

# Vijay Enterprises Limited Tolverth House

## 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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

# Summary of findings

## 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 /or mental frailty due to a diagnosis of dementia.

An inspector carried out this unannounced comprehensive inspection on 19 March 2018. At this visit we met with the staff and people who used the service. We also spoke with a relative. Following the inspection we spoke with the deputy manager and the registered provider and checked what action had been taken in relation to concerns raised during our last inspections in September 2015, February 2016, September 2016, January 2017 and April 2017. At those inspections we found systems were not being operated effectively to assess and monitor the quality of the service provided. Due to the repeated breach of regulation 17 of the Health and Social Care Act, we issued a warning notice in September 2016. We reviewed this warning notice in January 2017 and found there continued to be no robust system of effective auditing in place meaning the provider was unable to identify or address any areas of concern. We then issued an urgent letter asking the provider to respond immediately to tell us how they would address the shortcomings of the service to ensure that people were safe. The provider responded and assured us, via their action plan, that all issues would be addressed by the 27 February 2017.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tolverth House on our website at [www.cqc.org.uk](http://www.cqc.org.uk)

We received two anonymous concerns about the service prior to this inspection. Some of the concerns were in relation to staffing levels and premises.

We spoke with the provider about the management structure and our increasing concerns that since September 2015 there had been consistent failings at the service. The service was rated inadequate at the January and April 2017 inspection and remains inadequate at this inspection due to continued failings.

For the last eleven months the provider hoped that the service was going to be sold. Staff were aware of the potential sale of the service as were relatives and people who lived at the service. The provider had therefore not invested in the service, for example with the people they supported, in its staff or its environment. Following this inspection we were informed the sale was not proceeding.

There had been limited financial investment in the service. For example there continued to be no operating central heating in the older part of the home. This had been raised at the last two inspections and no action had been taken to address this. We found generic risk assessments were completed about aspects of the premises, for example the use of standalone heaters. However staff were not following them and therefore were not taking the appropriate action to ensure that potential risks were minimised.

Since the last inspection the call bell system had been updated. However staff told us that they could not hear the call bell system upstairs if a person called for assistance. This meant that it could not be relied on when people called for assistance. We found people were exposed to both inadequate heating and ineffective call bell equipment which could place people at risk of not receiving care safely or promptly.

People were complimentary about the food. Staff told us there continued to be issues with appropriate budgets being available to purchase foods, "Especially in the last three weeks." One staff member told us they had purchased food themselves and brought it to the service as there was insufficient food stock in the home at that time. This meant that people were at risk of not receiving sufficient nutrition.

At this inspection we found that the provider continued to be in breach of a number of regulations. There remained failings in the overall management of this service. We have reissued breaches of the regulations.

We have also reissued breaches in the area of inadequate care planning and records. For example there were no care plans in place to provide guidance for staff in how to support a person when they became agitated. Therefore care plans did not provide staff with up to date guidance in how to support a person consistently.

We found there continued to be no robust system of effective auditing in place and therefore the provider was unable to identify or address any areas of concern.

The provider had delegated responsibilities to the deputy manager and administrator. However they did not have meetings as a managers group to discuss their roles and their findings. Therefore there was no audit trail of how they planned to monitor and improve the service. We found there was inadequate leadership in place to support the staff team to work to improve the delivery of care.

The service is required to have a registered manager in post. The service had not had a registered manager in post since January 2014.

Due to continuing failures since 2015 we have no confidence in the provider's ability to address the issues raised and establish an effective and robust system of auditing to enable them to identify and address all concerns.

There had been some improvements to the service. The stair lift was now working. This meant that people who needed to use this stair lift were able to move around the service independently. Recruitment systems were now robust. Concerns that were brought to the deputy manager's attention were being addressed and referred as appropriate to commissioners.

The overall rating for this service remains 'Inadequate' and the service is therefore in 'special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## 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.

Risks to people were not being adequately assessed or addressed to keep people safe.

Medicines were not always administered correctly, managed or stored securely. This meant there was a potential risk of errors and people might not receive their medicines safely.

Some of the premises and equipment, such as the heating and, call bells were not properly maintained. This meant that people were exposed to inadequate temperature control within the service and ineffective equipment which could place people at risk of not receiving care safely or promptly.

