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	Requires Improvement

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

Summary of findings

Overall summary

About the service
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 16 people living at the service.

People's experience of using this service and what we found
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us they felt safe in the home and staff supported them in a kind and caring way. Staff knew how to report their concerns and keep people safe from harm. Medicines were managed safely. Risk assessments were developed and actions to mitigate risks were identified, however more detail was required to ensure staff had guidance on how to consistently apply measures to mitigate risks.

Care plans were developed in an electronic format and they were detailed in what people`s needs were and what support was needed from staff to meet those needs. These needed further development to ensure they accurately reflected people`s current needs, the support they were getting and to detail people`s likes, dislikes and preferences.

People were offered choices and staff knew they had to ask for people`s consent to support them with any aspects of care. People told us staff were kind and caring and their dignity and privacy was protected. The provision of individually tailored social activities was an area the provider was still working on to ensure people were living an active life. There were enough staff to support people with their daily needs, including support for people to go out when they wanted.

Staff felt supported to understand and carry out their job roles effectively. Training commenced to ensure staff were up-skilled to the roles of champions in their areas of interest. The interim management team were working to develop the way staff met people`s dietary needs.

Governance systems had improved since the last inspection. The way the provider collected feedback from people, audits and other data to help assess the quality of the service provided was more effective and helped the provider identify where more improvements were needed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was inadequate (published 13 March 2019).

The provider completed an action plan after the last inspection and sent us monthly updates to show what

they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

This service has been in Special Measures since 13 March 2019. During this inspection the provider demonstrated that improvements had been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Howe Dell Manor

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
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.

Service and service type
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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed the action plan the provider regularly sent us following the last inspection.

During the inspection
We spoke with eight people who lived at the service and two visitors to find out their views about the care provided. We also spoke with three care workers, a nurse, the deputy manager, the interim manager who was also the provider`s director of nursing and the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and asked them to submit further evidence to demonstrate how they monitored the quality and safety of the service provided. We looked at training data and quality assurance records.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question had improved to good.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● At our last inspection in October 2018 we found that systems to protect people from harm were ineffective, incidents had not been reported and lessons were not learned to reduce the likelihood of recurrence. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had made the required improvements.
● People's told us they felt safe living at Howe Dell Manor. One person said, "I do feel safe here."
● Staff were aware of what safeguarding was and how to keep people safe from harm. Staff knew how to report their concerns to managers however not all staff were aware of outside organisations like the Local Authority. One staff member said, "We are watching after a vulnerable person, and protecting them from harm and abuse. I would report self-neglect, or that they are withdrawn, anything that's not normal for them and when I see they are at risk of being harmed."
We recommended that information about how to raise concerns outside the organisation to be discussed in staff meetings or supervisions.
● Staff told us the process of reporting incidents or safeguarding concerns was now clear. Staff described examples where they had reported an incident and told us the interim management team responded appropriately. Staff were confident to raise concerns with managers or to whistle-blow if required.
● The provider had thoroughly reviewed and wholly changed the approach to analysing and monitoring incidents. These were now monitored and reviewed monthly. Themes and trends relating to incidents, injuries or safeguarding concerns had been analysed and addressed, and triggered reviews of people's care.
● We were told that staff discussed incidents through reflective practise and discussion. We saw two recent incidents that had documented; they had been reviewed as part of reflective practise to learn lessons. However, minutes of the meetings did not demonstrate this discussion had occurred. The management team told us that lessons learned was an area that was being developed and incidents in future would be reviewed regularly. This meant that reflective practice and lessons learnt were not yet imbedded and sustained in everyday practice.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found enough improvement had been made and the provider was no longer in breach of this regulation.
● Risk assessments were in place for areas identified as presenting a risk to people or others. The risk assessments detailed what risk was identified and actions were listed for staff to take, however the guidance

to tell staff how to consistently mitigate risk was lacking in detail. For example, the risk assessment for a person who was a smoker and had a health condition which could affect their breathing especially when smoking had no detail to give staff the sign and symptoms this person could experience for them to recognise when to report their concerns

● Staff were knowledgeable about risks and how to mitigate these.

● Risk assessments were in place for areas like people`s mental health, physical health, behaviour and others and staff were knowledgeable about these.

