Nouvita Limited

Howe Dell Manor

Inspection report

Old Rectory Lane
Hatfield
Hertfordshire
AL10 8AE

Tel: 01707263903
Website: www.nouvita.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection visit took place on 24 October 2018 and was unannounced.

At the last comprehensive inspection in June 2017 we found three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service overall as requires improvement. The areas of improvement identified were in relation to providing a safe environment, supporting decision making and consent, and leadership and governance.

At this inspection we found that improvements had been made to help ensure a safe environment however; other improvements had not been made and there were additional areas that did not meet the standards. We found breaches of regulations in relation to providing safe care, mental capacity and decision making, involving people in their care, staff training and leadership and governance of the service.

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

Howe Dell Manor is a converted manor house in Hatfield, Hertfordshire that accommodates up to 19 people living with mental health conditions. At the time of this inspection there were 18 people living at the service.

The service had a manager who was in the process of applying to be registered. 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.

Systems in place to protect people from harm were ineffective. Incidents had occurred at the service which were not recorded or reported appropriately to ensure the safety of people. Staff had received training on safeguarding procedures but not all staff were clear about identifying where people were at risk.

Risks to service users' health and well-being were not appropriately identified, assessed and managed. Risks assessments in place did not offer robust guidance to staff on how individual risks to people could be minimised. Assessments had not consistently been updated or reviewed following changes in people's care needs.

Staff had not received sufficient training to meet the individual needs of people. Staff had been supported with regular supervision and appraisals, however staff supervision did not seek to develop staff skills further.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this

practice. The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not met.

People told us that they had a variety of food and were complimentary about the meals that were provided at the service. However, on the day of our inspection, special diets were not catered for by the agency chef on duty.

People did not consistently receive caring support. Many people described staff as caring but others had experienced negative encounters. Language used in care records did not always promote people's dignity.

Care plans took account of individual needs but lacked detail with regards to people's preferences, choices and individuality. The plans were not reflective of people's needs and did not always include clear instructions for staff on how best to support people.

Quality assurance processes were not robust, effective or used to improve the service being provided. Audits had failed to identify the concerns found during our inspection. The provider and manager had not acted upon previous inspection feedback with a view to evaluate and improve practice and ensure compliance with the regulations.

The manager was a visible presence in the service and staff felt supported. However; the manager demonstrated a lack of knowledge about the systems in place at the service and had no awareness of the concerns we found. Staff were not clear on the visions and values of the provider organisation.

Safe recruitment processes were in place and had been followed to ensure that staff were suitable for the role they had been appointed to prior to commencing work.

People received support from health and medical professionals when required. Medicines were managed safely.

People's privacy was promoted throughout their care and staff sought people's consent before any care was provided.

Complaints were consistently managed, recorded and responded to.

The service was clean and tidy. Relevant infection control procedures were observed. Cleaning schedules and routines in place demonstrated the improved practices at the service in maintaining a safe, clean environment.

During this inspection we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to service users' health and well-being were not appropriately identified, assessed and managed.

Systems in place to protect people from harm were ineffective. Incidents had occurred at the service which were not recorded or reported appropriately to ensure the safety of people.

A consistent staffing level was maintained.

Safe recruitment processes were followed.

Medicines were managed safely.

Infection control procedures were observed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive sufficient training to meet the needs of people.

Mental Capacity Assessment had not been completed. The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not met.

People told us that they had a variety of food and were complimentary about the meals that were provided at the service. Special diets were not catered for on the day of our inspection.

Staff received regular supervision and appraisals.

People were supported to meet their health needs and had access to a range of health and medical professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans lacked detail with regards to people's preferences, choices and individuality.

People were supported by staff that were described as caring. However; some people had experienced negative encounters.

Language used in care records did not promote people's dignity.

People's privacy was promoted by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not reflective of people's needs and did not always include clear instructions for staff on how best to support people.

We received mixed views on the activities provided at the service.

The procedure to manage complaints was consistently followed.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance processes were not robust, effective or used to improve the service being provided or mitigate the risks to people. Audits completed had failed to identify the areas of concern found during our inspection.

The provider and manager had not acted upon previous inspection feedback with a view to evaluate and improve practice and ensure compliance with the regulations.

Staff were not clear on the visions and values of the provider organisation.

