "[Interim manager's name] is really supportive."

People were encouraged and supported to engage with a range of healthcare services and staff supported people to attend appointments. People's support plans included details of their appointments and staff we spoke with knew people well. Each person's care plan contained a health action plan that set out how his or her health care needs were to be met. Where changes to people's health or wellbeing were identified, records showed staff had made referrals to relevant healthcare professionals. For example, records for one

person showed, following an escalation of their anxieties, they had been referred to their GP for a medicines review. Following the inspection, we received feedback from healthcare professionals who confirmed that whilst the manager and staff made referrals or sought advice, it was not always clear that they fully understood or acted on the advice they were given. For example, one healthcare professional told us that staff had arranged driving lesson for one of the people living at the home after they had been told that it was not safe for them to drive due to their health.

People were supported to have enough to eat and drink to maintain their health and well-being. Staff knew people's food preferences well and described how they encouraged and supported people to be involved in the choosing, planning and preparation of their meals. We found people made decisions daily about what they ate and drank and when. People told us they enjoyed the food provided. One person said, "I like the food there is always there is always plenty of choice. Another person said, "if I don't want what's on the menu I can have a jacket potato, salad, pasta or a sandwich if I want." Care records provided guidance about how to support people who might have a difficult relationship with food and staff understood how this might affect their mental and physical health. People could help themselves freely to food and snacks throughout the day and we saw the kitchen was well stocked with tea, coffee, and soft drinks.

People's care and support was provided in line with relevant legislation and guidance. The Mental Capacity Act (MCA) 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the home was working within the principles of the MCA and found that people's rights were being protected. People had signed to say they consented to the care arrangements in place. Staff were aware of when people, who lacked capacity, could be supported to make everyday decisions and when people's capacity fluctuated due to their mental health. Staff we spoke with had a good awareness of the Mental Capacity Act 2005 (MCA).

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS). The registered manager was aware of their responsibilities, had liaised with professionals and made appropriate applications for three people who needed this level of support to keep them safe.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect and their fundamental right to privacy and confidentiality was not always respected.

On the first day of the inspection our expert by experience spent time talking confidentially to people about the care and support they received. Some people choose this opportunity to raise concerns and we agreed to discuss them with the provider's locality manager, who said they would look into the points that people had raised. During that afternoon we were made aware that this confidential information had been openly discussed by senior staff in front of another person living at the home. In turn this person was freely sharing this information within communal areas in front of other staff and people living at the home. We brought this to the attention of the provider's locality manager who agree to look into how this this had happened.

Following the inspection, we received information about how the mismanagement of people's mail and poor staff communication. This had led to one person not having the opportunity to have access to advocacy, advice and support when they had need it. This demonstrated a lack respect for this person's personal mail and their wellbeing. We discussed what we had been told with the provider's locality manager who assured us they were looking into how this had happened, but they had taken immediate action to prevent a similar situation from reoccurring.

People's personal confidential information was not always held securely in accordance with the General Data Protection Regulations (GDPR) which came into force May 2018. Throughout the inspection we found a number of documents containing confidential information of three people, who did not live at the service, were stored within the staff office.

Failure to treat people with dignity and respect and ensure people's right to privacy is respected and maintained is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able, told us they were happy living at Harbour and liked the staff that supported them. One person said, "Staff are kind, supportive and lovely to me," Another said, "There has been a lot of change which I can find difficult, but the [interim manager's name] is lovely." Some people were unable to share verbally with us their experiences of the care provided, we spent time observing the way in which care and support was provided.

Most people's care plans were clear about what each person could do for themselves and how staff should provide support. People's preferences were obtained and recorded during their pre-admission assessment and people's care plans contained personalised information about people's backgrounds, significant events as well as information about what was important to them. People told us they were involved in making decisions about their care and made choices every day about what they wanted to do and how they spent their time.

We found staff knew people well and had a good understanding of their individual likes, dislikes and personal preferences. Throughout the inspection, we saw and heard people being supported. We found staff spoke with people in a calm respectful manner, and allowed people the time they needed to carry out tasks at their own pace. For example, whilst in the lounge we saw one person was watching TV, we saw a staff member approach them in a sensitive manner and suggested that they might want to wear their glasses. On another occasion we saw a staff member offer to assist a person to do up their coat before leaving the home. The staff member did this in a polite way by asking them if they wanted any help or support.