Staffing and recruitment

● People were supported by sufficient numbers of staff to provide safe care. Staff told us rotas were covered and there were sufficient staff on duty to meet people`s needs. One staff member said, "For the moment, now there is enough [staff]. Since [person] came back the manager asked the owner to give us one more staff. [Person] needs more care and we also have to supervise two other people, so we needed an extra staff member. Now it's fine."

● The interim manager and provider had reviewed the hours they were required to provide. Rotas demonstrated people received the level of care they had been assessed as requiring.

● Staff working at the home were consistent staff members who people knew well. Where agency staff was used to cover gaps, these were regular agency staff to ensure consistency. The manager had been able to directly recruit from the agency and this helped to ensure staff were suitable for the role and competent prior to them starting permanently.

● Permanent staff underwent recruitment checks including criminal records checks to ensure they were suitable for the post they applied for.

Using medicines safely

● People's medicines were managed safely. We noted that the medicine administration was completed in accordance with good practice. Medicine records were completed accurately and the sample of medicines we counted tallied with the amount recorded. Staff had received training and they had their competencies checked before they administered medicines to people.

Preventing and controlling infection

● Staff demonstrated good practise when supporting people with their personal care. Staff had received training in this area, and supported people's care needs and nutritional needs in a safe and hygienic manner.

● Staff told us there was enough personal protective equipment such as gloves and aprons to use and our observations confirmed this.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care needs had been assessed and support plans had been created to guide staff on how best to meet people's needs. These plans did not all contain enough details to guide staff about people's moods and the specific steps staff needed to take to be most effective in caring for people. For example, where the support plan noted people experienced hallucinations, the assessment did not describe how these hallucinations affected the person or how staff had to support them.
- When needed, best practice was sought and communicated to staff to ensure people's care was provided effectively. Assessments of people's mental health and physical health needs had been developed with the person and health professionals. This also helped to ensure care was delivered in line with good practise and recognised standards.

Staff support: induction, training, skills and experience

At the last inspection we found that 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 this inspection we found that the provider had made improvements and they were no longer in breach of this regulation.

- People told us staff were sufficiently trained to provide effective care and support.
- Staff told us they received training which prepared and supported them for the roles they performed. This included supporting clinical staff meet the requirements of their professional registration.
- Training had been provided in key areas, and staff competency was regularly checked through discussion with staff and observations of their practise. However, some staff told us they had not received training in key areas such as mental health. One staff member said, "We will be doing training for learning disabilities next month. I haven't yet done mental health."
- Training continued to require improvement to enable staff to fully develop in their role. For example, the food pathway training had been offered to the manager, as opposed to the chef who was new in post and had no experience in working in care settings. The provider told us following the inspection that the registered manager was identified to attend the nutrition pathway to ensure they were then able to cascade this and train staff in the home. The chef received training and was supported by a chef from another service owned by the provider.
- Staff felt supported in the role and could access support from any of the management team. Staff confirmed they received regular supervision where they could discuss individual people's needs, and their

development. One staff member said, "The managers are hands on, they support us by being involved. If I need help or support, then I know they will do their best to help me. Supervision is good now, we can talk things through, more like problem solving so I think it works well."

Supporting people to eat and drink enough to maintain a balanced diet

● We observed lunch where we saw limited interaction between people and staff. Staff came to the servery whilst people were still eating their first helping and ordered their lunch, on one occasion calling across the dining room. Staff ate their lunch sitting at a table away from people and made little effort to interact with them.

● We gave this feedback to the managers. They told us that people had said they wanted lunch times to be quiet. However, the actions from staff did little to support or respect this request from people.

● People were supported to develop their own cooking skills and to make healthy choices. We were told, "We bought a bread maker for residents to bake bread, we bought slow cookers and help them prepare ingredients. Then they go in the kitchen and cook a meal. One person requested a vegetable steamer as they wanted them crunchy. People can cook their own meal, but staff encourage them to invite one person to sit with them for the sociable interaction."

● People's dietary needs were known to staff and the chef. However, identified needs were not always explored thoroughly to support those needs. For example, one person refused to accept they lived with diabetes. They had capacity so were aware of the decision they were taking. They also preferred complimentary or alternative therapies to medicines, however staff had not explored with the person how this could be used to support their diabetic diet and lifestyle.

● The chef's awareness of people`s needs were limited. They were not aware of people at risk of weight loss and were not involved in reviews of people's dietary needs. They told us, "I haven't worked in care. I don't know about modified diets. They [Staff] don't really include me with the residents." Following the inspection the provider sent us evidence about the support they had in place at the time of the inspection for the chef to get familiar with people's dietary requirements. The chef met with the dietician regularly to review people`s dietary needs. They were also included in the weekly community meetings with people where food is a standing item on the agenda.

