Mauricare Limited

Dallington House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced comprehensive inspection that took place on 17 and 19 January 2017 and was unannounced on the first day. We returned announced on the second day of inspection.

At the last inspection completed on 29 September and 3 October 2016, we found the provider had not met the regulations for people's safety, good governance and the safe recruitment of staff. At this inspection we found the provider had not made all the required improvements and the regulations were still breeched. We found a further breach of regulation.

The service had a registered manager who had been away on a long term absence. In their absence the service was managed by an interim 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.

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 11 people that used the service at the time of our inspection.

People did not always feel safe with the staff that support them. They told us that some night staff were not kind and compassionate when they supported them. The provider did not have systems in place to report and investigate incidents that had occurred at the service and did not report incidents to other relevant authorities such as the Care Quality Commission or the local safeguarding authority.

Staff did not consistently follow the provider's protocols to manage people's medicines. Medicines audits were not completed in line with the provider's guidance which meant that the provider could not be assured that people's medicines were managed safely.

The provider did not always assess the risks associated with people's care. Where risks had been identified, they did not manage them to ensure that people received safe care. This included where people may behave in a way that may challenge others.

People were not supported in accordance with relevant legislation and guidance. Staff demonstrated a limited understanding of the Mental Capacity Act 2015. Where people were deprived of their liberty, staff did not adhere to the conditions stated on their Deprivation of Liberty authorisation to ensure that any restrictions were lawful.

People were supported to access their doctor when needed. However, we saw that staff did not refer people to other health professionals where there was an identified need for such support.

People were supported with their nutritional needs. They had access to a choice of meals.

People told us that staff who worked the day shift were caring and kind to them. They told us that staff treated them with dignity and respected their privacy. We found the people's information was not always managed confidentially.

People were socially isolated. They were not supported to engage in meaningful activities. They were not supported to maintain links with their local community.

The provider did not maintain oversight of the service to ensure that people received a high standard of care. The service lacked good leadership to make the required improvements. The provider did not use their own systems to monitor the quality of the service. They did not ensure that they made the improvement to satisfy the relevant regulations.

The provider continued to breach of two regulations of the Health & Social Care Act 2008 Regulated Activities Regulations 2014 and was in breach of one regulation of the Care Quality Commission (Registration) Regulations 2009.

We have taken enforcement action against the provider, the details of our enforcement is at the end of the main report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's 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.

We will continue to monitor the service whilst the condition on their registration is in place, that is to prevent any admissions to the service without the prior written agreement of the Care Quality Commission.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always feel safe with the way night staff supported them.

The provider did not investigate incidents and did not have systems in place to mitigate risks associated with people's care including where people may behave in a way that could challenge others.

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 managed people's medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

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.

People were not supported according to relevant guidance and authorisation. Staff demonstrated a limited understanding of the requirements of the Mental Capacity Act (MCA) 2005 .

People were supported with their nutritional needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's private information was not always managed in a confidential manner.

People felt that staff respected their privacy and promoted their dignity.

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

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

They did not have access to meaningful activities that met their needs.

People had opportunities to provide their feedback about the service. They did not always think that the provided acted on their feedback.

People's care records did not always reflect their current needs.

Is the service well-led?

Inadequate

The service was not well - led.

There was a lack of clear leadership and oversight at the service. The provider had not ensured that they improved the quality of the service to comply with relevant regulations.

The staff were not supported to understand the standards expected of them.

The provider did not have sufficient systems in place to monitor the quality of the service. They did not address issues that their system had identified.

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 17 and 19 January 2017 and was unannounced on the first day. We returned announced on the second day of inspection. The inspection team consisted of two inspectors.

Before our inspection visit we reviewed information we held about the service. This included previous inspection reports, and notifications sent to us by or concerning the provider. Notifications tell us about important events which the service is required to tell us by law.

We spoke with three people who used the service, a relative of a person who used the service, two care assistants, two senior care assistant, a visiting GP, a manager from another Mauricare service, the registered manager and the provider. We also had telephone and email contact with the provider's quality assurance manager. We looked at the care records of four people who used the service, medication records of seven people, staff training records, three 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.

Inadequate

Is the service safe?

Our findings

At our previous inspections carried out on 19 and 24 June 2015 and on 29 September and 3 October 2016 and 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.

On 9 November 2016 we issued a warning notice under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requiring the provider to meet their legal obligation in relation to Regulation 12 by 9 December 2016. At this inspection we found that the provider had not made the required improvements to comply with the regulation.

