Blue Star Care Ltd

Venetia House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Venetia house is a residential care home providing personal care for up to 10 people. The service provides support to people with mental health and learning disability needs. At the time of our inspection there were seven people using the service. One of these people did not receive support with the regulated activity 'personal care'. Where a person does not receive support from the regulated activity, we do not include them within our inspection process.

People's experience of using this service and what we found
Systems had not been put in place to investigate and improve the closed culture identified at the last inspection. Safeguarding incidents had not always been responded to appropriately. Incident records had not been reviewed in a timely way. Staff did not have clear guidance on how to support people's individual needs. People were not safe from environmental risks (fire and legionella). Staff were not safely recruited to ensure they were of good character. Medicines were managed safely. There were enough staff to support people and staff were deployed effectively around the service.

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 and in their best interests. The systems in the service did not support this practice. People were at risk of their hydration needs not being met. Peoples care plans and risk assessments did not always consider protected characteristics, as identified in the Equality Act 2010. People had been referred to external health professionals; however, there was unclear communication processes in the event of a hospital admission. Staff had received training on how to support people.

We observed staff and people had positive interactions. People told us that staff were caring. However, poor governance processes did not promote a caring culture at the service. People had shared bedrooms and the dignity and privacy of this arrangement had not been considered.

Care plans did not always give guidance on how to provide personalised care. For example, care plans did not describe people's individual interests and routines. However, when we spoke to staff, they had good knowledge of people's preferences. The manager advised that no complaints had been made. We saw no evidence that people were unhappy with their care. End of life care planning had been completed for one person, the manager planned to improve other end of life care plans.

The service was not well led. At the last inspection, we sent the provider warning notices. These warning notices explained our concerns with the service and gave them until April 2022 to make improvements. The new manager started in May 2022 and we saw limited evidence of actions taken before they started employment. The work the manager had begun to do was good quality. However, the work had not yet been embedded to improve the quality of care. There had been a provider level failure to improve the service before the new manager arrived. The provider advised they would consider ongoing management structures to further improve the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review we found the service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture.

Right support: The model of care did not maximise people's abilities. Care records did not always guide staff to provide suitable care. However, staff had received increased training since the last inspection.

Right care: Care was not always person centred or safe. People were not involved with feeding back about the care provided.

Right culture: Staff reported that improvements to the service were because of the new manager. The culture was reliant on the new manager rather than a whole provider system.

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 service was last rated 'inadequate' in the safe, effective and well led domains. We decided to not provide an overall rating as the provider had only owned the service for a month and a half. The report was published on 27 April 2022.

After the last inspection, the provider also completed an action plan to show what they would do and by when to improve. At this inspection we reviewed this action plan and found it had been ineffective at improving the service.

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

We also looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Venetia House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding, safe care and treatment, recruitment, consent and

good governance.

Full information about CQC's regulatory response can be found at the end of the report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not effective Details are in our effective findings below	**Inadequate**
Is the service caring? The service was not always caring Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well led Details are in our well led findings below	**Inadequate**

Venetia House

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by one inspector.

Service and service type
Venetia House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Venetia House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was no registered manager in post. A new manager had been recently appointed and they told us that they intended to register at the service. There was a nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people about the care provided to them. 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 spoke with four care staff. We spoke with the newly appointed manager and two directors of the service. We reviewed four people's care plans and five people's medicine records. We looked at records related to audits, recruitment and training. We also reviewed a range of the provider's policies in place.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to ensure measures were in place to keep people safe from potential abuse. This is a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of the regulation.

- At the last inspection, we found staff were not confident in reporting concerns about abuse to the management team. This could lead to a closed culture, where abusive care is not recognised or acted on. We had reported these concerns to the provider. However, at this inspection we found a poor-quality investigation had occurred into this historical culture. This meant we were not assured about the provider's investigation processes when allegations of poor care are made. After our inspection, we raised concerns about this, and the provider arranged an external professional to investigate the historic allegations.
- We also found a lack of effective action had been taken to improve the culture of the service. One staff member told us that they still felt they could not report incidents to all members of the management team. We told the manager about this feedback. They held a team meeting to discuss this with all staff. They then reported back to us that multiple other staff members felt the same. So, they told us they would work to further improve this reporting culture.
- The recognition and reporting of safeguarding incidents had improved but was not fully embedded. The new manager had ensured that concerns, reported to themselves, had been referred to the local authority safeguarding team. However, the inspector saw a record which should have been reported to the local authority safeguarding team. The staff team had not reported this incident to the manager. As a result, the manager had not been able to take timely action in response to this incident.
- Since the last inspection, the provider notified us of a safeguarding allegation. At this inspection, it was not clear what action the provider had taken in response this incident. The failure to oversee clear action after potential safeguarding incidents leaves people at risk of abuse.

