Harbour Care (UK) Limited

The Moorings

Inspection report

69 Brixey Road
Parkstone
Poole
Dorset
BH12 3EY

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10 October 2016

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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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced on 7 and 10 October 2016.

The Moorings is a care home without nursing for up to six people with learning disabilities in Poole. There were five people living at the home at the time of the inspection.

There was a registered manager who had been in post since December 2015. 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.

Three people were able to talk with us and one person used Makaton (a type of sign language) to communicate. One person used body language and sounds to communicate their needs. This person was very relaxed and crawled towards and reached out for staff, they gave staff eye contact and smiled and giggled. There was a calm and relaxed atmosphere at the home.

Relatives told us they felt their family members were safe at the home. Staff knew how to recognise and respond to any signs of abuse.

Risks to people's safety were assessed and managed to minimise risks. Staff followed any risk management plans in place for people. Medicines were managed safely and stored securely. People received their medicines as prescribed by their GP. Staff knew when they should administer PRN 'as needed' medicines.

Staff knew people well and understood their needs and the way they communicated. People received care and support in a personalised way. This meant people were able to increase their independence, achieve and try new experiences. The impact this had on the individuals was outstanding and had resulted in them being settled, content and calm and helped them to lead full and active lives.

Staff were caring and treated people with dignity and respect. People and staff had good relationships. People were supported to take part in activities and try new experiences in the house and in the community.

People received the health, personal and social care support they needed. People's health conditions were monitored to make sure they kept well.

Staff received an induction, core training and some specialist training so they had the skills and knowledge to meet people's needs. Staff were recruited safely and people were involved in the recruitment of staff. There were enough staff to meet people's needs.

The culture within the service was personalised. There was a clear management structure and people, relatives and staff felt comfortable raising any issues. There were systems in place to monitor and drive improvements in the safety and quality of the service provided. There was an improvement plan in place.

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.

Medicines were managed safely.

Staff knew how to recognise and report any allegations of abuse.

Staff were recruited safely and there were enough staff to make sure people had the care and support they needed.

Any risks to people were identified and managed in order to keep people safe.

Is the service effective?

Good

The service was effective.

Staff received training to ensure they could carry out their roles effectively.

Staff had an understanding of The Mental Capacity Act 2005. There was a plan in place to ensure decisions were in people's best interests.

People were offered a variety of choice of food and drink. People were involved in food preparation.

People accessed the services of healthcare professionals as appropriate.

Is the service caring?

Good

The staff were caring.

Staff were genuinely caring and kind, they treated people with patience and were constantly aware of their needs.

People and staff enjoyed each other's company. Staff were proud of people's achievements.

Staff provided care in a dignified manner and respected people's

right to privacy.

People's end of life was planned for where appropriate.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People received highly individualised care that was tailored to their needs. The service was creative in enabling people to live as full a life as possible.

Staff were very flexible and responsive to providing person centred care which improved people's wellbeing.

Innovative ways of involving people were used so that people were at the heart of everything.

People were listened to and their comments acted upon.

Is the service well-led?

Good ●

The service was well led.

There were systems in place to seek feedback from people and their representatives. Actions were taken in response to any feedback or shortfalls identified.

There were systems in place to monitor the safety and quality of the service.

There was learning from accidents, incident and investigations into allegations of abuse.

The Moorings

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 7 and 10 October 2016 and was unannounced and was conducted by one inspector.

We met and spoke with and/or Makaton signed (a type of sign language) with all five people. One of the people we met had complex ways of communicating and was not able to tell us their experiences of the service. We observed staff supporting people. We also spoke with the registered manager, the area manager, the deputy manager, and five support workers.

Following the inspection we received email feedback from two relatives.

We looked at two people's care and support records, one person's fluid monitoring records and other records about how the service was managed. This included four staffing recruitment records, audits, meeting minutes and quality assurance records.

The previous manager completed a Provider Information Return (PIR) in 2015. This 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. We did not consider this information because a new manager had been appointed since this was submitted. We also looked at incidents that they had notified us about. We also contacted commissioners and health and social care professionals who work with people using the service to obtain their views.