At our last inspection we asked the provider to complete risks assessments to support the safe provision of care for people who staff had identified as having risks associated with their care. We also asked the provider to review people's risks assessments to ensure that they reflected their currents needs. We found that the provider had not completed these for the people whose care records we looked at. For example, people who were identified as being at high risk of falls or of refusing support did not have risk assessments to guide staff on how to provide support. This meant that staff still did not always have the guidance and support that they required to provide care in a safe manner and that people were at risk of receiving unsafe care.

The provider did not have systems in place to report incidents and accidents that occurred at the service. This meant that there were no protocols in place to support people and staff to minimise the reoccurrence of accidents and incidents. We also saw that the provider had not investigated incidents or reported them to other relevant agencies such as the local safeguarding authority and the Care Quality Commission (CQC). This meant that did not take steps to share information and work with relevant agencies to ensure that people received safe care.

The provider did not meet the needs of people who may behave in a way that may challenge others. We reviewed the records of a person who had been identified as behaving in ways that may challenge others. We saw that the deprivation of liberty authorisation the provider received from the local authority required that staff would monitor and record incidents regarding person's behaviour for monitoring purposes to guide staff to support them in a safe manner. We saw that staff did not always complete these records when incidents involving person occurred. We saw one completed record, however this was not dated to allow for monitoring trends and triggers to behaviour and providing appropriate support where required.

These issues, along with other highlighted under the 'Effective' section of this report, constituted a continued breech of Regulation 12 (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

At our previous inspections carried out on 19 and 24 June 2015 and on 29 September and 3 October 2016 and we found that the provider did not ensure that people's medicines were managed safely. These matters

were a breach of Regulation 12 (g) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. On 9 November 2016 we issued a warning notice under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requiring the provider to meet their legal obligation in Relation to Regulation 12 by 9 December 2016. At this inspection we found that the provider had not made the required improvements to comply with the regulation.

The provider had put plans in place to improve their systems so that people were safely supported with their medicines. This included staff completing a daily handover of medicines administration for auditing purposes. On the day of our inspection staff told us that they had not completed this for the past five days. This meant that the provider could not be assured that their systems were consistently followed to ensure that people received their medicines safely and that people could not be sure that they would receive the medicines they needed.

We reviewed people's Medicines Administration Records (MAR), and saw that staff did not always follow the provider's guidelines when they completed records to show they had administered people's medicines. We could not be sure that this had not had adversely affected people. We checked the stock of medicines available at the service which showed that people had received their medicines although this was not consistently recorded.

We saw that staff did not always follow current guidelines when they stored people's medicines. Staff checked the storage temperatures twice daily. However, we saw that the room temperature where medicines were stored was slightly higher than the recommended maximum temperature for the storage of medicines. We also saw that did not staff follow safe practice to store people's liquid medicines. Safe storage practices are essential to ensure that medicines remain safe and effective when people take them. We asked the provider to seek advice from their pharmacist.

This constitutes a continued breech of Regulation 12 (g) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

People did not always feel safe with the staff that support them. People told us that night staff were abrupt when they talked to them and did not take time to listen to their needs. One person told us that night staff disbelieved them and did not support them when they requested support with their needs at night. Care staff we spoke with told us that people told them that some night staff supported them in a manner that was lacking in kindness and compassion. A member of the care staff told us, "Some staff are good, some need more training. Some residents' complaint about staff." They went on to tell us that a person had alleged that night carers had not cared for them safely. Another care staff expressed concerns that some people who used the service were scared of the way the night staff spoke to them. They told us that they reported this to a social worker.

Most of the staff we spoke with told us that they had not received training on safeguarding people from harm and abuse and were not aware of provider's policy on safeguarding people from harm. However, staff were able to demonstrate that they were aware of what would constitute harm or abuse to people. They told us that they would report any concerns that they had about people's safety to the manager. They were also aware that they could report their concerns to the local safeguarding authority or to the CQC. A care staff told us they would, "Report to manager, take it higher. Contact safeguarding."

At our previous inspections on 29 September and 3 October 2016 and we found that the provider did not have safe recruitment practices because they did not complete Disclosure and Barring Service (DBS) checks before new staff commenced their employment. These matters were a breach of Regulation 19 (1) 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 improved. We reviewed staff files which showed that the provider had completed DBS checks and other pre-employment checks.