The manager was a visible presence in the service and staff felt supported. There was an open culture.

Howe Dell Manor

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 24 October 2018 and was unannounced. The inspection was undertaken by a team of two inspectors 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.

Before the inspection, we used information the provider sent us in the Provider Information Return to inform our planning. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us about the service such as information from the local authority, information received about the service and notifications. A notification is information about important events which the provider is required to send us.

During our inspection, we observed how the staff interacted with the people who lived at the service and how people were supported during meal times, individual tasks and activities.

We spoke with eight people who lived at the service and two relatives to find out their views about the care provided. We also spoke with two care workers, two nurses, the chef on duty, head housekeeper, the deputy manager and the manager. The nominated individual and chief executive officer from the provider organisation were also present at times during the inspection.

We reviewed the care records and risk assessments of four people who lived at the service and checked medicines administration records to ensure these were reflective of people's current needs. We looked at staff records and the training records for all the staff employed at the service to ensure that staff training was up to date. We also reviewed additional information on how the quality of the service was monitored and managed to drive future improvement.

Inadequate

Is the service safe?

Our findings

Not everyone living at the service felt safe. One person told us when asked if they felt safe, "Not really. I do not like living here anymore." Another person told us, "I do not feel safe here. My property is not safe." However other people, and their relatives, confirmed they felt safe and had no concerns over their safety or wellbeing.

Risks to service users' health and well-being were not appropriately identified, assessed and managed. We found that people's identified care needs lacked thorough risk assessment and where risk assessments had been completed they were not sufficient in detail or guidance. We also found that health professional advice had not been considered when assessing or reviewing risks, which exposed service users to potential harm.

Howe Dell Manor provides a service to people living with mental health conditions. We reviewed four care plans and found that no one had a risk assessment in relation to their condition, the signs and symptoms they may experience or any risk that the condition may pose to their physical or mental health and well-being.

People were not protected from the risk of inadequate nutrition and hydration. We found that one person who was identified as being at high risk due to a long-standing health concern had no risk assessment in place. A dietitian had provided guidance to the service and a dietary plan had been completed, however we saw no evidence of this within the persons care plan or within any risk assessment. Records confirmed that this person continued to lose weight. For another person, we saw that a weight loss of 3kg had been recorded in a period of 7 days. No action had been taken in response to this weight loss.

People were not protected from the risk of skin damage. We found that one person was described as having 'dry, fragile skin.' We found no care plan or risk assessment in place in relation to this person's skin integrity or how staff could help mitigate any risk to them. There was also no assessment of the risk of the incontinence experienced by this person which could further increase the risk of skin damage.

Risk assessments had not consistently been updated or reviewed following changes in a person's care needs. We found that one person had recently had a change in their prescribed medication. We found no record explaining the reason for this change in medication or any record of changes to the planned care and support of the person in managing their condition. There was also no change to or review of the risk assessment in place.

The above issues meant people were exposed to the risk of harm or injury by not having current risks to them assessed or action taken to mitigate those risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems in place to protect people from harm were ineffective. We found that a number of incidents had occurred at the service which were not recorded or reported appropriately to ensure the safety of people.

During our inspection we observed an incident of physical aggression from one person to another. No members of staff were present at the time. We reported our observation immediately to a senior member of staff who informed us that this was "usual behaviour" for the person who had instigated the aggression but that they would "go and review it." Members of staff that we spoke with failed to identify this incident as a potential safeguarding concern and a referral was only made to the local authority upon the repeated instruction of the inspector.

The manager had not ensured effective systems were in place to investigate unexplained injuries to people living at the home. For one person, we found a body map record of unexplained scratches on their body and swelling to their ankles. We found no other supporting documents or evidence that demonstrated action had been taken to investigate the cause of these injuries. We discussed this report with the manager who told us, "They [staff] write things. They hide from us, we don't always pick them up so now we are going to go and look for that." An incident report in relation to these injuries could not be found. Following our inspection, the manager forwarded us further documentation via email. However, the information provided evidenced only that the injuries sustained by the person were believed to be self-inflicted and we saw no evidence of how the risk of this type of behaviour was being mitigated by staff or any preventative measures that were being taken in response. It was also not clear what investigation had occurred to determine the cause of the injuries.

