Mauricare Limited

Dallington House Care Home

Inspection report

228 Leicester Road
Enderby
Leicester
Leicestershire
LE19 2BF

Date of inspection visit:
29 September 2016
03 October 2016

Date of publication:
01 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced comprehensive inspection that took place on 29 September and 3 October 2016 and was unannounced on the first day. We returned announced on the second day of inspection. At the last inspection completed on 24 June 2015, we found the provider had not met the regulations for people's safety and good governance. At this inspection we found the provider had not made the required improvements and the regulations were still breeched. We also found a breach of the Health & Social Care Act 2008 Regulated Activities Regulations 2014 with regards to safe recruitment of staff.

Dallington House provides accommodation for older people who require personal care and support. Some people who used the service lived with dementia or similar conditions. There were 14 people that used the service at the time of our inspection.

The service had a registered manager. 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.

People felt safe at Dallington House. Staff had a good understanding of their responsibilities and knew the provider's procedure to keep people safe from harm and abuse. There were enough staff on duty to meet people's needs.

The provider did not always complete relevant pre-employment checks which would have assured them that staff were safe to work with people.

Staff did not consistently assess and manage identified risks associated with people's care needs to ensure that they received care in a safe manner.

The provider did not have safe practice for the management of people's medicines. They did not have skills and protocols in place to check the people received their medicines in a safe manner. This meant that they could not be assured that people received their medicines as prescribed by their doctor.

People felt that staff had the relevant skills and experience to support them. Staff told us that the registered manager had ensured that they received the training they required. The registered manager had plans in place to improve the training available to staff. Staff demonstrated they understood the requirement of Mental Capacity Act (MCA) 2005 and how they would apply them in their role.

People had access to a variety of meals, but they did not always enjoy their meals. Staff did not always support people with their health needs. They did not always refer them to health professionals for the support they required.

Staff treated people with kindness and compassion. People felt that staff respected their dignity and privacy and promoted their independence where possible. We observed that staff practice did not always promote people's dignity and privacy.

People who did not have dementia or similar conditions did not feel that the provider supported them to avoid social isolation. This was because they did not access to meaningful activities. People knew how to raise concerns or complaints and were confident that their concerns would be dealt with.

People complimented the registered manager and were happy with the way the home was managed. Staff felt supported by the registered manager and were confident that they would improve the service.

The provider quality assurance processes included a limited range of audits. We saw that their audits and checks were not completed regularly. We found that the provider had not made the improvement they told us they would at their previous inspection.

You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider did not always ensure that they had plans in place to safely manage the risks associated with people's care. Staff did not follow safe practices when they supported people with their medicines.

The provider did not complete relevant pre-employment checks to ensure that staff were suited and safe to deliver care to people that used the service.

People felt safe at Dallington House. Staff knew what actions to take to protect people from avoidable harm and abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not have the skills and guidance to support people with their behavioural needs.

People did not always have the support they required to manage their health conditions and wellbeing. Staff did not consistently refer them for support from health professionals.

Staff demonstrated a good understanding of the requirements of the Mental Capacity Act (MCA) 2005 .

Is the service caring?

Requires Improvement

The service was not consistently caring.

People felt respected and that staff treated them with dignity and respect. We observed that staff practice did not always show that they respected people's right to receive dignified care.

Staff supported people to be as independent as they chose to be.

People's friends and family could visit them without restriction.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans did not consistently reflect their individual needs.

Some people were socially isolated. They did not have access to meaningful activities that suited their needs.

People and their relatives knew how to raise any concerns or complaints and were confident that the provider would respond to them.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had a limited range of audits and checks to monitor the quality of the service. Their current audits were not regularly completed and recorded.

The provider had not made the changes stated in their action plan regarding the issues identified in their previous CQC inspection.

Staff felt supported by the registered manager.