Following the inspection, the registered manager sent us the service's internal action plan, the overall

improvement plan and staff training information.

Good

Our findings

One person was able to tell us they felt safe and said, "I don't worry about anything here". Another person gave us thumbs up Makaton sign when we asked if they felt safe. People were relaxed with staff, and freely approached, talked with and sought out staff. This indicated they felt safe at the home with staff. Relatives told us their family members were safe and they did not worry about their safety. Commissioners and professionals told us they did not have any concerns about the safety of the service.

There were posters displayed in the communal and staff areas about how people and staff could report any allegations of abuse. The staff had all received safeguarding training as part of their induction and ongoing training. All of the staff we spoke with were confident of the types of the abuse and how to report any allegations.

The manager had reported any allegations of abuse as required to the local authority and CQC. Following any allegations actions were taken to minimise the risk of recurrence of any safeguarding incidents between people. This included recognising one person's vulnerability because they were not able to mobilise independently.

One person, supported by a staff member, showed us their medicines cabinet and told us, "Staff help with my tablets, I have that pink one (pointed at liquid paracetamol) for my pain". Another person showed us where their medicines were safely stored because they did not want to have a medicines cabinet in their bedroom.

Staff had received training in medicines administration. Staff had their competency assessed following completion of their training. This was repeated annually and if there were any concerns identified with a particular staff's administration practices. There were robust daily checks and audits of the medicines by staff administering the medicines. In addition the deputy manager undertook monthly medicines' audits.

We saw from Medication Administration Records (MAR) that medicines were administered as prescribed. Staff were able to consistently describe how and in what circumstances any PRN 'as needed' medicines would be administered. This reflected the information included in people's 'as needed' care plans. We saw there had been a positive reduction in the use of PRN medicines that were used as part of any behaviour management plan. This was because there had been a decrease in incidents where people were frustrated, upset or distressed.

Staff had been trained in the administration of epilepsy rescue medicines. There were systems in place for the recording, administration and storage of specialist medicines.

People had risk assessments and plans in place for: specific health conditions, access to activities at home and in the community, epilepsy management and behaviours that may require a positive response from staff. For example, there were positive behaviour support plans in place for people who needed them. Staff were clear about the strategies to reassure people and how to positively support people's behaviours that presented challenges to themselves and others. Staff supported one person as described in their risk management plan when they initially became upset by our presence in the home. The person was quickly reassured by staff and relaxed and then happily interacted with us.

There was a focus on positive risk taking and supporting people to try new things at their pace so they felt safe. Two staff had been identified as positive behaviour support leads and were responsible for mentoring new and existing staff. They were enthusiastic about their roles and passionate about supporting people's behaviours in a positive way. They were genuinely pleased and proud of the some of the small things that people had achieved. They acknowledged that these were actually great achievements for those individuals. For example, one person had been on public transport and another person had eaten in a restaurant.

Relatives, professionals and staff told us there were enough staff to meet people's needs. The manager told us that staffing was calculated on people's individual needs and they ensured that where people were funded for one to one or two to one staffing this was provided. Each day staff were allocated to work with specific people. Where people actively sought the support of specific staff members this was supported. People were also given clear explanations when staff were working with or going out with another person. For example, one person sought the attention of a staff member who was going out with another person. The staff spent time with the person and told them they were going out later together and asked them what they wanted to do when they were working together. This reassured the person and they visibly relaxed.

People had the opportunity to meet any prospective staff and the manager and deputy manager observed whether people were comfortable with them. Two of the people had chosen to be involved in the staff interview process. We looked at four staff recruitment records. Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. In addition all new applications included an on line personality test to ensure new staff had the personal attributes to work with people with learning disabilities and complex needs. This made sure that people were protected as far as possible from staff who were known to be unsuitable.

There were emergency plans in place for people, staff and the building maintenance. This included specific plans for a staff member's health condition. In addition to this there were weekly maintenance checks of the fire system and water temperatures. There were robust systems in place for the maintenance of the building and equipment.

A member of staff was employed to keep up with general maintenance and repairs across the provider's homes in the local area. During the inspection they were doing maintenance work at the home. People who lived at The Moorings had a positive relationship with the staff member and actively sought them out to spend time with.