There were sufficient numbers of staff on duty to meet people's needs. One person told us that they were confident that staff would respond quickly should they use their alarm to request for staff support. During our inspection, we saw that staff were available to support people in the communal areas of the homes.

Requires Improvement

Is the service effective?

Our findings

At our previous inspections carried out on 29 September and 3 October 2016 and we found that the provider did not ensure that referred people to other health care professionals such as a dietician. These matters were a breach of Regulation 12 (i) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. On 9 November 2016 we issued a warning notice under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requiring the provider to meet their legal obligation in Relation to Regulation 12 by 9 December 2016. At this inspection we found that the provider had not made the required improvements to comply with the regulation.

We reviewed the records of a person that staff had identified 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. At our last inspection, the manager told us that they would refer them to a dietician. We found that they had not been referred to a dietician for support with their weight and nutrition.

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

People felt that staff skills depended on the care staff who was supporting them. They felt that some staff were more skilled and experience than their colleagues. One person told us, "[Staff name] is absolutely brilliant, as good as gold. It's the rank structure I'm not sure of. Senior [staff] needs to gain some experience."

Care staff felt that their training was sufficient to guide them to meet people's needs. A recently employed member of staff told us, "I had a tour of the building when I first came. I did a couple of care shifts first to get to know the residents." We reviewed the provider's records of training that staff received and saw that staff required 'refresher' of training courses including Safeguarding training. Staff told us that the provider had arranged for them to complete updates to their training. A care staff member told us, "Lots of training is coming up, there is a long list booked."

We observed staff support people with their mobility needs. They demonstrated the skills to support people effectively using appropriate equipment.

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. Staff we spoke with demonstrated a limited understanding of MCA. They told us that they had not received training on MCA. A care staff told us, "I have done little bits with previous employer." We observed that staff sought people's consent before they supported them. A care staff told us, "We would advise them to the best we could, we couldn't force them."

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. We reviewed the records of a person who was deprived of their liberty. We saw that the provider had received the required authorisation from the local authority. However, we saw that they had not complied with the conditions stated on the authorisation which included ensuring that the person's risks assessments were completed and reviewed regularly and that their behaviour was monitored and recorded. We saw that the person's representative had reminded staff to comply with the condition. However these were not completed to comply with the authorisation. We saw that the person's risk assessments were last reviewed in August and September 2015. This meant that the provider had not followed guidance to ensure that the deprivation was done in a lawful way.

People were supported to eat and drink. Some people told us that they liked their meals. Other people did not agree. For example, one person told us, "I think [food] quite good - very very good [staff name] was a senior carer, is a qualified chef and is a brilliant cook.!" They told us that there had been improvements by the provider to ensure that they had sufficient stock of their preferred foods. Another person said, "Food is terrible. The cook does her best with what she's got available. I would like sandwiches occasionally- you don't want it thrown at you all the time."

We observed the support that people received during lunch time. We saw that people were offered a choice of hot meals. Condiments were made available when people requested them. Staff were available to support people with their meal where this was required.

People were supported to access their doctor. Staff promptly referred people to their doctors when required. During our inspection, we spoke with a visiting GP who told us that staff had promptly referred a person to the surgery when they noted a change in the health.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff who worked the day shift were kind to them. They told us that the caring attitudes were not always consistent with the staff that worked during the night. A relative told us that they noted caring interactions from staff whenever they visited the service.

Staff knew the needs and preferences of the people they support. A visiting health professional told us, "Staff seemed to be aware of the two residents [visited] and their care needs." We observed staff handover between shifts. We found that the information shared was detailed regarding people's physical and emotional needs, their health care appointments, any changes to their need and support people required.

We observed the care people received in communal areas within the home. We saw that staff were kind in their approach and supported people at their own pace. Staff showed an individual interest in people and spoke to them in a kind manner and at each person's eye level. A care staff told us, "We have to take the time to care for them. We are like their family. I'm here because I care about them."

Care staff thought that people were looked after well. We saw that when they supported people with their medicines used their knowledge of people to support them accordingly. For example, they knew that one person preferred to take their medication from a tea spoon and this was supported. A staff member told us, "People are well looked after. The carers do a [good] job, everything they do they do good. I would definitely have them here [own family member]. It's a small home, staff have more time for people." Another care staff told us, "It's nice it's a small homely environment. Residents get one to one time. It's nice to sit down and chat with them."

