Vijay Enterprises Limited

Tolverth House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Tolverth house provides care for primarily older people, some of whom have a form of dementia. The home can accommodate up to a maximum of 14 people. On the day of the inspection 13 people were living at the service. Some of the people at the time of our inspection had physical health needs and some mental frailty due to a diagnosis of dementia.

We carried out this unannounced inspection of Tolverth House on the 23 and 29 September 2015.

The service is required to have a registered manager and at the time of our inspection there was no registered manager in post. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run. However a registered manager application was being submitted to us.

A person told us "Staff are busy but if you need them they come." Relatives echoed this view commenting staff were always available if they had any queries at any time. Throughout the inspection we saw staff responded to people when they called for assistance.

Staff told us they felt for the majority of the day there was enough staff on duty. They identified that the morning

Summary of findings

times were busier as they were supporting people to get up. In addition care staff along with night staff prepared breakfasts and therefore this placed additional pressures on them. We saw people's care needs were being met during our inspection. However we also observed times in the lounge area where no staff presence was available for some time. Staff worked long shifts and the possible impact if staff were tired could have a negative impact on people's care needs being met in a safe manner.
The manager acknowledged staffing levels could be stretched and that at particular times of the day additional care staff would be beneficial. Commenting "Ideally we want three care staff on shift, either a morning or twilight shift."

The manager was included on the service rota two days a week to provide support to people who used the service. If the service was short staffed at short notice, i.e. sickness, then the registered manager would cover the shifts. The manager acknowledged that this had impacted on the amount of time she had to complete management responsibilities. This inspection demonstrated, as can be seen in the sections of safe, effective, responsive and well led that whilst peoples care needs were being met, there were issues in respect of the systems and processes within the service.

The manager was not able to show us any recruitment records or records relating to the person having any induction or supervision. Training in accordance with the requirements of the care certificate had not been provided. It was not clear the service had completed all necessary employment checks to ensure suitable people were employed to work with vulnerable adults.

The manager was not able to confirm what training staff had completed or was booked to attend. Therefore we were unable to clarify what training staff had undertaken.

From reviewing peoples care plans we found that one person did not have a care plan and that the other care plans were not up to date. This meant people's care needs had not been assessed formally. Staff had not been given clear strategies in how to provide consistent care to people. We therefore found that care plans did not accurately reflect people's current needs. Vital information for staff to follow to ensure people's safety and welfare was not always recorded in care records.

The manager told us they undertook some quality audits of the home such as gaining peoples feedback on the quality of the food in the service. She was aware that the registered provider undertook some other audits but was not able to produce their report or tell us their findings.

People told us they felt safe living in the service. They told us "I feel safe here." A relative told us "Mum's really settled here, there are no more tears," and "This is the best place for mum, she is cared for well. We can relax now." We saw throughout our visit people approaching staff freely without hesitation and that positive relationships between people and staff had been developed.

People told us "It's lovely here, this is my home", "I'm looked after so well here I don't want to be anywhere else" and "Food is lovely, plenty of it." People told us they had made many friends with other people living at Tolverth House and we saw that friendships had been developed. People were complimentary about the staff telling us they are "Marvellous" "caring" and "lovely". They told us they were completely satisfied with the care provided and the manner in which it was given. Relatives were complimentary about the care provided.

People told us they received their medicines on time. Medicines were stored as per the medicines guidelines. Liaison with health professionals occurred to ensure people's health needs were addressed.

People chose how to spend their day and a wide range of activities were provided. Activities were provided by the service individually and in a group format, such as for arts and crafts and through outside entertainers coming into the service. Relatives told us they were always made welcome and were able to visit at any time.

The manager and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Where people did not have the capacity to make certain decisions the home involved family and relevant professionals to ensure decisions were made in the person's best interests.

We saw staff providing care to people in a calm and sensitive manner and at the person's pace. When staff talked with us about individuals in the service they spoke about them in a caring and compassionate manner. Staff demonstrated a good knowledge of the people they

Summary of findings

supported. Peoples' privacy, dignity and independence were respected by staff**.** We saw many examples of kindness, patience and empathy from staff to people who lived at the service.

We saw the service's complaints procedure which provided people with information on how to make a complaint. People and relatives told us they had no concerns at the time of the inspection and if they had any issues they felt able to address them with the management team.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of the full version of the report.