● A folder was available in the kitchen which the chef did not refer to. This provided instructions for things such as diabetic diets, limited high calorie diets, sugar free diets and allergens. However, one person`s dietician advice noted that they must not skip meals. This person had chosen to not eat on the day, and regularly skipped meals. Staff did not prompt or encourage with alternatives and did not follow the advice given. This was an area the managers were working to improve further.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support

● Staff were able to promptly identify when people`s needs changed and seek professional advice. We saw that people were promptly referred to GP, dieticians, physiotherapists and other professionals when their needs changed. One person told us they spent a long time in bed due to health reasons and they had seen the physiotherapist recently to plan for getting up. They said, "There is a plan to get me up. There is also a plan to get me fully mobile again."

● Staff worked in partnership with health and social care organisations appropriately sharing information about people to ensure that the care and support provided was effective and in people`s best interest.

● People had been seen by health professionals when needed and regularly saw the GP, various nursing teams, dieticians, psychiatrists, psychiatric nurses and therapists as required.

Adapting service, design, decoration to meet people's needs

● The home is an old converted property set within the grounds of a historic house. The provider had

considered accessibility as a key factor of the ongoing renovation and maintenance works in the building.
● People's rooms were personalised and reflected their personalities and individuality with their own furniture, pictures, and bedding.
● However, further cyclical decoration was required in some areas. The interior of the building, and communal areas were tired and dated and in need of improvement.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not followed. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made, and the provider was no longer in breach of this regulation.
● Staff asked people for their agreement prior to offering support and offered choices, respecting people's right to decline.
● At our last inspection assessments had not been completed as required for specific decisions. Staff had made assumptions regarding capacity and had not completed thorough assessments. At this inspection, improvements had been made. Assessments were comprehensive and sought people's views about the decision being made. For example, a recent assessment had explored a person's views about living at the home and the fact they wanted to leave.
● Staff explored if they understood the risks if they were left unaccompanied and how they may manage and keep themselves safe. Staff established the person lacked capacity and a best interest assessment concluded that the person needed close supervision within the home as they were unaware of the risks if they left the building unaccompanied. A Deprivation of Liberty Safeguard application was made.
● DoLS applications had been submitted where required. However, whilst awaiting an assessment staff had not developed a care plan to ensure they managed any restrictions applied on people`s freedom effectively. We spoke with the management team about the importance of developing these plans to ensure the deprivation is monitored in the least restrictive manner possible.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us staff were kind and caring. One person said, "They are kind and caring." Another person told us staff and other people living in the home were like family and staff were kind.
- Staff, and the management team, demonstrated that they knew people's needs and preferences well.
- People were cared for in a compassionate manner by staff who were caring and respectful to them. People were seen to be at ease with the staff members supporting them.
- Staff were seen to quickly support people when they needed this. When staff intervened, they did so showing a genuine level of concern for the person.
- People's life histories and information about their interests or relationships important to them were not well documented. For example, one person's care plan noted, "I have a good relationship with my mother and father." No further information about how often the person met with their parents or what staff could do to encourage this relationship.
- Staff when talking about people did so with enthusiasm and genuine compassion.

Supporting people to express their views and be involved in making decisions about their care
- People were involved in decisions about their care, and staff were able to tell us how they observed people taking part in different activities and establish if they liked it or not.
- Each person had a named keyworker, who managed the persons daily needs, such as appointments, care plan reviews, or some advocacy work. They were central to ensuring people's relatives were kept informed and were responsible for monitoring the persons support needs. One person said, "I have a key worker and a lead nurse. It is good living here this is my home."
- Staff gave differing views on their role as a key worker. Although staff enjoyed being able to develop the care people received, they felt reviews were clinical and not centred on the person. One staff member said, "I am trying to be involved, like where I am the keyworker. I am involved only when it is my key residents. [I understand that at my next supervision with [Nurse] we will be looking at the care plans. We need to understand them. The care plans have a lot more of the nurse thoughts, and we need to be more involved."
- Staff clearly knew people well and were able to interpret people's responses.

Respecting and promoting people's privacy, dignity and independence
- People's right to privacy and confidentiality was respected. Staff addressed people in a dignified manner. One person told us, "They respect me and my privacy."