We saw that safeguarding referrals had been made to the local authority since our last inspection. There was no record held of the outcome of the referrals or if any action had been taken by the service. The manager did not maintain a log of the referrals that had been made and could not provide confirmation of the outcomes or any guidance that they had received from the local authority without "looking through emails".

Staff told us they had received training on safeguarding procedures but conversations we had showed that not all staff were clear about identifying where people were at risk. One member of staff told us that safeguarding was, "Anything that is related to the safety and security of the people, such as offering the food, how much to have, how they are treated by staff and other residents, families. I would report sexual abusing, physical, verbal abusing." We asked specifically if they knew what abuse was and to give any examples and what they would consider necessary to report. They responded, "I think if I have to report straight away from a situation where a client uses violence or when verbal abused. When someone leave the door open with the chemicals. I won't tell him the silly things such as [Name of person's] behaviour." Another member of staff told us, "That is when we act to protect someone we feel could be hurt or at risk. The staff report to me and I review and discuss with the manager. Either will report to safeguarding." All staff told us they would report any concerns to the manager and CQC but were not consistently aware of what they would report. Staff were not aware they could also approach other external agencies directly such as the local authority safeguarding team. However; the manager had ensured information regarding external agencies was prominently displayed.

We received mixed views from people regarding staffing levels in the service. When asked if there were enough staff on duty one person told us, "Yes, in day." Another person told us, "Yes. In the morning they have more staff on." However, a third person told us, "No, there are not enough staff to look after me. I can be quite erratic at times and need more staff support than is generally available." Another person commented, "There are not enough staff on Sunday mornings."

We observed a high number of staff on duty during our inspection. Staff were generally available to meet the needs of people living in the service when required or requested. However, there were some periods of time during the afternoon where staff were not visible or available to provide support to the people in communal areas. When asked about the staffing levels in the service a member of staff told us, "Sometimes there are

not enough, we have a lot of tasks to do. We may not have enough time to do things."

A formal staffing level assessment which considered the needs of people whilst taking into account the layout of the building was not in place. The manager explained to us that their assessment of the staffing level was "ongoing" but they did not used a recognised dependency tool or method to assess the level of need of all the people living in the service or the support they required. We reviewed past rotas and found there was consistently the number of staff on duty that the manager told us had been determined by their assessment.

Robust recruitment and selection procedures were in place and were followed consistently. Relevant pre-employment checks including obtaining references from previous employers, checking the applicants previous experience, and Disclosure and Barring Service (DBS) reports had been completed. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. This meant that steps had been taken to ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

People received their medicines safely and as prescribed. Medicines were stored securely and at the correct temperature. There were effective procedures for medicine management, which included the use of PRN (as required) medicines. Staff authorised to administer medicines had attended training in this area and additional training was planned due to a change in pharmacy. Medicine Administration Records (MAR) were completed accurately and checks were in place to ensure that all medicines were in date and stored according to the manufacturer's guidelines.

At our inspection in June 2017 we found that an appropriate level of cleanliness was not maintained throughout the service. We found that people's bedrooms and a number of communal areas were unclean and the methods used by domestic staff when completing cleaning tasks were ineffective. We also found that the courtyard and communal gardens were poorly maintained.

During this inspection we found that standards of cleanliness throughout the service has improved and redecoration had occurred in many areas of the building. A head housekeeper had recently been appointed and it was clear that action had been taken to address the concerns previously raised. The service was clean and tidy and no offensive odours were observed. Housekeeping staff were present, attentive and observed relevant infection control procedures during their work. Cleaning schedules and routines in place demonstrated the improved practices at the service in maintaining a safe, clean environment.

Requires Improvement

Is the service effective?

Our findings

People said they felt staff were suitably skilled and experienced to support them. One person said, "Yes, they are qualified." Another person told us, "They have all been trained to care for us."

Staff told us they received training, however, training provided was not sufficient to meet the individual needs of people. One member of staff said, "I became a keyworker three weeks ago. I key work [Name of person] now. I didn't have any extra training, the only training we have is mandatory and anything on top is like first aid training, breakaway training, but that's it." We looked at records of training provided to staff. These showed training had been provided in areas such as health and safety, safeguarding adults, diversity and fire safety. Staff had not completed training in key areas such as continence care, tissue viability, or mental health. It was clear given the broad range of needs that people had, the training staff had received did not sufficiently support their understanding of people's needs.