Summary of findings

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 always safe in that staff recruitment processes were not robust. Staffing levels should ensure that sufficient staff are on duty to keep people safe and meet their needs at all times.

People felt safe living in the home and relatives told us they thought people were safe.

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused

Is the service effective?

Requires improvement

The service was not effective. Staff did not receive appropriate induction and training so they had the up to date skills and knowledge to provide effective care.

The manager and staff had a general understanding of the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People were able to see appropriate health and social care professionals when needed to meet their healthcare needs.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

Staff respected people's wishes and provided care and support in line with their wishes.

Positive relationships had been formed between people and supportive staff.

Is the service responsive?

Requires improvement

The service was not responsive. Some people's needs had not been thoroughly and appropriately assessed. This meant people did not always receive support in the way they needed it.

People had access to activities that met their individual social and emotional needs.

People and their relatives told us they knew how to complain and would be happy to speak with managers if they had any concerns.

Is the service well-led?

Requires improvement

The service was not well-led. The provider had not identified areas of the service that required improvement to ensure the care provided met people's individual needs.

Summary of findings

The service's quality assurance processes were not operated effectively as these systems had failed to identify areas of significant concern.

Staff said they were supported by management and worked together as a team,

Tolverth House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 29 September 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection team consisted of an inspector.

Before visiting the service we reviewed previous inspection reports, the information we held about the service and notifications of incidents. A notification is information about important events which the service is required to send to us by law.

During the inspection we spoke with nine people who were able to express their views of living in the service and a visiting relative. We looked around the premises and observed care practices. We used the Short Observational Framework Inspection (SOFI) over the visit which included observations at meal times and when people were seated in the communal lounge throughout the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with two care staff, catering staff, an activity coordinator, two administrators and the manager. We spoke with the registered provider during and after the inspection by phone. We looked at three records relating to the care of individuals, staff recruitment files, staff duty rosters, staff training records and records relating to the running of the home.

Requires improvement

Is the service safe?

Our findings

A person told us "Staff are busy but if you need them they come." Relatives echoed this view commenting staff were always available if they had any queries at any time. Throughout the inspection we saw staff responded to people when they called for assistance.

Staff felt for the majority of the day there was enough staff on duty. They identified that the morning times were busier as they were supporting people to get up. In addition care staff along with night staff prepared breakfasts and therefore this placed additional pressures on them. The rota for the service showed that two care staff were on duty from 8am to 7pm and two waking night staff from 7pm to 8am. A domestic was employed as were administrators and a cook. The cook prepared the lunches and teas. An activities coordinator was employed for 32 hours a week. On the first day of inspection there were two care staff, a cook, administrator and an activity coordinator on duty. Domestic staff were not on duty and therefore care staff were also having to complete some household tasks as well as caring for people. Staff stated this occurred on occasions and felt they worked well together as a team to ensure that people's needs were met. A care staff member said "If the cleaning doesn't get done it doesn't. It's more important that people are cared for."

We noted that people's care needs were being met during our inspection. However we also observed times in the lounge area where staff were not present for some periods of time. A person needed support from two carers to assist with transfers, this meant that staff at these times were not available to meet the needs of other people in the service. Care staff worked eleven hour shifts and by their own choice they shortened their break as they were aware that people would not have access to them. The duration of the shifts are lengthy and carers need to have breaks so that they have the stamina to continue with their duties for the remainder of the shifts. The possible impact could be that if staff are tired this could have a negative impact on people's care needs being met in a safe manner.

The manager was included on the service rota two days a week to provide support to people who used the service. If the service was short staffed at short notice, i.e. sickness, then the registered manager would also cover those shifts. This had an impact on the manager being able to undertake management responsibilities in the service. The manager acknowledged that staffing levels could be stretched and that at particular times of the day additional care staff would be beneficial. Commenting "Ideally we want three care staff on shift, either a morning or twilight shift." There was a current night care staff vacancy and an advertisement for this post was in process.

Therefore we found that the current staffing levels were not able to meet people's needs safely at all times. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed six staff files. Of these we noted that all had reference to a disclosure and barring check being made to ensure that the staff were safe to work with vulnerable people. However, only two of the files we reviewed included references from previous employers. Staff files did not include application forms and it was not possible for us to check the robustness of the recruitment process from the documentation available. The manager told us that she did not know where the recruitment files were and was unable to produce them for us. This meant that it was not clear that recruitment processes were robust to ensure suitable people were employed to work with vulnerable adults. This contributes to a breach which is referred to in the well led section of this report.