The provider had failed to ensure systems were in place to investigate and improve the closed culture of reporting concerns. Safeguarding incidents had not been always been reported and responded to appropriately. This is a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure measures were in place to ensure people were safe from harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation.

● At the last inspection, staff did not have clear guidance on how to support people's needs. We saw that care plans still did not provide clear information. For example, care plans had contradictory guidance on a person's health diagnosis. They also did not describe how to support people's mobility, expressions of emotional distress and physical needs. This lack of clear guidance, risked staff providing unsafe care.
● People were not safe from potential legionella infections at the service. The provider had not completed the required checks to prevent a potential build-up of legionella bacteria in the water supply. If water systems are not managed safely, legionella bacteria can put people at serious risk of ill health.
● People were potentially not safe in the event of a fire. The fire alarms and the emergency lighting system were not regularly checked. So, we could not be assured that these systems were working safely. A lack of evacuation guidance meant staff and the fire service would not be clear on which people needed additional support when evacuating, or how to do this safely.

Learning lessons when things go wrong
● The new manager had started to review incident records, to improve care plan guidance for staff. However, they had only fully completed this process for one person. This meant lessons had not always been learnt from incidents to guide the care of other people living at the service.
● The manager had reviewed incidents that had taken place after they started employment (in May 2022). There was no evidence that incidents between our last inspection (February 2022) and the new manager's start date had been reviewed. This meant timely action was not taken by the provider to review incident records that we highlighted as a concern at the last inspection.

Systems were not in place to ensure staff had suitable care plan guidance to support safe care. Systems were not in place to ensure people lived in a safe environment. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to ensure staff were safely recruited. This was a breach of Regulation 19 (Fit and proper person's deployed) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation.

● Three staff had been recruited since the last inspection. Two of these care staff had had suitable employment checks to ensure they were of good character. However, an additional staff member had not received any employment checks before starting employment. We expressed concern to the provider, and the staff member's employment was suspended until these recruitment checks occurred.

At the last inspection, there were not enough staff deployed to meet people's needs. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvements had been made, so the provider was no longer in breach of that regulation.

● There were enough staff to support people at the service. People who always needed a staff member with them, were not left unsupported.

Using medicines safely

● Medicines were stored appropriately.
● People were given their medicines as prescribed.
● Where people had medicines to be taken 'as needed', staff had clear guidance on how to support these types of medicines.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider had suitable processes in place to ensure visiting arrangements were safe.

Inadequate

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 our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection the provider had failed to follow the principles of the Mental Capacity Act. This was a breach of Regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation.

- At the last inspection, we identified that staff had imposed restrictions on people's daily routines that had not been part of a mental capacity assessment. At this inspection, we found limited action had been taken to resolve concerns listed in our last inspection report.
- Two people still had their wardrobe doors locked so they could not access their clothes freely. One person was still not allowed to smoke a cigarette alone. The restrictions on these people's freedom's had not been subjected to a mental capacity assessment, or best interest planning to ensure it was the least restrictive option.
- Another person's care plan described that they needed support with the management of their finances, management of their medication, road safety and deciding where they live. However, no specific capacity assessments had assessed the person's abilities to make decisions about these areas. There was no best interest care planning to decide how to support the person in the most suitable and least restrictive way for these decisions.
- On the first day of the inspection, the manager told us that the provider had not given them a record of

which people had a Deprivation of Liberty Safeguard (DoLS) in place. When we returned on the second inspection day, the local authority had provided this information to the manager. It was identified that at least one person needed a DoLS referral that had not been made in a timely way. The poor provider oversight of DoLS authorised at the service, had impacted the manager's ability to effectively oversee people's DoLS needs.

There was a failure to ensure people's mental capacity was clearly assessed. In addition, there was a failure to ensure any restrictive practices had been decided in the person's best interests. There was ineffective oversight of which people required a DoLS at the service. This was an ongoing breach of Regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●People's needs and choices were not clearly assessed. Care plans did not give staff enough guidance on how to care for people effectively. Staff understood people's presenting needs, but were guided in how to respond by the new manager rather than high quality care plans.
● Peoples care plans and risk assessments did not always consider protected characteristics, as specified in the Equality Act 2010. This included people's needs in relation to their gender, age, culture, religion, ethnicity and disability.