Staff said they felt supported by managers. They said they received regular supervision and appraisal. One member of staff member said, "I can have this [supervision] anytime I need with the manager, next one is with the nurse. We talk about what I can improve, develop and help the residents more. I know where I can go to get that support I need. Appraisals are yearly." However, staff supervision did not seek to develop staff skills further. For example, staff were not encouraged to take on areas of responsibility such as being a champion for areas such as mental health, nutrition, or safeguarding.

Staff were provided with insufficient training to meet the individual needs of people. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in June 2017 we found that the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not always followed. People's capacity to make and understand the implication of decisions about their care were not consistently assessed or documented within their care records. At this inspection we found that the required improvements had not been made.

We observed that staff sought people's consent prior to assisting them. Staff clearly explained to people how they wanted to assist them, or the activity they wanted them to engage with. When people refused, staff acknowledged the persons wish and left them alone. However, care records were unsigned for people's consent to areas such as sharing their information, photographs and receiving care. Staff had recorded in one person's care records, "[Person's] presentation affects their ability to express their thoughts about their mental health. They show no understanding of their condition." This was the consistent approach that underlined decisions made for people living at the service, and did not follow the principles of the Mental Capacity Act 2005 (MCA).

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.

Assessments completed did not consistently seek to ascertain people's understanding of the decision they were required to make. The GP had documented that, in their opinion, one person lacked capacity to make decisions. There was no assessment of capacity completed, nor were there records to show what had been considered in this person's best interest around the decisions made. Where an assessment of capacity had been completed, it was not clear how the persons views were sought, or where independent advocacy had been sought. In the section of the assessment record where it was asked whether an advocate was required; this was disregarded. The assessor concluded, "Service user is in agreement that their money can be managed by Howe Dell." This did not ensure the views and opinions of the person were sought.

Other assessments when asked to consider what the persons view was of the decision, simply recorded, 'Lacks capacity.' These examples demonstrated the views of the person or, where appropriate, their appointed representative had not been sought. When we showed this example to the manager they agreed that further work was needed to improve the MCA process.

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 saw that applications to deprive people of their liberty had been submitted to the managing authority and were awaiting these to be authorised. We saw that where the application had been made to deprive people of their liberty, people's relatives and advocates, where needed, had been consulted.

All the people living in Howe Dell Manor were not free to leave the building when they wanted. However, DoLS applications had not been made to the managing authorities to legally deprive people of their liberty. Where these had been made, for example for the use of covert medicines, or close supervision, the MCA and Best interest process had not been followed prior to the application being made. For example, the conditions of one person's DoLS being granted was for the manager to complete the relevant assessments. However, the DoLS had been granted two weeks prior to our inspection and had been emailed to the manager. When we asked for a copy of this they were unable to provide this to us. They were unaware of the conditions set in the authorisation, so therefore were not aware of how to ensure the conditions were lawfully met.

Staff knowledge of MCA 2005 and DoLS was variable across the home. Some staff demonstrated a basic awareness of how to support people who may lack capacity. However; other staff spoken with; who were responsible for developing and assessing people's care needs were unaware. For example, one member of staff when asked about this area said, "I'm sure you have got me there, I don't know."

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not followed. This was a continuing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they had a variety of food and were complimentary about the meals that were provided at the service. One person told us, "I really like mealtimes." Another person told us, "The food is good here." A third person told us, "We have sandwiches after supper time at about 9 pm. We have fruit and biscuits 24/7." We saw the menu in place offered people a variety of meals and were told alternative meals available on request.

We observed the lunchtime meal in the dining room and found that the meal time was a social event, with

staff and people chatting in a friendly manner. Staff were attentive to the needs of people and we observed that people were provided with drinks of their choice.

On the day of our inspection an agency chef was on duty. This was the second occasion in recent months they had worked in the service. We spoke with the agency chef who told us that the food was freshly prepared at the service and they had been provided with instruction as to the meals they were to prepare on that day.

Some people living at the service required a special diet. The agency chef told us that they had not been informed of any changes that they were required to make to the meals served to meet the needs of these people. We saw they made no changes to the lunchtime meal, such as increase of the calorie content for some people or preparation of a suitable alternative to the for people who required a diabetic diet. We saw that a fresh fruit salad had been prepared and served to people, including the people with diabetes. There were no records held in the kitchen that detailed people's preferences and specific dietary needs.