People told us they felt safe living in the service. They told us "I feel safe here." Relatives told us they felt their family member was cared for safely. A relative told us "Mum's really settled here, there are no more tears," and "This is the best place for mum, she is cared for well. We can relax now." People and their relatives were complimentary about how staff approached them in a thoughtful and caring manner. We saw throughout our visit people approaching staff freely without hesitation and that positive relationships between people and staff had been developed.

Staff were aware of the service's safeguarding and whistle blowing policy. This policy encouraged staff to raise any concerns in respect of work practices. Staff said they felt able to use the policy, had received training on safeguarding adults and had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. The manager was aware of and had followed the Local Authority reporting procedure in line with local reporting

Requires improvement

Is the service safe?

arrangements. This showed the service worked openly with other professionals to ensure that safeguarding concerns were recognised, addressed and actions taken to improve the future safety and care of people living at the home.

Staff had worked with other professionals to develop different ways of working so appropriate measures could be put in place to minimise risks to people. Risks were identified and assessments of how any risks could be minimised were recorded. For example, how staff should support people when using equipment, reducing the risks of falls, the use of bed rails and reducing the risk of pressure ulcers. From our conversations with staff it was clear they were knowledgeable about the care needs of people living at the service.

Staff supported people with mobility difficulties. We observed staff competently supporting people as they mobilised around the service. As they supported the person staff spoke to them telling them what they were going to do and ensured the person felt comfortable and safe at all times. Staff had received training in this area of care.

People told us they received their medicines on time. Medicines were stored as per the medicines guidelines. The Medicines Administration Records (MAR), showed that medicines had been administered in accordance with the dispensing instructions. The medicines in stock tallied with those recorded on the MAR. Staff had attended medication training and understood how medicines should be stored, administered, ordered and returned.

If a person requested, the service would hold a small amount of money for them safely. The manager and administrator were the only people who could access the money to help ensure that safe processes were adhered to. The registered provider audited the money monthly to ensure all monies were accounted for. Individual records were kept of all transactions and expenditure so that all monies held were accounted for at all times. We reviewed two people's financial records and found that all income and expenditure was receipted, recorded and tallied correctly with the money held. However, we noted that some people's money exceeded the amount stated in the service policy that the service would be able to keep. This contributed to a breach of the regulations which is described in detail in the well led section of the report.

The manager, staff and relatives had noted that some environmental improvements to the service had been made. New carpets had been purchased and new flooring in the kitchen was to be laid. An on going maintenance plan to ensure that all areas of the service were safe was in place.

Requires improvement

Is the service effective?

Our findings

We reviewed three staff files who had been employed in April/ May 2015. The manager was not able to show us any recruitment records or records relating to these staff having any induction or supervision. The manager was aware of the implementation of the Care Certificate and the new induction guidelines which commenced on the 1 April 2015 with new staff. However this had not commenced.

Staff told us they had not attended "for some time" meetings (called supervision) with their line managers. These meetings provided staff the opportunity to discuss; their current performance, any training needs and ensure staff has sufficient knowledge to meet people's care needs. Annual appraisals of staff performance had also not been completed.

Staff told us they had attended some mandatory training such as safeguarding and fire courses. Staff files however did not record details of the training staff had completed and the services did not have any systems in place to ensure staff training needs were met. When asked the manager was unable to produce any records demonstrating that staff training needs had been met. Therefore we were unable to clarify what training staff had undertaken.

The failure to provide staff with an appropriate induction and regular training represents a breach of Regulation 18) of The Health and Social care Act 2008 (Regulated Activity) Regulations 2014.

People were able to make choices about what they did in their day to day lives. For example, when they went to bed and got up, who they spent time with and where, and what they ate. A person told us, "I'm looked after so well here, I don't want to be anywhere else."

We used our Short Observational Framework for Inspection tool (SOFI) in communal areas during our visit over the lunchtime period. This helped us record how people spent their time, the type of support they received and whether they had positive experiences. People were able to choose where they wanted to eat their meals, and ate in the lounge or in their bedroom. Lunch was leisurely and people enjoyed their food. Some people needed assistance from staff with eating. Staff provided sensitive prompting and encouragement to one person to ensure they ate their meal. Staff checked with people that the food choices were to their liking and offered people regular drinks.