During our inspection we saw and heard people chatting pleasantly with staff and sharing jokes with them. Staff engaged people in conversations about their interests and preferences. Staff were familiar with people's individual communication methods and used this knowledge and understanding to support people to make choices and have control over their lifestyle. Staff described how they supported people to be as independent as possible and recognised that it was important that people could gain new experiences and take risks through clubs, work experience and social events.

People's rooms were personalised and furnished with things that were meaningful to them. For instance, photographs of family members, treasured possessions, favourite ornaments, or pieces of furniture. If people wanted, they had a key to their bedroom door to protect their possessions and to prevent other people walking into their room uninvited.

Staff recognised the importance of people's family and friends. Relatives said they could visit the home at any time and were always made to feel welcome. We saw there were no restrictions on people visiting the home and people were supported by staff to visit their family and friends.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving care that did not meet their needs.

People's needs were assessed prior to coming to live at the home. This formed the basis of a care plan, which was further developed after the person moved in and staff had gotten to know the person better. We looked at the care and support records for three people with a variety of care needs. Support plans contained detailed information about people's health and social care needs. They were written using the person's preferred name and reflected how the individual wished to receive their care. Each section of the care and support plan covered a different area of the person's care needs, for example, personal care, physical health, continence, diet and nutrition, communication and medicines. This provided staff with valuable information to enable them to build positive relationships and help them understand what matters to people and how they wish to be supported.

We found each person had in place a personal daily outcome sheet (PDO) and a monthly PDO review. Daily PDOs gave a brief overview of the person's support needs and contained a list of activities/tasks which were linked to the person's support plan. Staff were asked to confirm daily if the activity/task took place and provide a comment when an activity/task not taken place or was declined. We found staff were not completing people's PDOs in accordance with the guidance they had been given. People's PDOs contained significant gaps. For instance, where people had declined to take part in an activity or complete a task, staff did not always provide any explanation as why, what had been offered as an alternative or how they had supported the person. Where care and support plans identified that people needed support/encouragement to manage their health or choose healthy life style choices, there was no evidence to suggest how this was being provided. For example, one person's care plan guided staff to provide the person with support and encouragement to eat a healthy balanced diet. This was also important for the management of a health-related condition. Records showed staff were regularly recording that the person had either refused meals or was making unhealthy choices which might impact on their overall health. Staff had not recorded any information to show if or how they supported this person with this area of their life in accordance with their support plan.

Monthly PDOs were used to review a person's individual support needs/outcomes. Staff were guided to review a person's individual progress in an agreed area of support and provide information as to any progress that had been made. We found monthly PDO's were not consistently being completed. It was not clear if people had been involved or were part of this process, or that the registered manager had seen this information, or if the information was being effectively used to develop/update people's care and support. A healthcare professional said "It is not always clear if staff fully understand how to support people to plan, motivate or set themselves goals. We provide the home with additional one to one funding for [person name] specifically aimed at developing life skills and increasing their independence. As we have seen no increase in [person's name] level of independence, we are looking to provide this additional support via an external provider."

This meant the system in place for monitoring and reviewing people's care were ineffective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were aware how to make a complaint, and most of the people we spoke with felt able to raise concerns if something was not right. The home's complaints procedure provided people with information on how to make a complaint and was available in an easy to read format. Some people told us they were not confident that their concerns would be taken seriously. One person said, "I would speak to my care manager, there is no point telling staff as nothing ever happens." Another said, "I know how to complain but I would call my care manager or the police." A third person told us they had recently raised concerns with senior staff member about the way they had been spoken with. However, when we reviewed the home's complaint file we were unable to find this or evidence that the persons concerns had been appropriately investigated. We discussed what we had been told with the provider's locality manager who assured us they would speak to the person involved.

We recommend the provider reviews the system in place to record and respond to concerns and complaints.

Staff told us they had received training in equality and diversity and gave us examples of how they provided support to meet the diverse needs of people living at the home including those related to disability, gender, ethnicity, faith and sexual orientation. Each person's support plan contained important information about people who mattered to them as well as information about people's backgrounds and histories. This gave staff the opportunity to understand a person's past and help to enabled staff to support people to maintain important relationships.