One person, who was identified as being at high risk of inadequate nutrition and hydration, had a dietary intake plan in place from the dietitian. The plan stated that food should be fortified, along with the use of prescribed nutritional drinks and that staff should offer foods that the person likes. We found that no records that alternative meals had been offered for twelve days prior to our inspection. We spoke to the member of staff who had provided the mealtime support to this person on the day who confirmed that the person had not eaten the meal prepared and that no alternative had been offered. When asked what action they had taken, the staff member told us that they had found some sweets in their room and offered these instead. No one had considered making, storing and offering foods this person enjoyed.

We spoke with the deputy manager and manager regarding our concerns. They told us that the agency chef had been provided with information regarding people's needs and had been given instruction on the morning of our inspection by the administrator. They could not explain why there was a failure to provide the meals required to meet the specific needs of people.

People were assisted to access healthcare services, if needed. Care plans confirmed that people had been seen by a variety of healthcare professionals including the GP, psychiatrist and mental health team. However, information recorded did not always include the reason for the appointment or the advice given from the health professional. We also found that when a person had refused to attend an appointment or accept an invite to health screening there was no record of how the person had been supported to understand the benefits of attending the appointment or the efforts made to reschedule the appointment.

Requires Improvement

Is the service caring?

Our findings

People did not consistently receive caring support. Many people told us that staff were caring but some people had experienced less positive encounters. One person told us, "Yes, they [staff] are very caring. 10 out of 10 for care. The staff are lovely." Another person told us, "The staff are very caring. Much kindness." A third person told us, "Some are [caring], some not so much." A relative told us, "Things are much better now than they were. The staff were very bossy when [Name of person] first came here but now they are much more laid back."

People we observed appeared at ease and relaxed when in the company of staff. Staff spent time engaged in conversation with people at various periods throughout the day. However, these interactions were limited in duration and most staff spent little time engaged with people in conversation or in social activities. Staff appeared consistently busy and looked unapproachable as they hurried past people.

The language used by staff within care records did not always promote people's dignity. For example, one person's care records contained "[Name of person] had wet [themselves]" and "[Name of person] playing with [sensory object]." This language did not promote respectful, dignified support.

People told us they felt staff knew them well and their independence was promoted. One person told us, "The staff know me very well and they make an effort to do this." However, care records were inconsistent in detail and lacked information about people's preferences, their planned goals and the support needed to achieve them. A goal for one person was "Manage mental health." There was no further detail relation to this goal or the steps to be taken. A care plan review completed by staff for another person stated, "I feel it unrealistic to consider doing any work at this moment in time but [they] used to work for [Name of company]" No further detail was included how staff could support the person to make progress towards their employment goal and the opinion of the member of staff did not promote the person's aspiration of gaining employment.

There was mixed feedback about whether people had been involved in their care planning and decision making. The manager told us people's care plans were completed with people and that regular opportunities to be involved in reviews were provided. However, this was not consistently supported by feedback from people. One person told us, "I have had many meetings about my care plan." Another person told us, "My [relative] comes to see me, and has been involved with my care plan." However, another person told us, "They do not always listen to me." A relative told us, "The family is involved but we are not sure how much notice they take of what we feel." It was not clear from the care records that we viewed how people had been involved in their care plans.

People's right to privacy was respected. One person told us, "All the staff here are very considerate and treat all of us with a great deal of respect. They always knock before coming into our rooms." Staff had a good understanding of how to respect people's right to privacy and described actions such as knocking on doors before entering, holding private conversations where they could not be overheard and ensuring that doors were closed when supporting people with personal care in bathrooms or bedrooms. Staff all clearly

explained that information held about the people living at the service was confidential and would not be discussed outside of the service.

Requires Improvement

Is the service responsive?

Our findings

People were unable to tell us the extent of their involvement within their care planning. They were unsure if they had been involved in deciding what care they were to receive and how this was to be given. However, everyone we spoke with could remember attending meetings.