Dallington House Care Home

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 checked 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 29 September and 3 October 2016 and was unannounced on the first day. We returned announced on the second day of inspection. The inspection team consisted of an inspector and an expert by experience (ExE). An ExE is a person who has personal experience of using this type of service or caring for someone who uses this type of service.

Before our inspection visit we reviewed information we held about the service. This included previous inspection reports, and notifications sent to us by the provider. Notifications tell us about important events which the service is required to tell us by law. We also reviewed the Provider Information Return (PIR). This is a form completed by the provider, where the provider gives key information about the service, what the service does well and improvements they plan to make.

We spoke with four people who used the service, relatives of three people who used the service, a care assistant, a senior care assistant, the registered manager and the provider. We looked at the care records of four people who used the service, medication records of four people, staff training records, four staff recruitment files and records associated with the provider's monitoring of the quality of the service. We observed staff and people's interactions, and how staff supported people. From our observations we could determine how staff interacted with people who use the service, and how people responded to the interactions. This was so that we could understand people's experiences.

Requires Improvement

Is the service safe?

Our findings

At our last inspection carried out on 19 and 24 June 2015 we found that the provider did not ensure that risks associated with people's care were managed safely. These matters were a breach of Regulation 12 (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had not made the required improvements.
Staff completed risks assessments for the support people required. However, we saw that this was not consistently done. Where staff had identified that people could be at risk and required additional support, staff did not always have guidance on how to support those needs. Where risks assessments had been completed, these were not regularly reviewed to ensure that they reflected people's currents needs and supported staff to provide support in a safe way that minimized such risks. For example, one person had a surgical procedure that had been identified to increase their risk of falls and their records did not include a detailed assessment of how staff would support them to minimize this risk. Another person needed further support with managing their health condition; we saw that a risk assessment was completed; however this was not reviewed regularly. This meant that people did not have the support that they required to receive care in a safe manner.
The provider had plans in plans for reporting incidents and accidents that occurred. We saw that the registered manager had investigated a recent incident that occurred and had notified relevant agencies including the CQC and the police. However, we saw that there were no clear action taken by staff to minimize the risk of incidents or accidents reoccurring such as reviewing and updating people care plans.

The issues showed a continued breech of Regulation 12 (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

We found that the provider did not have safe recruitment practices. They did not complete relevant pre-employment checks which ensured new staff were safe and as far as possible were suited to supporting the people who use the service. The provider did not always ensure that the relevant level of a Disclosure and Barring Service (DBS) check was completed for new employees. This meant that the provider could not be assured that before staff commenced their employment that they were suitable to work with vulnerable adults. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. The registered manager showed that some of the checks had been completed by the second day of our inspection.

This constitute a breech of Regulation 19 (1) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

At our last inspection carried out on 19 and 24 June 2015 we found that the provider did not ensure that people's medicines were managed safely. These matters were a breach of Regulation 12 (1) (2) (b) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had not made the required improvements.

People did not always receive their medicines as prescribed by their doctor. We received mixed reviews from people about the support that they received from staff to have their medicines. One person told us, "The seniors are responsible for dishing out medication. Occasionally they slip up and I tell them and it's quickly sorted." Another person said, "The medication is there and they just sort it out." Other comments included, "If I run out of anything they call up the chemist." We reviewed people's Medicines Administration Records (MARS), and saw that these were not always completed to show that staff administered people's medicines. This included gaps in recording whether people who required controlled drugs had received them. Controlled drugs are medicines controlled under the misuse of drugs legislation. We brought this to the attention of the registered manager who could not offer assurances that people's medicines had been administered. They told us that they were due to complete a medicines management course in the following week which would help them support staff better with administering and managing medicines.