Recruitment processes were being followed. Therefore the provider could ensure people were protected from staff that may be unsuitable for work with vulnerable individuals.

### Is the service effective?

Requires Improvement ●

The service was not entirely effective.

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. For some people restrictive practices were in place without evidence of consent or adequate assessment and authorisation.

Staff supervision and training had not occurred which meant staff skill and knowledge was not kept up to date with best practise or legislation.

At times there was insufficient foods available for people to maintain a balanced diet appropriate to their dietary needs and preferences.

### Is the service caring?

Good ●

The service was caring.

Staff spoke about people fondly and demonstrated a good knowledge of peoples' needs.

People were asked about their preferences and choices. Staff respected people's wishes and provided care and support in line with those wishes.

### Is the service responsive?

The service was not responsive.

The service failed to respond to people's changing needs by ensuring amended plans of care were put in place. This meant people did not always receive support in the way they needed it.

There were limited activities for people to participate in.

Information about how to complain was available

**Requires Improvement** ●

### Is the service well-led?

The service was not well-led.

The service did not have a registered manager. Management of the service was not delivering a good quality service.

We found a number of concerns during our inspection which had not been identified by the provider. This showed a lack of robust quality assurance systems.

Records relating to the management and running of the service and people's care were not consistently or adequately maintained

**Inadequate** ●

# 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 19 March 2018 and was unannounced. The inspection was carried out by one adult social care inspector. We met with care staff, people who used the service and spoke with a relative. We contacted the deputy manager and provider following this inspection to share the findings of our inspection visits.

The inspection was planned to check if the service had met specific concerns identified following previous inspections in September 2015, February 2016, September 2016, January 2017 and April 2017. Before the inspection we reviewed these inspection reports and other information we held about the service. We spoke with local commissioners about their views on the service. We had received two concerns since the last inspection in April 2017 about the service and looked at the issues raised from these concerns during the inspection. We also looked at notifications we had received from the service. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we spoke with six people who were able to express their views of living in the service. We looked around the premises in detail and spent time observing care practices.

We spoke with four care staff, domestic staff, and the administrator during our visit. We looked at three sets of 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.

# Is the service safe?

## Our findings

At the February and April 2017 inspections we found that when a person might display behaviours that challenged staff, there were no care plans in place. Such care plans would be a guide to staff on how to manage a person's behaviour when they became anxious or distressed. Care staff did know the people they supported well but acknowledged that they might provide support in a different way to their colleagues which could cause confusion for the person they supported. At this inspection we observed a person become agitated which impacted on other people around them. Staff were prompt to intervene to defuse the situation. However there remained no care plans in place to guide staff on how to consistently support people when they were distressed. Staff told us how they managed these situations but demonstrated that they approached this in different ways. This meant staff may have been inconsistent in their approach to people which could have resulted in them becoming increasingly confused and anxious.

We concluded that there continued to be a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments identified different ways of working with people. Risk assessments are important so that appropriate measures are put in place to minimise risks to people. 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 the four care plans we reviewed, we found systems for assessing risk were inconsistently followed.

From a tour of the premises we saw that there continued to be a number of standalone portable heaters in people's bedrooms and communal areas. We saw that while one person was out of their bedroom their standalone heater's were left on and the room temperature had become very hot. Generic risk assessments had been implemented for the standalone heaters on 4 April 2017. These stated 'Staff are to continuously check on a daily and regular basis that all heaters are placed properly, no trailing wires and switched off when clients are not in their rooms and positioned away from combustible materials.' However, we saw that in one room two heaters were left on at a high temperature when the person was not present. Also staff were not aware of the need to monitor the use of the heaters. Although a risk assessment was in place, staff were not following the guidance to ensure that the heaters were used safely for all those who lived, visited or worked at the service.

Since the last inspection the call bell system had been updated. However staff told us that they could not hear the call bell system upstairs if a person called for assistance. This meant that it could not be relied on when people called for assistance.

We were told that areas of the premises had also deteriorated. For example there was a leak in the roof and concerns about the wiring and plumbing of the service.