Good

Our findings

Relatives told us and we saw staff had the skills and knowledge to effectively support and care for people.

Staff completed core training, for example, infection control, moving and positioning, epilepsy management, safeguarding, fire safety, health and safety and food hygiene. Because of the specific needs of one person all staff were trained in the use of a VNS magnet (some people with epilepsy have an implanted vagus nerve stimulator (called VNS Therapy) and will have a magnet that can be used at the time of the seizure).

Staff told us the induction training they received had been effective and that they had felt well supported throughout their induction period. New staff were completing the care certificate which is a nationally recognised induction qualification. There was a training plan in place.

Staff told us they felt very well supported and records showed they had regular one to one support sessions with the manager and team leader. The manager and staff said and records showed staff had their annual appraisals.

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. We checked whether the service was working within the principles of the MCA.

The manager understood their responsibilities in regards to the Deprivation of Liberty Safeguards (DoLS). DoLS applications were correctly completed and submitted to the local authority. There were systems in place for monitoring and ensuring any conditions set by the authorising authorities were met. The manager had systems so they knew when people's DoLS expired and by what date they needed to make any new applications.

Staff had been trained in the Mental Capacity Act 2005, and the staff we spoke with had a good understanding about this and making decisions that were in people's best interests.

Mental capacity assessments and best interest decisions were in place for people in relation to specific decisions. For example, a mental capacity assessment and best interest decision had been made for one person in relation to the use of their preferred name. For another person, mental capacity assessments and best interest decisions had been made in relation to their ongoing medical and palliative care treatment, finances, and medicines.

Staff sought consent from people before care and support was provided. Each person had a 'decision making profile' that clearly set out what decisions they could make and how the person made decisions including what body language, Makaton signs and or words they used. These profiles also included when staff would need to consider undertaking a mental capacity assessment and best interest decisions for the person.

People's nutritional needs were assessed, monitored and planned for. People were weighed monthly dependent on the risk for each person and whether they wanted to be weighed. Action was taken if their weight changed significantly. For example, one person was receiving support from the palliative care team and there was a clear plan of what action needed to be taken if the person lost a specific amount of weight in a month.

Where people had specific health conditions that needed to be monitored there were plans and records in place. For example, two people's fluid intake and output was monitored and there were clear risk management plans in place about their hydration.

One person Makaton signed they 'cooked' with staff. Another person told us they didn't like to help with the cooking but told us the staff were good cooks and chose their meals. The menus were planned four weekly and were based on people's preferences. One person would only eat specific foodstuffs and these were prepared when they wanted them. Staff were slowly encouraging this person to try new foods. Staff gave the person choices as to what they wanted to eat and drink throughout the inspection. They suggested different foods and respected the person's choices. A third person needed pureed foods due a health condition and these specialist meals were chosen by the person and delivered on a weekly basis.

People had health care plans in place and they also used yellow health books to record any health professional visits and appointments. These are health records that are supported by pictures so that they are easier for people to follow.

People's health conditions were closely monitored and procedures were followed as detailed in their care plans. People had their annual health checks with their GP where they were happy to participate in these. Staff had worked with one person who was very anxious and reluctant to attend any health appointments such as the GP or dentist. The staff had turned the experience in to a positive activity by going on a carousel following the appointment. Staff said this meant the person was now looking forward to their next health appointment.

People had access to specialist health care professionals, such as physiotherapists, community mental health, palliative care and learning disability nurses, dieticians, occupational therapists, speech and language therapists and specialist consultants.

Good

Our findings

There was a calm relaxed and friendly atmosphere in the house. We saw good interactions between staff and people. They were chatting, laughing and smiling with each other and this showed us they enjoyed each other's company. One person sought out physical comfort from a staff member and staff sat with them and allowed them to have the comfort they sought before gently moving away when the person relaxed. Staff sat with another person in their bedroom looking at books with them and quietly talking with them. This was part of their positive behaviour support and pain management plan.

Relatives told us staff were caring and good relationships with their family members. Professionals fed back to us that staff were caring and acted in people's best interests.