We also saw that staff did not follow current guideline in storing medicines. They did not always complete records of storage temperatures of medicines to ensure that people's medicines were stored safely. When records showed that the temperature had vastly exceeded the recommended maximum range, there was no evidence of the action staff took to ensure that medicines remained safe for people. Where people had been deemed able to administer their own medicines, the provider did not have guidance to support people and staff with this. Risk assessments relating to people administering their own medicines had not been reviewed at the time of our inspection. We also saw that where people required medicines that should be taken under precise instructions to be effective, there was no guidance to support staff with this. This meant the person was at risk of receiving medicine which would be ineffective and cause irritation to their throat. We asked the registered manager for their medicines policy. We did not receive this.

This constitute a breech of Regulation 12 (g) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.
People told us that they felt safe at Dallington House. One person told us, "I don't have any worries about anything here really. I've only had one fall since I've been here." This person told us they were prone to falls and had several falls before they came to live at Dallington House. A relative told us that they were confident that their loved one was safe because, "There's always somebody about. They come in and check on [person]." People told us that they felt safe because they were confident to raise any concerns that they may have about their own welfare with staff and particularly the registered manager. One person said, "I think so, everybody is different in the way they work, their attitude and behaviour; you have to contend with that. [Staff name] is always available and [staff name] is exceptionally good, she'll always find times to talk to you."

Staff demonstrated that they understood their responsibilities to keep people safe from avoidable harm and abuse. They understood the provider's protocols of reporting incidents and accidents. They were aware of other agencies where they could raise any safeguarding concerns such as the local safeguarding authority and the Care Quality Commission (CQC). One care staff told us, "I usually go straight to my senior or [registered manager]. I have no qualms of whistle blowing. I will stand and be accountable to it." Another care staff told us of a recent incident that happened at the service. They said, "I rang [registered manager], she did everything I would have done. She is proactive like that." We saw records which showed that the registered manager had notified relevant authorities of the incident.

The premises was not maintained to meet people's needs in a safe manner. For example, we saw that there were areas in the home and people's bedrooms where the floor covering was torn, uneven or worn. This posed a risk of falls especially for people who may require support with their mobility needs. We saw that the mattress in one's bedroom was very sunken. We brought these issues to the attention of the registered manager who told us that they would raise these issues with the provider. The mattress was changed before

the end of our visit.

During our visit we saw that some areas in the home were littered and needed vacuuming. The registered manager told us that the cleaner was off on sudden absence and that they were in the process of recruiting a new cleaner. They told us that staff took turns to complete cleaning duties around the home until a cleaner was recruited. One person told us, "We haven't got a cleaner, the staff do it as they go round." They told us that their room had not been cleaned since the previous week. A care staff told us that they also completed cleaning duties and knew that the registered manager was in the process of recruiting a new cleaner.

People's records included a personal emergency evacuation plan in place to detail how much support that they required in the event of an emergency. We ask the registered manager for their business continuity plans or policy on how they would continue to provide service to people in the event of any emergency. We did not receive this.

There was sufficient numbers of staff on duty to support people. People told us that staff were readily available to them when they needed their support. One person told us, "Every time I push the bell, it all depends really. They did come quick earlier, It depends on how many people are on, but usually." Another person told us, "'I've only pulled it once… They [staff] were up within a couple of minutes." Care staff said there were enough staff to allow them meet people's needs. One care staff told us, "Yes, there's enough staff – there's enough on my shifts anyway. Where any further staff needed like cleaning [registered manager] is onto it." Another care staff told us, "There's enough staff." She told us that the provider did not use agency staff to cover any staff absences. They said, "Because of how good [registered manager] is to us, we cover absences. It goes both ways."

Requires Improvement

Is the service effective?

Our findings

People told us that they felt staff had the relevant skills and experience required to support them with their needs. People felt that some staff were more skilled than other. Staff felt that they had relevant training and support to fulfil their roles and responsibility. One care staff told us, "[Registered manager]'s got us on so much training." Another care staff told us, "It wasn't that great when I first started but since [registered manager]'s been here it's been training, training, training. If you need any additional training she'll put you straight on." Staff records did not consistently show that they had received training that they required to fulfil their role. After our inspection, the registered manager sent us evidence that they had arranged for staff to complete relevant training.