Supporting people to eat and drink enough to maintain a balanced diet
● People were at risk of their hydration needs not being effectively met. Some people needed staff support to drink enough. However, there were gaps in record's suggesting people had gone long periods without being offered a drink. Conversely, one person's health condition meant they were supposed to have a limit on how much they drank. Records showed that staff regularly provided them with more drinks than was suitable for their health diagnosis.
● People told us that the food was good quality and that they could eat what they chose.

Adapting service, design, decoration to meet people's needs
● At the last inspection we reported that some people shared bedrooms. However, there was no care plan guidance for staff to know how to support this living arrangement effectively. For example, how to give the person privacy or how to support mutually agreed décor. These people could display emotional distress that may impact the other person. No changes had been made to care planning by the provider in response to these historic concerns.
● We raised the above with the provider. When we returned a few weeks later, two people who shared a room had been given separate bedrooms. However, two other people still shared a bedroom and care planning had not altered for them. This meant these two people continued to use living arrangements that may not have been effective for their personal needs.
● The service had some refurbishments since the last inspection. For example, new flooring in communal areas. This had improved the décor of the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals had been made to other health and social care professionals to get advice on people's needs.
● The new manager had begun to improve the quality of 'emergency grab sheets'. These were designed so if someone went to hospital in an emergency, then a summary of their needs could be passed to medical staff and enable effective support. These 'grab sheets' had not yet been put in place effectively for all people at the service. This increased the risk that not all people would have an effective transfer to hospital.

Staff support: induction, training, skills and experience
At our last inspection, staff were not suitably trained and skilled to complete their roles effectively. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvements had been made, so the provider was no longer in breach of this regulation

- Staff had received training in how to support people effectively.
- Staff spoke highly about the recent training provided to them.
- Training had only recently been provided. It will therefore take time to embed improved care within the staff team. We will assess the impact of training further at our next inspection.

Requires Improvement

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 our last inspection, the key question was rated good. At this inspection, this key question has been changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- While staff were individually kind to people, the overall management of the service meant care may not always be given in a caring way. For example, the care plan described that staff should support a person's financial decisions. There was no guidance on how to do this in the least restrictive way and respecting the person's dignity.
- The manager had updated one care plan, which described a person's equality and diversity needs. Other care plans had not yet had the same quality update. This meant staff did not always have clear guidance on how to support people's diverse needs. For example, one person enjoyed looking at their clothes and wanted to do this regularly. However, their clothes had been locked in their wardrobe so they did not have free access. There was no guidance for how staff could encourage the person to touch and look at their clothes regularly. This impacted the caring nature of the service.
- People told us that staff treated them well. One person said "The staff are always kind to me. They are always sweet. They are my friends."
- We observed staff and people had positive interactions.

Respecting and promoting people's privacy, dignity and independence

- Staff were seen to give people privacy by knocking on their doors first, before entering.
- Staff were seen to treat people with dignity, for example quietly discussing the person's personal care needs with them so they did not share this information with other people nearby.
- A person told us that their independence was promoted when they had personal care. They said, "Carers help me wash my hair. I do as much as I can on my own, but then they'll help if I need it."

Supporting people to express their views and be involved in making decisions about their care

- We saw people being given options about their daily routines. For example, what they would like to wear or where they would like to go that day.
- People told us that they were regularly given choices about their daily routines.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection, the key question was rated good. At this inspection, this key question has been changed to 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

- Care plans did not always describe how people could have personalised care. For example, care plans did not describe people's individual interests and routines.
- However, when we spoke to staff. They had good knowledge of people's preferences. For example, a staff member described the unique way a person liked to do their crossword puzzles. Therefore, this lack of person-centred care planning was more of a risk for new staff who would be reliant on care plans to guide them.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The manager had updated one person's care plan. This included easy read information, so the person could understand the care they were provided. The manager told us that they intended to put the same information in place for other people that needed it.
- Staff knew people's communication needs well. For example, one person could speak very fast. A staff member said "(Person) can get upset if you can't understand them the first few times. If we say, 'talk a bit slower.' Then they will relax and we can talk." We observed this effective communication happen by different staff.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans did not provide detail on the types of activities that people liked to take part in. However, the manager advised plans were in place to improve this care plan guidance.
- We saw people engaged in activities outside of the care home (like going to the pub or going shopping). We saw people chose what activities they wanted to take part in, and staff were flexible if people changed their mind. People were not at risk of social isolation.