People told us that staff treated them with dignity. They told us that staff respected their privacy. One person told us that staff recognise and treated their bedroom as their private space. Staff gave us examples of how they promoted people's dignity and privacy. A care staff told us, "When I go into a person's room I knock and say 'good morning'." During personal care, I give dignity; encourage them to do what they can. This is their home. You can't rush people. I give privacy, cover them."

We saw that the provider did not take ensure that people's information was managed securely and confidentially. We saw that people's private correspondence was stored on a table in the lounge. Staff were unable to tell how long these had been left on the table. We found the among these was a letter addressed to a person who had recently moved out of the home. This meant that there was a risk that people did not receive important personal information, and increased the chances of unauthorised access to people private information. We brought this to the attention of the visiting manager who told us that the practice we observed was not in line with the provider's procedures and arranged for letters to be stored in the manager's office. We also observed that staff handover was completed in a communal area with confidential information about people being shared to the hearing of other people who used the service.

People's friends and family could visit them without restriction. During our visit, we saw that people received visitors. One person told us, "No restrictions at all. My family and mates take me out."

Requires Improvement

Is the service responsive?

Our findings

People were not supported to follow their interests and engage in meaningful activities. One person responded, "No activities in here." Another person told us, "We had an activities co-ordinator; they didn't spend a lot of time with me but more with the people in the lounge. I got a couple of games of dominoes a week. In the summer I sit in the sun." Staff told us that the activities coordinator had left the service, and the care staff now supported people with activities when possible. A relative told us, "They had a play specialist before. No activities have happened since, which is a shame. Trips out would be nice. It was nice for them to have activities."

People had limited opportunities to maintain links with the wider community. One person told us that they would like to see links and interactions between people who lived at the home and the local community. They said, "I would l like more community involvement – visit from local 'copper', vicar or a priest. Where's the open day? There's no need for a show - just chatting, have a sing song."

At our last inspection we saw that people's care plans were not consistently completed to reflect their needs and preference. At this inspection, we saw that the provider had made improvements to people's care plans. However, they had not always completed the relevant assessments to ensure that the care plans reflected people's current needs and preferences.

At our last inspection we saw that some bedrooms appeared to require decoration due to wear and tear. At this inspection we saw that improvements had been made to improve the décor of bedrooms where required. We saw that the provider had changed flooring in a bedroom and cleared clutter from the bathroom and lounge areas. People's bedrooms were personalised to the individual preference. One person told us, "I'm quite happy. I brought bits and pieces in from my home. Do what you like they say, it's your home. I keep the door open. People are always welcome." "It satisfies my needs."

People had opportunities to give feedback about the service they received. They did this through residents meetings. People were not always confident that they provider acted on their feedback. One person told us, "We had a residents meeting at the end of November. We have another one at the end of January. At the last meeting there were promises." They went on to tell us that the provider had not acted on the promises they made. Another person told us that they had requested for a shelf to be installed in their room. They told for they had been asking for this for the past 12 months and that this had not been completed. We reviewed records of the relatives' meeting in November 2016 and saw that the manager and provider attended the meeting. People told us that they were not provided with the minutes of the meeting.

Another way that people gave their views about the service was through questionnaires and surveys. We saw that people's responses to the recent survey showed that people were mostly satisfied with the service they received. However they noted that improvements were required with regard to the activities available to people. A relative told us that they were satisfied with the support and care their loved one received.

Inadequate

Is the service well-led?

Our findings

At our previous inspections carried out on 19 and 24 June 2015 and on 29 September and 3 October 2016 and 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) (b) (c) (d) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

On 9 November 2016 we issued a warning notice under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requiring the provider to meet their legal obligation in Relation to Regulation 17 by 9 December 2016. At this inspection we found that the provider had made some improvement. However, these were not sufficient to show a compliance with the regulation.

The provider had introduced a range of audits which included environmental audits and medicines audits. We found that the audits were not used effectively or used as a tool to improve the service. Where audits identified actions which were required to keep people safe action had not been taken. For example an audit had identified that a wardrobe needed to be secured to the wall to help prevent it falling on people using the service. It had not been secured and remained a risk to people's safety.. Other audits were not being carried out. For example medicines audits should have been completely weekly to ensure that staff managed medicines safely. We saw that this audit was completed only for one week in December 2016. We also saw that checks such as water temperature checks had not been completed since October 2016. This meant that people may have been at risks of burns or legionella. The provider was not clear on how the audits would be used to improve the quality of the service and ensure that people received a good standard of care.

The provider showed us the manager's action plan which stated that actions had been taken to address the warning notices and that they had become complaint with the regulations for over a one month period. However, the provider was not able to show us evidence in line with their action plan to show that they had implemented the changes as stated.