People's independence was promoted and they were encouraged to participate in things around the home. One person did their own laundry, assisted with cleaning and cooking the evening meal. Staff told us this person had become much more independent in managing and doing things around the house over the last year. Other people moved freely around the house and helped themselves to food and drinks from the kitchen fridge. People were being supported to manage their finances where possible. For example, one person had a planner that showed the days they would be spending money. This had meant the person was able to understand when they were able to go out and spend money on things.

Relatives told us they were free to visit and keep in contact with their family members. They said they were made to welcome when they visited. The manager and a relative told us the staff had been sending photographs and email updates of what one person had been doing. This was important because the person was not able to communicate with their relative by themselves.

We observed staff were respectful of people's privacy. They knocked on people's bedroom doors and discreetly asked one person to use the toilet or to have personal care. People's care plans included when and how people's privacy was to be respected, for example, when they wanted time in their bedroom alone. One person had an audio device that was used at night to monitor any seizures. This device was turned off whilst the person was receiving personal care and when the person chose to spend periods of time alone in their bedroom or other people were in communal areas during the day.

People had a planning for the future care plan that considered any end of life wishes. One person had an end of life care plan in place and was receiving support from the palliative care team. The person and their relative had been involved in developing the plan.

Outstanding

Our findings

During the inspection all of our observations showed us that staff were responsive to people's needs. Staff had outstanding skills and an excellent understanding of people's individual needs. For two people there had been a reduction in occurrences of people feeling anxious, or distressed, this had increased people's wellbeing and had supported them to become more independent.

People's support was planned proactively and in partnership with them. There were creative and innovative ways of providing person centred care. One person had previously followed rigid daily routines. They were now given pictorial choices every day. They indicated by circling or ticking the activity they wanted to do. The person had also developed an understanding of the circumstances when things may change at short notice. For example, when staff were off sick at short notice or there was not a driver available. As a result the person had tried using public transport and that had also been very successful. The person had also undertaken some additional responsibilities with the running of the house. This included helping the staff balance the house petty cash each week. This increased involvement of the person in making daily choices and the development of their life skills had led to a dramatic reduction of incidents where they became upset with themselves or others. This meant the person could now start working towards living in a more independent environment.

Staff were flexible and responsive to people's individual needs and preferences. People's care plans had been updated as their needs changed. For example, one person's mobility deteriorated and they were also at risk of developing pressure sores. The person was referred to an occupational therapist, district nurse and physiotherapist. Specialist walking equipment, pressure cushions, wheelchairs and specialist air mattresses were provided. The person's care plan had been updated to reflect these changes.

This person was receiving palliative care support. There were very clear plans in place that were personalised and responsive. For example, the staff had worked with the person's consultant and palliative care nurse to develop a plan of how to respond to the person, in a way they could understand, if they asked any questions about their care and diagnosis. A social care professional involved with the person told us the deputy manager had been very responsive when the person was admitted to hospital in relation to their health condition. They ensured support workers were on the hospital ward to support the person and contacted the health and social care professionals and family members so any future plans could be coordinated.

A second person found it difficult to participate in different, new activities, or do things with the people they

lived with but recently they had started participating and trying new things. For example, the people in the house had started a superhero noticeboard where they had identified themselves and staff as certain superheroes. Staff and people had superimposed the people and staff's heads on to the superheroes. The person had said they did not want to be involved and staff respected this but they did make the person a laminated photo and name and gave it to the person. The person had added their photograph and name to the superheroes notice board after a couple of weeks. This showed great progress for this individual. This person had also chosen to go along to a local night club with the manager, certain staff and other people at the home. The person had said they would just go for the ride in their car and then on arrival went into the club and stayed the whole evening. The manager and staff were very proud of the person's achievement and acknowledged what a big step it was for the individual. In addition the person was willingly accepting the offers of personal care from staff such as bathing. Again because of the way staff were involving and responding to the person there had been a significant reduction in the amount of incidents where the person was upset and anxious with themselves and others. This meant the person was more relaxed and willing to try new experiences that they would previously not considered.

A third person had previously become upset and distressed when the fire alarms were tested. The person and the staff now tested the fire alarms each week together. The person set off the alarms during the inspection; they were smiling and laughing with staff whilst they did it. They told us the liked being involved and doing a job.