Improving care quality in response to complaints or concerns

- The provider had systems in place to respond to any complaints. The manager told us that no complaints had been made. We saw no evidence that people were unhappy with their care.

● People told us that they felt staff would listen to them if they were unhappy with the quality of care.

End of life care and support

● The manager had updated one person's care plan. The person was not at the end of their life, but the manager had pro-active discussions with the person about what their end of life preferences would be. This discussion was recorded so staff knew how to support the person if they suddenly became unwell and reached the end of their life. The same update had not occurred for other people's end of life care plans. Therefore, good quality end of life planning was not yet embedded at the service.

Inadequate

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 our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection, poor governance had meant that unsafe care was not recognised and rectified. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last inspection, we reported that care plans did not give enough guidance to staff. At this inspection, only one care plan had been fully updated by the new manager. There was a provider level failure to ensure prompt action had been taken to improve all care plan guidance for staff.
- At the last inspection, we highlighted potential fire and legionella risks with the environment. At this inspection, we found these risks were ongoing (as reported in the Safe section- above). A provider audit had recognised that environmental checks needed doing; however, there was no evidence that these checks were then completed and recorded. We were told that these checks were assigned to a new staff member who had not yet been recruited. There was a failure to ensure that these checks were completed while this new staff member was being employed.
- At the last inspection, we sent the provider warning notices because of the breaches of regulation. These notices explained areas that needed improvements and required the provider to make improvements by April 2022. We saw limited evidence that action was taken until the new manager started in May 2022. The actions taken by the new manager had not resolved the ongoing breaches listed in this report. There has been a provider level failure to act on concerns at the service in a timely way.
- While the new manager had begun to make changes to the service, their positive actions had not yet been fully embedded. For example, they had put in place records to assess how much people were drinking. They had not yet had chance to audit these records and recognise the hydration concerns that we found (reported in the Effective section - above).
- There has been a lack of effective provider engagement to improve the service. The improvements seen within the service were mostly due to a newly recruited manager. The reliance on a single manager is not a sustainable way to improve a service. As improvements will be impacted if they are away from the service. It also will not allow ongoing timely improvements to be made. The provider told us that they will consider changes to the management team to ensure improvements continue to be made in a timely way.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people
● People did not always have good outcomes. People still had restrictive routines that had not been subject to a mental capacity assessment. We had raised this concern at the previous inspection, but limited action had been taken.
● Staff spoke highly of the new manager and the impact on the atmosphere within the home. One staff member told us that staff were very reliant on the manager, they said "I don't think we'd still be open, everyone would have left without them." The culture of the service had improved with the new manager but was not yet embedded.
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; Continuous learning and improving care
● The last inspection highlighted multiple concerns with the service. The provider had failed to ensure action was taken when things went wrong at the last inspection.
● There was no action plan in place, to clearly guide improvements at the service. We therefore could not be assured that the provider's management team had clear oversight of when improvements would be made and by whom.
● Audits that had been completed did not clearly identify what was wrong with documents that had been audited. Vague audits can impact the effectiveness of improvements at the service.
● Minutes from meetings showed staff and people had been informed of the previous inspection findings. This meant the duty of candor had been met.

There was a failure to ensure improvements were made at the service. This was an ongoing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were engaged with day to day decisions about their routines. However, regular reviews about their care plans did not occur. No satisfaction surveys had been completed with people. This risks people not being able to feedback fully about the care provided.
● People's diverse needs had not been considered in care plan documents. For example, people's religious and sexual preferences had not been recorded to guide staff.

Working in partnership with others
● Since the last inspection, the local authority provided guidance on how to write positive behavioural support plans. Despite this external advice, staff still did not have care plan guidance for how to support all people's needs in this area.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure staff had suitable care plan guidance to support safe care. Systems were not in place to ensure people lived in a safe environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment processes were not in place to ensure staff were of good character

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 11 HSCA RA Regulations 2014 Need for consent Systems had not been put in place to investigate and improve the closed culture of reporting concerns. Safeguarding incidents had not been responded to appropriately. This is a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We have imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been put in place to investigate and improve the closed culture of reporting concerns. Safeguarding incidents had not been responded to appropriately. This is a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure improvements were made at the service. This was an ongoing breach of Regulation 17 (Good Governance) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed conditions on the provider's registration