● People were well-groomed and were appropriately dressed. Staff were quick to change people's clothes if needed or prompt those who could manage this to do so.
● When people needed support with personal care staff made sure this was provided in their own rooms behind closed doors.
● Records were stored securely, and staff understood the importance of respecting confidential information. They only disclosed it to people such as health and social care professionals on a need to know basis.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At the previous inspection 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. At this inspection we found that some improvements were made to this area and the provider was no longer in breach of this regulation, however further improvements were needed to ensure care plans were reflective of people`s current needs and the support they received.

- People`s care plans were developed in an electronic format. These were developed to show what people`s needs were, what level of support they needed to meet their needs and, what people and staff had to do to meet the desired outcomes.
- Care plans were not always clear on what was a historic care need or support and what support people received currently. For example, for one person the care plan detailed that their wound management was carried out by the district nurse team and not the nurses in the home. When we asked staff, they told us this was no longer the case as nurses in the home received wound management training and they were meeting the needs of this person. Another person was identified having behaviour that challenged others. The risk assessment instructed staff to de-escalate these behaviours without describing how they had to do it. For example, the care plan said, "Staff to de-escalate as quickly as possible and re-direct to the bedroom". There was no detail to tell staff how they could de-escalate challenging situations. The provider told us staff received training about the different techniques to de-escalate challenging behaviours. However, this was an area still in development.
- People told us they enjoyed the trips out and the visits outside the home. Staff developed an individualised timetables based on feedback from people on what they liked to do. Staff told us they asked people what they wanted to do, however at times it was difficult to motivate people to do something. Activities needed further developing to ensure people were involved and had been occupied to avoid boredom.
- Therapeutic activities had been commenced at the home led by the head of therapies from another service owned by the provider. Although this was a new initiative, initial results showed that the outcome from these therapies had a positive impact on people's wellbeing and mental health. One person told us, "I go out with the fitness trainer for walks. We go to a local café for coffee. It is a nice walk to this café. The staff encourage us to do things. We choose what we want to do."
- A service user council was led by people living in Howe Dell Manor. This group, along with others across the providers homes, met regularly to discuss issues important to them. It was clear from minutes reviewed that the council held the provider to account around issues that mattered to them.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People living in Howe Dell Manor had good communication skills. We observed staff communicate with people in a clear way, giving people time to respond and make decisions and choices.

Improving care quality in response to complaints or concerns

● There were systems in place to support people to make complaints if they required. People told us they felt confident raising any concerns. One person said, "I can raise complaints and concerns. I am listened to."

● Information was available in communal areas informing people how they could make a complaint.

● Records showed complaints had been responded to and resolved in line with the provider's complaints procedure.

● Compliments were recorded and shared with staff. Howe Dell Manor had received two compliments via email from relatives. One noted the following, "My experience of the staff is that they are responsive, helpful and very caring."

End of life care and support

● At the time of the inspection nobody received end of life care. Care plans were not detailed to show how staff approached this delicate subject with people and how they prompted people to think about their end of life care needs. This was an area in need of improvement.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
At the previous inspection we found that systems and processes for governance and quality assurance were ineffective and had 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. At this inspection we found the provider made significant improvements to their governance systems and although some of these needed further developing they were no longer in breach of regulation.

- The service had a manager who was registered with CQC as required. However, they had just started working at Howe Dell Manor at the time of the inspection.
- The previous registered manager left in March 2019 and in the interim period the service was managed by the deputy manager and senior management team. Staff were positive about the managerial changes.
- Staff were enthusiastic about people living full and happy lives, however people's goals and outcomes were not clear. The management team told us that people's independence was planned from the first assessment. However, when we spoke with people they were not clear about the long-term plan for them and how long they would live at Howe Dell Manor. For person centred care to be planned and delivered, people must be aware and involved in developing and shaping this care to move towards independence.
- People's care plans were task focused and did not clearly identify how the care provided could meet people's continued holistic needs. Care plans were not written in a person-centred format and did not always contain achievable outcomes.
- At this inspection the provider told us, "Whilst the CQC inspection at Howe Dell Manor in October 2018 was deeply disappointing, it reinforced the challenges we face as an organisation and highlighted the areas we needed to prioritise and where we urgently needed to make changes." We saw at this inspection several new initiatives were either in place, or in the process of being embedded.
- The provider had identified key areas of risk. Notably they had identified their systems and processes to monitor the quality of care at board level were not sufficiently robust. An electronic care planning system was introduced. This enabled managers to have a better overview when carrying out spot checks and helped staff to ensure key daily tasks were completed in a timely manner.
- Staff completed a daily 24-hour report which they submitted to senior management team daily. This identified any potential issues or concerns such as staffing, incidents, or clinical concerns. This enabled senior managers to maintain a more in-depth oversight of what was happening in the home.