The provider told us that they employed a quality assurance manager to support them to improve the quality of care at Dallington House and other homes owned by the provider. We had a telephone discussion with the quality assurance manager as part of this inspection. They informed us about the extent of their role which included a monthly visit to the home and an advisory role on quality and compliance with the relevant legislation and regulation. They also sent us evidence of their involvement with the service which include minutes of their meeting with the manager and provider and documentation of their support to the home. Records showed that they had identified some of the issues noted on our visit. However, the provider did not take action to address the issues.

The provider told us that they believed that the changes had been made by the manager but did not check to confirm this themselves. This showed a lack of oversight, clear leadership and good governance at the service.

These issues showed a continued breach of Regulation 17 (1) (2) (a) (b) (c) (d) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014 and a breach of Regulation 17 (2) (e) (f).

People were not confident in the leadership of the service. One person told us, "It's not very good at the moment. Its deteriorated since I've been here, with [previous manager] it ran like oiled silk, now we have [manager] it's early days yet."

People told us that they did not find it easy to approach the manager when needed. One person told us, "I never see him. He never comes in to ask if I am ok, or what do you want? Another person told us, "I'm not impressed with [manager] he is unapproachable." They went on to tell us that they had requested to time to speak to the manager and they were not given an opportunity to do so. This person however felt they could approach the provider when available.

Some staff felt that they could approach the manager for support, other did not. A care staff told us, "I like the manager he is nice but doesn't do things straight away. You have to chase him for things. The manager always seems to be very busy. I ring him, if I can't get hold of him I get hold of [another Mauricare service], there is always somebody." Another staff told us, "If I need him he is always there to help me. He tells me how I'm doing. Even at the weekend I can ring for advice." Other comments included, "The manager has a bad attitude, which is not good."

Following this inspection, the provider informed us that the registered manager of the service who was away on long term leave had returned and would take responsibility of the management of the home. 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.

The service did not have an open and transparent culture. Staff were not involved in the development and improvement of the service. A care staff member told us, "We have not yet had a staff meeting, one is due this month. They need to call a meeting with all the staff and sort things out. I think if they give us a chance we will turn things around." A senior care staff told us, "Senior meeting took place recently - discussed paperwork, daily reports, care plans; first one since I've been here. We've not had a staff meeting. Our manager is new as well." We saw records which showed that there was a staff meeting following our inspection in October 2016. However, this meeting records did not show that information was shared to involve staff in the improvements required at the service.

Staff were not clear of the expectations required of them. They told us that they were not informed of the impact and importance of some of the tasks required of them. A care staff told us, "It is not always clear on what is expected, different people expecting different things." Another staff said, "There is an awful lot of paperwork at the moment. It all takes time. A lot of repetitive paperwork, I don't see the point." Other comments included, "[Manager] is always given the seniors paperwork. The most important thing is the residents. They should be clean and safe. We have to take our time to do things for them, not spending all the time doing paperwork."

Staff told us that there was a culture of team work was lacking. A care staff told us, "If we work as a team we make the residents happy. If they sort the staff out this is a lovely place to work." A person who used the service told us, "Generally the relationship between the carers and things are not as smooth as they appear to be. You want the carers to sing off the same song sheet."

Following our inspection on 29 September and 3 October 2016, the provider employed a new manager. The manager was not available at this inspection due to temporary absence. The manager did not understand their responsibilities to report events such as accidents and incidents to the Care Quality Commission (CQC). We found that that relevant incidents had not reported to CQC as required including that a person was being deprived of their liberty. These notifications are an important safeguard for people using services and failure to notify CQC denies people and important level of oversight and protection.

This was a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider failed to notify CQC of notifiable incidents.18 (2) (b) (e).

The enforcement action we took:

We placed a condition on the registration to prevent any admissions to the service without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider continued to fail to: * assess people's risks and do all that was reasonable to mitigate these risks. (12 (2) (a) * ensure the proper and safe management of medicines 12 (2) (g) * ensure that people were referred to health professionals when required. 12 (2) (i).

The enforcement action we took:

We placed a condition on the registration to prevent any admissions to the service without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider continued to fail to have effective systems in place to assess and monitor the service to improve quality and safety. 17 (1) (2) (a) (b) (c) (d).

The enforcement action we took:

We placed a condition on the registration to prevent any admissions to the service without the prior written agreement of the Care Quality Commission.