People said the food was "Good." People told us they had chosen what they wanted to eat for their main meal that day. The cook confirmed menus were discussed with people on the day so they chose their main meal and also what they would like for tea. People had discussed with the registered manager and the catering staff their likes and dislikes so they were provided with meals they liked. The catering staff had a good knowledge of people's dietary needs and catered for them appropriately, for example soft and diabetic diets. The cook prepared lunch and tea, brought stock locally, and had an appropriate budget to buy all foods needed. Catering staff had attended relevant training. Care staff prepared breakfasts.

People were complimentary about the staff, stating they were "lovely" and that they were able to meet their care needs. A relative told us they were involved in the admission of their family member to the service. The relative told us during the admission process staff ensured they found out as much information about their family member so that they could get to know them, their likes, dislikes, interests they wanted to know all about their life. This information helped staff to understand each person's individual preferences.

There were no care plans in respect of how to support people with behaviours that may challenge. Staff told us a person at times expressed themselves in ways that challenged them. When asked staff had different ways to respond to the person and therefore the person was not supported in a consistent way by all staff. Staff had not been provided with appropriate guidance on how to support this person when they exhibited behaviours that challenged others. This meant staff had not been given clear strategies about how this behaviour could be prevented or instructions for staff on how they should respond when it occurred.

The manager and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Some people living in the service had a diagnosis of dementia or a mental health condition that meant their

Requires improvement

Is the service effective?

ability to make daily decisions could fluctuate. Staff had a good understanding of people's needs and used this knowledge to help people make their own decisions about their daily lives wherever possible.

Where people did not have the capacity to make certain decisions the service acted in accordance with legal requirements. Where decisions had been made on a person's behalf these decisions were made in their 'best interest'. As the service front door was locked at all times, best interest meetings were held to decide if the person was able to go out of the service, and if so unescorted. For two people this had been agreed with a plan to ensure the person had sufficient safety measures in place if they needed assistance. These meetings involved the person's family and appropriate health professionals.

The manager considered the impact of any restrictions put in place for people that might need to be authorised under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act 2005 (MCA) and requires providers to seek authorisation from the local authority if they feel there may be restrictions or restraints placed upon a person who lacks capacity to make decisions for themselves. Records confirmed that the manager had made appropriate applications to the DoLS team.

Staff made referrals to relevant healthcare services quickly when changes to health or wellbeing had been identified, such as GP's dentists and opticians. Care records demonstrated staff had listened and acted on advice given so that people's treatment needs were being consistently met.

Good

Is the service caring?

Our findings

We received positive comments from people who lived at Tolverth House. Comments included staff were; " Lovely", "Caring", "Kind" and one person commented "I'm so happy to be here, they rescued me." People told us they were completely satisfied with the care provided and the manner in which it was given.

One person told us that her pet dog had been allowed to stay at the service with her. This meant a great deal to the person. Her dog had recently died and staff had recognised this loss was impacting on the person's wellbeing. After consultation with other residents the service made arrangements for a kitten to join them The person said she understood why a kitten had come to live at the service as this placed less pressure on staff as where staff had needed to walk the dog this was not the case for the kitten. Everyone had responded positively to the new arrival.

People spoke fondly of each other referring to each other as 'my friend.' If a person had not joined them in the lounge they asked staff if the person was ok and would be joining them. The activity coordinator supported one person to visit their spouse who did not live at the service. The person on return said they appreciated the opportunity to visit their spouse and spend time with them. Other people in the service asked the person about their visit which showed people had a genuine interest in each other's wellbeing.

We received positive comments from a relative about the care their family member received. Comments included: "Mum's really settled here, there are no more tears", "This is the best place for mum, she is cared for well. We can relax now", "Mum has new friends now, she is no longer on her own" and, "Staff are fantastic, they genuinely care." They told us they were always made welcome and were able to visit at any time. People could choose where they met with their visitors, either in their room or different communal areas.

The manager valued her staff and believed they provided good care. The manager and staff shared the view that they needed to remember the people they cared for were dependent on them, therefore vulnerable and it was essential they provided care for the person in a way they wanted them to.

Staff spoke about people fondly and were proud of people's accomplishments. For example, at the time of one person's admission health professionals had identified that the person was unable to walk. Staff had supported and encouraged this person to be as independent as possible and this person was now walking with the aid of a walking frame. The person told us they were so pleased to be able to walk.