Staff did not always have the skills and support to communicate and meet the needs of people that may behave in a way that may challenge others. For example, we reviewed the records of one person who had lived in the service for several years. We saw that the commissioning authority's assessment had identified that they may behave in a way that may challenge and put the person and staff at risks. The provider had not regularly reviewed their risk assessment regarding this or provided guidance to support staff to communicate and provide the support that they needed. We saw that there had been a recent incident at the service relating to this person's behaviour.

People told us that staff supported them to access health care services when required. One person told us, "If you require a doctor they're on the ball as far as that goes." People's records showed that staff supported them to access their doctors when needed. However we saw that where staff had identified that people required support with some aspects of their health and wellbeing, they did not refer them to health care professionals or support them with meeting those needs. For example, one person's records showed that staff had identified a person needed support with managing their nutrition and weight. This person also had a health condition that could increase risks to their health due to poor nutrition. Staff were not able to tell us how this person was supported with managing their weight. They also did not show that they referred them to any other service or professional for support.

This constitute a breach of Regulation 12 (i) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

We received a mixed response from people when we asked them about their meals. One person told us, "It's varied, most of it's quite good." Other responses included, "Depends who's cooking." "Sometimes it's good. As for the puddings, yuk. Cake and custard, yuk. And I had pears and jelly the jelly was like water." And "We were talking about menus today, you just have to say what you fancy and she'll do her best to get it." Some people felt there was enough in terms of quantity and variety of food, other people did not think that this was the case. One person told us, "We are told we can have whatever we want to breakfast. You get a choice at lunchtime. Teatime is a bit iffy; most residents have a sandwich, that's not enough for me so I have baked beans on toast or a salad. Sometimes they run out of stuff so that's a bit iffy, you could end up with a lettuce and cucumber and no tomato and beetroot and no egg." Another person said, "If I'm hungry at night I ask for a slice of toast or biscuit and they bring it."

We observed lunch time the support that people received. People received a choice of hot meals and could change their mind about the choice they had originally made. Staff were available to offer support where required. For example, supporting people to cut up their food into small portions and ensuring that people were positioned comfortably. We saw that one person sat separately, staff told us that this was the person's wish.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 so that they can 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 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 were being met. One person was deprived of their liberty. This was done lawfully because the provider had received the required DoLS authorisation from the local authority. Staff we spoke with demonstrated a good understanding of MCA and DoLS. They gave us examples of how they ensured that they complied with MCA when they supported people such gaining people's consent before they support them. We observed that they sought people's consent before they provided care and support.

Requires Improvement

Is the service caring?

Our findings

People told us that staff treated them with dignity and respect. When we asked people if staff promoted their dignity, they replied, "Oh yes, always." Another person told us, "Oh yes. This is my home, my room, and they know that." They told us that staff respected their privacy when they needed it. One person told us, "They don't interfere. If I wanted to stay in bed all day I'm sure I could and they'd bring my food in for me." However, during our observations we saw several instances where staff did not show that they had considered people's dignity especially when supporting people with their personal hygiene. For example, we observed a care staff was not discreet when they asked a person whether they needed support with their personal hygiene. They also loudly announce to another care staff about the support that this person required. We observed another member of staff shout across the room that there were going to support a person with their personal hygiene. These incidents showed that the care staff involved had not respected or considered the dignity of the people involved nor the other people who were present in the lounge at the time.

People complimented the caring attitudes of staff. They told us that staff were kind to them. One person told us, "They're lovely staff. They're happy staff. You can see that and it makes a difference." Another person said, "Oh yes, they're quite easy to speak to, you can bring up any topic you like." Other comments included, "They can't do enough for you." And "Here it's down to earth staff, they're carers and the care is what you want." However they felt that some staff were more caring than others. One person said, "[staff name] is the best of the lot, [staff name] was very good. [staff name]'s very calm, some of them get a bit het up but she's very calm." Another person told us, "I quite like living here; it all depends who's on. I get on with most of the staff."