Support plans identified people's communication needs and how they could be supported to understand any information provided. For example, through visual aids, planners and communication cards. One person told us how they found it difficult to communicate when they became upset and explained how their communication cards helped them to communicate during these times. This approach helped to ensure people's communication needs were known and met in line with the Accessible Information Standard (AIS). The AIS is a framework making it a legal requirement for all provider's to ensure people with a disability or sensory loss can access and understand information they are given

People were encouraged and supported to maintain links with the community to help ensure they were not socially isolated. People's support plans contained information about people's hobbies and interests. We saw people had many different opportunities to socialise and take part in activities if they wished to do so. Throughout the inspection, we saw people coming and going from the home independently and with staff support. People routinely visited friends and family or went for days out to Exeter, Plymouth and Torquay, were they enjoyed socialising, shopping, or having lunch.

All the people living at the Harbour were young adults and did not have life limiting conditions. As such, end of life care planning had not been discussed with them. However, each person's support plan contained a health passport which contained detailed information about the person's care and support needs. This helped to ensure people's wishes and needs were known and respected in an emergency.

Requires Improvement

Is the service well-led?

Our findings

The home was not always well led.

We received mixed views about the management of the home. A relative and staff told us the home was well managed. However, healthcare professionals felt that it was not. One healthcare professional said, "There has been a lack of leadership for some time within the home. However, since the new interim manager has been in post it appears that this has been improving." Another said, "Poor communication, staff attitude and lack of leadership has had a negative impact on outcomes for people."

We found there was insufficient management oversight to ensure people received the care and support they needed, in a respectful and dignified way that promoted their wellbeing and protected them from harm. Where staff displayed poor practice, this was not always known or challenged by senior staff which impacted on the culture of the home. This had led to one person being subjected to improper treatment and another not having access to advocacy, advice and support when they had need it.

We looked at the home's quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality and safety of the services provided. The provider used a variety of systems to monitor the home. These included a range of meetings, audits, and spot checks, for instance checks of the environment, medicines, infection control, health & safety, and accident and incidents. However, we found these had not been undertaken robustly enough to identify the issues seen during the inspection. For example, the homes daily shift planners were not consistently completed by staff.

Whilst premises checks had been completed, risks to people's health and wellbeing had not always been identified, assessed or mitigated. Accidents and incidents were not always recorded which meant action had not always been taken to minimise the risk of further occurrences. Systems in place to manage risk were not effective and could not be relied upon.

Quality assurance systems had failed to ensure people's medicines were stored or managed safely. Care plan reviews and audits had not identified that some risks to people had not been assessed or have associated care plans with guidance for staff to follow.

The provider could not be assured that all personal and confidential records relating to people's employment, was being stored securely or managed in accordance with the General Data Protection Regulations (GDPR). On the second day of the inspection, we asked to see staff recruitment files. We found these were stored within a cabinet in the main office which all senior staff has access to. We brought this to the attention of the provider's locality manager to restrict access to this confidential information.

Systems had failed to ensure that people's personal and confidential information was being held securely or that confidential information was not being discussed openly.

Failure to ensure systems were effective in assessing, monitoring and improving the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we identified an incident that should have been reported to the Care Quality Commission and the local safeguarding team in line with provider's legal responsibilities. The provider's locality manager told us this was an oversight as the incident had not been recognised as reportable. Following the inspection, the provider submitted a notification retrospectively.

Failure to notify CQC of significant events at the home is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

Throughout the inspection, we found the provider's locality manager to be open, honest and transparent. Whilst they had not been aware of all the concerns we identified they were aware of the need to improve. They accepted and recognised the home needed to make a number of changes to improve the quality and support being provided and had already started to put together a service development plan.

The locality manager told us their vision for the home was to create a safe and supportive environment that aimed to empower people to take responsibility for managing their own behaviours and move towards independent living. Staff spoke passionately about the people they supported and were proud of people's achievements. Staff told us they enjoyed working in the home and felt supported by the homes management team. One staff member said, "I think [interim manager's name] is great." Another said, "They're [meaning the interim and locality manager] both very approachable. If you need anything all you have to do is ask."

The management and staff structure provided clear lines of accountability and staff knew who they needed to go to if they required help or support. There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through handover meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns.

Records showed the provider held regular staff meetings. Staff meetings were used to discuss and learn from incidents, highlight best practice and identify where any improvements were needed. People and staff told us they were encouraged to share their views and had confidence in the interim or locality manager when they needed to.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People's right to privacy was not always respected or understood by staff. 10 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. Regulation 12(1)(2)(a)(b)(d)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse or improper treatment as systems and processes were not established and operated effectively to prevent abuse. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems and processes in place to assess, monitor, and mitigate risks to people. Records were not accurate, up to date, complete, or maintained securely at all times. Regulation 17 (1)(2)(a)(b)(c)(d)