People did not receive personalised care that was responsive to their needs. People had care plans in place but the content in each was inconsistent and the quality of the information contained in them was variable. Whilst there was information about care needs and the support people required; the plans lacked detail on people's preferences, their abilities and interests. It was not possible to know or understand people's personality, strengths or background from reading their care plans. There was a plan in place to update and review all care plans prior to the service moving to computerised care planning. This was scheduled to be completed by December 2018. We looked at care plans that had already been reviewed and those that were still awaiting an update.

The plans were not reflective of people's needs and did not always include clear instructions for staff on how best to support people. We found that care plans detailed goals and planned outcomes for people but these were too broad and had not been broken down into specific detail. For example, one person had a goal of "manage mental health". There was no record of how staff should be supporting the person towards achieving this goal. For another person, the recorded goal in a review was "Self care planning." There was no explanation of this goal or any achievable steps to make progress towards this goal that staff could support. We spoke to people about the goals within their care records. No one was aware of any goals having been set.

Care plans did not accurately reflect people's current needs and lacked personalisation. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed opinions from people regarding the activities provided at the service. One person told us, "It's alright. Some stuff to do." Another person told us, "It's boring." A third person told us, "We all go out to the cinema and go out on regular trips." Activities were provided by members of care staff, an activities coordinator and visiting professionals. Members of staff we spoke with were able to describe some individual activities at the service that people enjoyed but told us that trips out were very well received. Staff explained the difficulties the service had in providing meaningful activities for everyone due to the variety of needs people living in the service were experiencing. They also shared with us a difficulty in motivating and encouraging people to participate in activities. One member of staff told us, "Who wants to stay in here 7 days a week, the things we need to offer is not enough. Watching tv is a daily thing, but to have a normal life they need to go out, they expect more from us."

There was an activity schedule available so people knew the activities that were on offer or any future events that were planned. During our inspection we saw limited activities being completed by people with the support of staff on duty. During the morning of our inspection we saw an exercise training programme being delivered by an external company, who visit the service three times a week. In the afternoon, we saw one

member of staff completed some nail care for people in the communal area in the entrance hallway.

People and relatives we spoke with were aware of the complaints procedure and who they could raise concerns with. One person told us, "Yes. When I first came I made some complaints." One relative told us of a concern they had, "I have raised this matter many times but the home has not managed to resolve this."

There were systems in place to support people to make complaints if they required. We saw that information was available in communal areas informing people how they could make a complaint. We looked at records held on complaints and saw that where a complaint was made, this had been responded too and resolved in line with the providers complaints procedure.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in June 2017 we found the provider was not meeting all the legal requirements in the areas that we looked at. During this inspection we found that the required improvements had not been made. The provider had not taken sufficient action to fully rectify the earlier inspection findings and had failed to act upon the feedback provided.

The service had a manager who was in the process of applying to be registered. 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.

Systems and processes for governance and quality assurance at the service were not effective. They did not enable the manager and the provider to assess, monitor and improve the quality of care being provided at the service and failed to mitigate the risk of harm to people living in the service. The audits completed had failed to identify the concerns we found on our inspection.

We found that there were a range of audits and systems in place by the manager and provider. The responsibility for completing audits had been delegated by the manager to members of nursing staff and senior members of staff. A wide range of audits were completed and we saw an allocation record which clearly identified the responsible member of staff. The deputy manager told us that they, or the manager, then reviewed the audits completed and ensured that action was taken to address any issues found.

During our inspection we found concerns regarding the management of incidents and accidents, including possible incidents of abuse. There was no audit in place or monitoring of incidents, accidents or potential safeguarding concerns. Quality assurance procedures failed to identify when incidents and accidents were not recorded, reported or analysed effectively.

We also found that risks to people's health and well-being had not been identified or assessed. Where risk assessments had been completed they were not effective or reflective of the current levels of risk. A quality audit report form completed in August 2018 detailed actions required following an audit of the care plans completed by the manager in April 2018. It was not clear why there was a delay of four months between the manager audit being completed and the corrective action plan being put into place. With no consistent, regular audit process in place for service users care plans the concerns that we found on inspection surrounding the risks to service users had not been identified. An action plan to review all care plans in the service was in place with a deadline for completion of December 2018.