We spent time observing the way staff supported people. We saw that they were knowledgeable about people's likes and dislikes. Staff demonstrated an interest in the people that they support. They were kind in their approach. One care staff told us, "I've been here a long time [for 14 hours] and it doesn't feel like it. If feels like family."

Staff supported people to make decisions about their care and support. Staff we spoke to demonstrated that they supported people to be involved in decisions about their care and make their preference known. Staff told us that they supported people to make choices by giving them "visual clues". We observed this when staff supported people with their meals. We saw that they brought people plated meals in order to help them make a choice from the menu.

People told us that staff supported them to be as independent as possible. One person told us, "They encourage you to do it. They walk with you but are there if you need them." Another person told us, "I do exactly as I want to do, there's no restrictions on anything." Another person commented, "I'm free to go as I please." Their relative went on to say that they required support with their mobility needs and used a mobility scooter independently before they came to live at the home. They said they no longer used this because, "There is nowhere to put a mobility scooter."

People's relatives and friends could visit them without any restrictions. We observed that relatives visited as they wished. We confirmed this from the visitors signing in book.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were involved in developing their care plans. One person told us, "It's not changed that much. If it does change someone tells me. I don't think it's reviewed unless needed."
Another person said, "It was discussed at the infirmary [hospital], they [staff] talked to me." Their relative went on to say, "[staff name] keeps me posted, she updates me. This home is better than the last one [person] was at." People's care plan included varying levels of information; some had detailed information about people's history and support needs and others did not. Information in care plans support staff to provide care that is tailored to each person's needs and preferences. We saw that some care plans had conflicting information about some support that people required. For example information on one person's 'emergency grab sheet' which they used to share information with health professionals should they require a hospital admission was different to information on other records in their care plan. We brought this to the attention of the registered manager who told us that they were in the process of auditing care plans and would address this issue.

People's bedroom were personalised. Their bedroom were decorated with their personal belongings. Some bedrooms appeared to require decoration due to wear and tear. The registered manager told us that for some people the décor in their bedroom was due to their personal choice. One person who had lived in the service for several years had their own key to their bedroom. The registered manager told us that this person saw their bedroom door as the entrance door into their own home.

We received mixed responses from people regarding how staff support to them to avoid social isolation. People told us that the activities staff offered were not suitable for every person at the service especially for people who were not living with dementia or similar conditions. One person said, "It's a bit daunting when you've got all your marbles, which some [people] haven't." They went on to say that they found it upsetting living with people who had dementia and did not feel that staff catered for their own needs. Another person told us, The majority of the time I'm fine, I sometimes think, 'What am I doing here?' when I look at the others." Another person told us, "I don't really like looking at [other people]. They're always falling out. I spend a bit of time on my own." Other comments included, "Have you seen the quality of the paintings they do? Not a good quality, I wouldn't want to." A relative told us, "[Person] does a lot of colouring and watches TV. She used to do puzzles but she doesn't do them now. They don't fit on the table. Her other table was bigger but it wouldn't fit in this room."

People also told us that they had limited opportunities to maintain links with the wider community. They told us that the registered manager was working on improving this. They told us that staff also took people out I haven't been out. One person told us, "The manageress hasn't been a manager for very long but apparently they've had a letter about a park near Kettering. She's on about taking a few to see Leicester City, she's a football fan." Another person told us, "They're talking about having some trips out but that's in the future."

During our visit we saw pictures of people during the home's summer fete which they appeared to enjoy. They also a selection of resources such as puzzles, dolls, arts and crafts in the lounge. However, these were

cluttered and not easily accessible to people. The registered manager told us that they had began work to support people with their individual interests. For example, they told us that they were supporting a person who was interested in birds to get a budgie. They said, "He wants a budgie and we're getting him on a Saturday." One person told us, "I was promised all sorts of things when I was thinking about coming here, including working in greenhouse." They went on to say, "They don't have a greenhouse!"