Staff commented; "I like to treat people as if they are my mum or dad." Some staff had worked at the home for many years, and told us "The people are lovely here I wouldn't want to work anywhere else." Staff interacted with people respectfully. All staff showed a genuine interest in their work and a desire to offer a good service to people.

Staff were seen providing care and support in a calm, caring and relaxed manner. Interactions between staff and people at the home were caring with conversations being held in a gentle and understanding way.

People's privacy was respected. Staff told us how they maintained people's privacy and dignity. For example, by knocking on bedroom doors before entering, gaining consent before providing care and ensuring curtains and doors were closed. Staff told us they felt it was important people were supported to retain their dignity and independence. As we were shown around the premises staff knocked on people's doors and asked if they would like to speak with us. Where people had requested, their bedrooms had been personalised with their belongings, such as furniture, photographs and ornaments. Bedrooms, bathrooms and toilet doors were always kept closed when people were being supported with personal care.

Where possible people were involved in decisions about their daily living. Staff knew peoples' individual preferences regarding how they wished their care to be provided.

We saw that some people had completed, with their families, a life story which covered the person's life history. Relatives told us they had been asked to share life history information and had provided photographs and memorabilia. This gave staff the opportunity to understand a person's past and how it could impact on who they are today.

The manager told us where a person did not have a family member to represent them they had contacted advocacy services to ensure the person's voice was heard.

Requires improvement

Is the service responsive?

Our findings

We reviewed three peoples care records. We found that one person who had been resident at the service for the last five months did not have a care plan. Information about this person's care needs was recorded on scrap and loose pieces of paper with no formal care plan written. There was no assessment of the individual's needs from which a comprehensive care plan could be developed to describe how care should be delivered to meet those assessed needs. Staff said they felt they were able to meet the person's needs by getting to know them.

We reviewed a further two care plans and found they had not been regularly reviewed and did not reflect people current care needs. For example one person's care plan said that the person liked to sit out in their chair. However, the person was confined to bed and in talking with the person they stated as their health had deteriorated this had not been possible for some time. Another care plan stated that the person needed to use mobility equipment, a stand aid and a wheelchair. However in talking with this person they told us all transfers were undertaken by hoist and had been for some time, which staff also confirmed. This care plan was last reviewed in June 2014 and even though the person's care needs had altered in that time the care records had not been updated which meant the information was not accurate. There were also uncompleted assessments such as waterlow, general health and safety and, nutritional assessments. The registered manager agreed that care plans were not up to date and in one case there was no care plan.

People's care plans did not provide staff with sufficient accurate information to enable them to meet people's current care needs. We found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In all the care plans we looked at there was differing levels of information of how people's social and emotional needs could be met. Therefore care plans varied in detailing individual's needs in relation to how they wished to spend their time and what type of activity they might wish to take part in to promote their emotional wellbeing.

We spoke with the service activities coordinator who worked four days a week. A variety of activities were provided which included; outings to various attractions, gardening in the summer as well as bingo, singing and, arts and crafts. In addition the service had a resident's choir and a reminiscence group where people were encouraged to bring along items to s share and reminisce. The activity coordinator intends to expand the variety of activities available within the service and was at the time of our inspection developing a mini film club. The local vicar visited the service each month to meet with any person who wishes to see them.

The activity coordinator had met with people to ask people what were their likes, dislikes and interests were. This was also discussed in the residents meetings which she facilitated. This allowed an opportunity for people to share their ideas on future activities and events. We saw the activity coordinator undertaking an arts and crafts session with five people. An activities memo given to everyone each month informed them what events were available. The activity coordinator told us they also ensured that they spent individual time with people, especially those that remained in their rooms.

People told us they enjoyed the activities provided and there was enough variety of things to do within the home. They spoke highly of the activity coordinator and said they enjoyed spending time with her and fellow friends in the service.

People and relatives told us staff were skilled to meet their needs. They told us when they wished to move into the service they had met with the manager or senior carer prior to admission. This was to ensure that the service would be able to meet their care needs. Relatives commented that the move to the service was completed in a sensitive manner. The senior carer and manager were knowledgeable about people's needs and made decisions about any new admissions by balancing the needs of any new person with the needs of the people already living in the service.