We found that mental capacity assessments for people had not been completed. This repeats the findings of our inspection in June 2017. During this inspection we found an action plan had been issued by Hertfordshire County Council, Clinical Commissioning Group and Hertfordshire Foundation Primary Trust following their joint compliance visit. The action plan was dated 23 January 2018. The plan included an

action to complete mental capacity assessments for people and was marked as completed on 1 February 2018. We found that neither the action identified as required during our inspection in June 2017 or the action required following the compliance visit had been completed. The manager and provider failed to act upon feedback with a view to improve practice and ensure compliance with the regulations. Quality assurances processes in place failed to identify this lack of action.

During our inspection we found that the training provided to staff did not meet the needs of the people living at the service. The training 'audit' completed by the manager consisted of a printed copy of the staff training matrix placed within the quality assurance folder. There was no record of any evaluation or checking of the information within this document to ensure training provided was sufficient or if any additional training may be required to meet the needs of people that staff were supporting.

Since our inspection in June 2017 the provider had not completed any audit or visit to the service with a view to evaluate and assess the quality of care being provided at the service. A monthly report was shared with the provider by the manager giving an overview of the service and any issues arising. We reviewed three of these monthly reports and found inaccurate information had been reported. The manager had requested an internal inspection and this was planned for November 2018, with a provider led inspection visit planned for September 2019. The lack of provider oversight meant that the failure in quality assurance processes at the service were not found and this led to remedial action not having been identified and taken

Systems and processes for governance and quality assurance were ineffective and failed to assess, monitor and improve the quality of care being provided or mitigate the risk of harm to people living at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives knew who the manager was. One person told us, "Yes, see him all the time. The managers are very good here." Another person said, "All the managers are good here." A relative told us, "I see [them] occasionally."

During our inspection we saw the manager was a visible presence in the service. We saw the manager interacting with people living at the service and they were actively involved in the running of the service. We saw the manager responded positively to staff regarding the support and well-being of the people living in the service and the experiences of the staff on duty. However; they demonstrated a lack of knowledge about the systems in place at the service and had no awareness of the concerns we found. The manager consistently needed to refer to other staff to establish the information we were requesting and then to others should they not have the information required.

Staff told us that there was an open culture at the service and found the management supportive. One member of staff told us, "[Manager] is supporting me and the rest of the guys, he is trying his best for the good of the clients." Another member of staff told us, "[Manager] helps me a lot with my understanding and I think he has made a lot of things better since he is here." Staff were aware of their roles and responsibilities and were clear on the lines of accountability within the staff structure. Frequent team meetings had been held and all staff members were expected to attend. We reviewed the minutes from the past six meetings and found that topics for discussion included rota, annual leave, pay, agency staff, training and safeguarding.

Staff were not clear on the visions and values of the provider organisation and the direction of the overall service development. The PIR completed prior to our inspection stated that the aim of the service as "We are an aftercare unit, providing and supporting residents, preparing to go back into the community. We use the

recovery star model to support with their recovery journey. We retrain their living skills, encourage social inclusion, educate them on mental health and provide an understanding of their medication. We help build their confidence, trust and hope, self-esteem and encourage independence and awareness of healthy relationships." This was not clear within the service, records reviewed or shown by staff.

We spoke with people and relatives about their involvement in the development of the service and whether they were asked for their feedback and opinion of the care provided. People could recall completing a satisfaction survey but were unaware of any outcomes. Many of the responses seen were positive, however some concerns had been expressed. We saw that a response had not been compiled or an action plan completed to address the concerns raised. The manager had completed an evaluation of the results which resulted in a percentage score but it was not clear how this was used to develop the service or drive improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not accurately reflect people's current needs and lacked personalisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not followed. Mental Capacity Assessments had not been completed for people who required these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were provided with insufficient training to meet the individual needs of people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were exposed to the risk of harm or injury by not having current risks to them assessed or action taken to mitigate those risks.

The enforcement action we took:

The CQC inspected the service on 24 October 2018 and determined that the provider had failed to meet the fundamental standards. We issued a Notice of Decision to impose conditions on the provider`s registration to help them improve the quality and safety of the care people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes for governance and quality assurance were ineffective and failed to assess, monitor and improve the quality of care being provided or mitigate the risk of harm to people living at the service.

The enforcement action we took:

The CQC inspected the service on 24 October 2018 and determined that the provider had failed to meet the fundamental standards. We issued a Notice of Decision to impose conditions on the provider`s registration to help them improve the quality and safety of the care people received.