People knew how to raise any concerns or complaints that they may have about their care and support. They told us that they reported concerns to the registered manager or to the care staff who acted on them. One person told us, "I'd talk to [registered manager]; she's alright, you can talk to her. If I didn't get anywhere I'd call up the boss." Another person told us, "Any problems we've had we approached [staff name], [staff name] or [registered manager] and it's been dealt with." Other comments included, "The boss [owner] has been in and said any problems you just contact me." And "I'd soon have a word with the manageress." A relative responded, "We can come to [CQC] with a deeper concern."

People and their relatives told us that the registered manager had recently introduced a residents meeting where they could share any feedback about the service. One person said, "They have residence meetings, plus relatives are invited. At the last meeting, which was the first, because of the condition of some of the residents there was only two there and two relatives. I think they're going to be too monthly."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection carried out on 19 and 24 June 2015 we found that the provider did not have effective systems in place to assess and monitor the service to improve quality and safety. These matters were a breach of Regulation 17 (1) (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. We checked to see if the provider had made the required improvements. We found that they had not. The provider had procedures in place for assessing and monitoring the quality of the service. The provider's quality assurance procedures consisted of a limited range of audits. These included audits of people's care and support and the general maintenance of the building and equipment. They did not check to see that records and practice regarding people's care such as risk assessment and medicines management were safe and met the needs of the people that used the service. The records of checks and audits we reviewed had not been completed regularly. We brought this to the attention of the registered manager who told us that some of the checks not recorded had been completed but had not been transferred into their records. This meant they could not be used to identify where improvements were required or identify if improvements had been made.

The provider did not show that they involved people and their relatives in the development of the service. The registered manager told us that they had sent out questionnaires to people's relatives but had not received any feedback on this. They told us that they would consider ways to be flexible with involving the people that used the service and their relatives to improve the service.

These matters showed a continued breach of Regulation 17 (1) (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

The service had a registered manager. The registered manager had been in their role for six months. It is a condition of registration that the service has a registered manager in order to provide regulated activities to people. The registered manager understood their responsibilities to report events such as accidents and incidents to the Care Quality Commission (CQC). However they did not have knowledge of the issues identified in the home's last CQC inspection and a clear plan of how they would address areas where improvements where required.

The registered manager told us that they had support from the provider to improve the quality of service people received at Dallington House Care Home. They told us the provider had employed a quality assurance manager who would be providing them with support to improve the service. They said this including developing an action plan of how they would make the required improvements including audit tools for reviewing people's care plan and supporting care staff through improved training. They told us that they would start a 'corrective action plan' by the end of October 2016.

People, their relatives and staff told us that the registered manager was open, transparent and easily accessible. We saw that people knew the registered manager and appeared relaxed with them. One person told us, "I can talk to [registered manager], she walks by, she pops in to ask if I'm alright." One care staff told us, "Anytime day or night she's available. I tested out the theory and she was available."

Staff told us that they felt supported by the registered manager to meet the standards they expected of them. They told us that they felt confident that the registered manager would implemented the changes that the service required. One care staff told us, "Since [registered manager]'s been here things have improved. We know what to do. I'll go as far as saying if she left, I would too. There's been vast improvement. . .exciting times!" Another care staff told us, "[Registered manager]'s very supportive. I am not trying to score brownie points but she's good like that. Best manager I've ever had."

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not complete relevant pre-employment checks which ensured new staff were safe to support people using the service and as far as possible were suited to supporting the people who use the service.

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 The provider did not always support people to safely manage risks associated with their care. The provider did not ensure that people's medicines were managed safely. The provider did not always refer people to relevant professional for support with their health and social care needs.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems and checks in place to improve the quality of the service.

The enforcement action we took:

warning notice