The service's complaints procedure provided people with information on how to make a complaint. The policy outlined the timescales within which complaints would be acknowledged, investigated and responded to. It also included contact details for the Care Quality Commission, the local social services department, the police and the ombudsman so people were able to take their grievance further if they wished.

Requires improvement

Is the service responsive?

We asked people who lived at the service, and their relatives, if they would be comfortable making a complaint. People told us they would have no hesitation in raising issues with the manager or staff. All told us they felt the manager was available and felt able to approach her, or staff with any concerns.

Staff felt able to raise any concerns. They told us the management team were approachable and would be able to express any concerns or views to them and felt they would be listened too. Staff told us they had plenty of opportunity to raise any issues or suggestions.

Requires improvement

Is the service well-led?

Our findings

The service is required to have a registered manager and at the time of our inspection there was no registered manager in post. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run. However a registered manager application was being submitted to us.

The service was short staffed. The manager was roistered to provide care and support two days per week and had covered additional care shifts during periods of staff sickness. The manager acknowledged that this had impacted on the amount of time she had to complete her management responsibilities. This inspection demonstrated, as can be seen in the sections of safe, effective and responsive that whilst peoples care needs were being met, there were issues in respect of the systems and processes within the service.

As detailed in the safe section of this report care staff had many demands placed on them. This meant that at times people were left unsupported. Staffing levels should be reviewed to ensure there are sufficient staff in all aspects of the service so that peoples assessed care needs can be met at all times.

We found one person did not have a care plan and where care plans were available these were out of date and did not accurately reflect people's current care and support needs. There was no assessment of the individual's needs from which a comprehensive care plan could be developed to describe how care should be delivered to meet their assessed needs. We also found that care plans did not accurately reflect people's current needs. Vital information for staff to follow to ensure people's safety and welfare was not always recorded in care records.

Staff files were incomplete and when asked the manager was unable to produce documentation to demonstrate the robustness of the services recruitment processes. Staff had not received appropriate induction training and there were no effective systems in place to ensure the training needs of staff were met. In addition staff had not received regular supervision or annual performance appraisals.

The services policies and procedures did not reflect current practices within the home. For example If a person requested, the service would hold a small amount of money for them safely. The service's policy and procedure stated the maximum amount of money that could be held for individuals and what action should be taken if they exceeded their limit. However we noted that for two people this limit had been exceeded and the actions specified in the service's policy had not been taken.

The manager told us they undertook some quality audits of the home such as gaining people's feedback on the quality of the food. The manager said the provider also undertook some audits but the manager was not aware of what these audits entailed and was unable to produce any reports or tell us their findings. As the manger was unaware of the results of the provider's quality assurance assessments they were unable to address any areas of concern these assessments may have identified. This meant the service's quality assurance processes were not operated effectively as these systems had failed to identify the areas of significant concern detailed in the safe, effective and responsive section of this report.

This is in breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

The manager and staff shared values and aimed to, "promote independence as much as possible." It was important to all the staff and management at the service that people who lived there were supported to be as independent as possible and live their life as they chose. We saw this being carried out in the delivery of care that was personalised and specific to each individual. Staff told us how this had been achieved. For example, one person whilst at another care service needed assistance with their food. Staff described how they had supported this person to become more independent and proudly told us that this person was now able eat independently.

Staff had a good understanding of the people they cared for and they felt able to raise any issues with their managers if the person's care needed further interventions. Daily staff handovers provided each new shift with a clear picture of each person at the service. This helped ensure everyone who worked with people who lived at the service were aware of the current needs of each individual. Staff had high standards for their own personal behaviour and how they interacted with people.

Requires improvement

Is the service well-led?

Staff spoke positively about the manager and felt able to raise concerns with them and were confident they would be listened too. Staff said they “worked as a team” and were proud to work at Tolverth house.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving care that was inappropriate or unsafe. Care and treatment was not planned and delivered in such a way as to meet people's individual needs. Regulation 9 (1) (b) (i) and (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service failed to provide staff with sufficient support, training, professional development and appraisal to enable them to meet people's care needs. Sufficient numbers of suitably qualified competent skilled and experienced persons must be deployed in order to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have an effective system in place to regularly assess and monitor the quality of service provided and identify, assess and manage risks relating to the health, welfare and safety of people who used the service. Regulation 10 (1) (a) & (b)