Staff were focused on meeting people's individual needs. Staff responded to people's verbal and non-verbal gestures and communication. For example, one person frequently changed their mind as to what they wanted to eat and do. Staff responded to the person every time and calmly reassured them when they changed their mind. There was a core, stable staff group and staff had a good understanding of people, their lifestyle preferences and the way they liked to be cared for. They were very knowledgeable about people's communication and were able to explain how people let them know if they wanted anything.

People had their needs assessed and from this a written care plan was produced. This detailed how staff were to provide care and support to the person. People's care plans were reviewed monthly. In addition each person had an annual review. Where people were not fully able to participate in these reviews their family members, representatives or advocates were invited and consulted. People's care records included their life history, important relationships, how they communicated their strengths, things they enjoyed and things they didn't like. People's care plans were personalised and focused on them as individuals.

People were supported to take part in activities they enjoyed both in the home and in the community. People went to the local shops for newspapers, to the cinema, for walks, out for meals, bowling and using public transport. Some of the people had chosen to go to the Zoo together earlier in the week. Whilst in the house people chose to spend where and how to spend their time. One person did their laundry, another person did some drawing and another person watched DVDs in their bedroom. People sat and chatted with staff and planned their days. Everyone planned to go out at different times and some people chose to do things with other people and other people preferred to do things on their own with staff.

Information for community events were displayed on the notice board well in advance of the date so people could decide whether they wanted to attend or be involved.

People's care plans detailed the different types of activities people liked to do and including any sensory activities. Photographs of the activities were given to people so they had a visual record of the activities and the photographs were regularly emailed to two people's relatives. The manager told us they had ordered computer tablets so they could explore people being involved more in their day to day and activities record

keeping.

There was a written and pictorial complaints procedure displayed and each person's communication plan included details as to how they would let staff know if they were unhappy or worried.

People and relatives told us they knew how to make a complaint. There had not been any complaints received in the last year.

Good

Our findings

Observations and feedback from staff, relatives and professionals showed us the home had a person centred culture. This was because there were regular opportunities for people to contribute to the day to day running of the home through 'Your voice meetings'. These meetings were held on a monthly basis. A staff member facilitated these meetings. We saw that one person had ticked the minutes that were supported by pictures to show they were correct and that the actions agreed at the last meeting had been completed.

People who chose to be were actively involved in the day to day running in the home. For example, one person checked the staff rota and then put the photographs of which staff were on duty and put them on the daily planner on the notice board so everyone knew who was on duty.

Staff told us they felt valued and were listened to. We found, from staff records and from speaking with staff, they understood their roles and responsibilities. The staff were committed to people and wanted to look at ways of improving people's lives. There were monthly staff meetings and the minutes were available to staff. Staff knew how to whistleblow and had key tags with contact information on them and information was displayed.

There were arrangements in place to monitor the quality and safety of the service provided. These were a combination of full reviews of the service, finances and health and safety undertaken by the internal quality team for the provider. This unannounced internal review had happened the month before this inspection. The manager sent us a copy of this review and they had already taken action to meet any areas for improvement identified by the quality team. In addition, the manager and staff team undertook reviews of medication, infection control, housekeeping, health and safety, care plans, staff training, safeguarding, accidents and incidents. Where any shortfalls were identified in these reviews actions were taken.

Information and good practice was being shared across the homes in the area by the managers at their monthly managers meetings.

The manager had produced an overall improvement plan that included actions from the internal audits, external contract monitoring and areas of improvement identified by people and the staff.

Unannounced evening, night time and weekend spot checks were undertaken by both the manager and other managers in the area. Records of these visits were kept.

There were systems for monitoring any accidents or incidents. This included reviewing all accidents or incidents across the home on a monthly basis. This was so they could identify any patterns or areas of risk that needed to be planned for. There was learning from safeguarding, accidents, incidents and complaints. The manager fed back at staff meetings any learning. For example, following the recent admission of one person to hospital staff had a debriefing session at the team meeting and explored whether there was anything different they could have done.

The manager told us they were very proud of how the people at the home had embraced and grown by taking more control of their lives and that the staff had worked hard and supported people to do this.