● At our last inspection accidents and incidents were not investigated, and governance did not ensure the quality of care people received was monitored and safe. At this inspection the provider had undertaken a significant and substantive review of their governance framework. Incident management and transparency had significantly improved. However, investigations of incidents were not always clearly documented. For example, where a person fell on their back, the manager had not reviewed with the person what had happened. They made a decision to ensure the person wore appropriate footwear, without considering what other factors may have contributed to the fall. The managers were working to improve this further.
● In January 2019, the provider implemented a new performance monitoring system for managers. This required managers to report to the board across a number of measurable outcomes. This was then reviewed and enabled the provider to set objectives across the organisation. The formalised approach to governance enabled the provider to standardise auditing and reporting across the organisation. They can now identify key areas to focus on, such as recruitment and stabilisation of staffing and manager vacancies.
● All identified areas for improvement and development were reviewed by the board. Minutes of recent meetings demonstrated operational information was being received by the board and formed part of the overarching organisational action plan. This meant the provider had embedded a greater level of transparency and accountability across the whole organisation following the previous inspection at Howe Dell Manor.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The managers understood the importance of being open and transparent when things went wrong. They notified CQC and the local authority about any notifiable incidents or accidents and they discussed with people and staff what went wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Continued management changes led to uncertainty and a poor culture with the staff team. This had been identified as an area for development by the provider and we saw there were plans to address this.
● There were regular staff meetings and daily shift handovers that detailed risks and changes to care plans that could affect how a person was supported.
● Staff performance was now closely monitored with supervisions and their competency was reviewed regularly. Managers were subjected to closer scrutiny with clear objectives set and regularly reviewed. Where managers were not achieving the agreed goals, performance management was carried out, and where they were unable to meet the standards required, disciplinary action was taken.
● Staff were positive about the changes in the service and the leadership. One staff member said, "It's much better now since [previous registered manager] left. I think [deputy manager] and [director of nursing] are really bringing about good changes."
● Audits were completed for a range of areas including care plans, medication administration charts and daily notes. The provider regularly reviewed the quality of care by carrying out their own reviews, alongside 'Mock inspections' designed to identify areas for improvement and to support staff with the inspection process.
● A quality assurance group had been developed where staff were able to discuss developments across the group. Recent discussions were about how wound care training had supported clinical staff knowledge, and discussions about challenging admissions and how to support those.
● Staff were clear about their role, however further training and development was required to ensure they provided person centred care based on realistic and achievable outcomes.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

● The provider had changed the way they collected people's feedback about the service and their care. In addition to the usual satisfaction survey, they had introduced a focused set of questions that rated areas of people`s lives and satisfaction with treatment. As this was a new initiative, it was too early to draw any conclusions from the initial results, however this did demonstrate the provider had sought people's views. One person said, "There is a black box in reception where we can give anonymous feedback." Another person told us, "I have filled out questionnaires every month."

● A satisfaction survey had been completed in March 2019 completed by 12 of the 17 people living in Howe Dell Manor. This showed that at least 9 people felt the service was safe, effective, caring, responsive and well led.

● A staff survey had been completed in 2019 and the results analysed by the provider. However, of the staff working in the service, only nine responded. All felt they knew what was expected of them in their role, and that they were enthusiastic about their job. All said they would recommend the company to friends or relatives. Staff were less positive about previous management in the home, with some staff feeling they did not have enough resources, or they were not always supported to develop. However, they gave us positive feedback about the current management team.

Continuous learning and improving care; Working in partnership with others

● Systems were in place to ensure staff continued to learn, were trained and supported in their role. However, it was not clear where lessons learned had become part of day to day practise.

● The provider had recently approached an NHS trust to look at ways they could engage with people and track their treatment journey in real time outcomes.

● The provider planned to further develop their therapeutic activities and was also recruiting a companywide occupational therapist to drive the development forward.

● The service had links with external services that enabled people to engage in the wider community, and for staff to receive quality training and development.