We had identified previous breaches of regulations in this area at previous inspections and found at this inspection that little progress had been made. We found people were exposed to both inadequate



management of the heating within the service and ineffective equipment which could place people at risk of not receiving care safely or promptly. Although concerns had been highlighted to the provider in earlier inspection reports no action had been taken to address these failings.

We reviewed the medicines systems at the service. We found that there were some gaps in the Medication Records Administration (MAR) records which meant that we could not be certain that people had received their prescribed medicines on time. When the service received medicines from the pharmacist these were not recorded on the MAR sheets, therefore the service was not able to account for all medicines in the home. We also found that the stock balance for one prescribed medicines was not accurate. Systems in place for the management and administration of medicines were not robust. People were at risk of not receiving their medicines safely and as prescribed which could have had a detrimental effect on their health and well-being.

We concluded that there continued to be a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found improvements to the service recruitment processes. We reviewed two newly recruited staff files and found that all relevant recruitment checks had been completed. This meant people were protected from the risk of being supported by staff who were not suitable for the role.

People told us they felt safe at the service, a relative echoed this view. Staff were able to tell us what they would do and who they would contact if they had any suspicion of abuse taking place. However the training matrix showed that five staff had completed safeguarding training in 2016 and one person in March 2017. Seven staff did not have this mandatory training..

The deputy manager was monitoring the number of accident reports. We discussed with the registered provider the need to evidence what action has been taken, if needed, following the monitoring of the falls, as the current audit process did not identify if any further action had needed to be taken.

People felt that there were sufficient staff on duty to meet people's care needs. The staffing levels remained the same as that at the previous inspection. Where there was a shortfall agency workers were employed to cover these shifts. Staff continued to be satisfied with the staffing levels and felt it was sufficient to meet people's current care needs.

The provider had employed two new domestics. Feedback from people, a relative and staff, and our observations was that the service was much cleaner and looked more homely in appearance. We undertook a tour of the premises and found that the service was clean in all areas. We spoke with the staff member responsible for cleaning who told us they felt they had sufficient time to undertake their duties.

## Is the service effective?

### Our findings

People were complimentary about the food. Staff told us there continued to be issues with appropriate budgets being available to purchase foods, "Especially in the last three weeks." One staff member told us they had purchased food themselves and brought it to the service as there was insufficient food stock in the home at that time. This meant that people were at risk of not receiving sufficient nutrition.

The catering staff prepared the main meal, snacks and tea. Care staff prepared breakfasts and served tea. As care staff were involved in the preparation and serving of food, it is important that they have basic food hygiene skills, which would require training in this area. This concern was identified at the April 2017 inspection. An environmental health inspection took place in October 2017 which also identified the need for this training which had not been addressed. Issues regarding the cleanliness of the kitchen were also raised. We reviewed cleaning schedules in the kitchen and found the last one completed was on 22 January 2018. This meant there was no evidence that the kitchen was being cleaned to appropriate standards. The rating of the food standard for the service had reduced to a four star rating.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had recruited three new staff and we were told by staff that they had not completed an induction. Their personnel records confirmed this. Supervision sessions for the seven permanent staff were last held in June 2017. Newer members of staff had not had any supervision sessions. Training in the areas of moving and handling and fire safety were due for updating. The training matrix provided evidenced that no further training had occurred since the inspection in April 2017. We concluded staff had not received regular training or support to provide them with the knowledge and skills to carry out their roles safely.

Staff did not receive effective support or on-going training to ensure that their skills were kept up to date in line with current legislation and best practise.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. The manager had some knowledge of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

People's liberty was restricted as they were not able to leave the service without support. DoLS applications for the people living at the service had been appropriately submitted. Staff undertook training in this area in December 2016.

Staff asked people for their consent before providing care or treatment. People were involved in making choices about how they wanted to live their life and spend their time. The service asked people, or their advocates, to sign consent forms to agree to the care provided but staff were not confident that they had the legal authorisation to do this. We continued to find, as at our last inspection, that consent forms were not consistently signed or an explanation recorded if it was not possible to obtain written consent from the person.

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.

People had access to healthcare services and received on-going healthcare support. Specialist services such as speech and language therapists, occupational therapists and community psychiatric nurses were used when required. We spoke with a district nurse who told us that the service contacted them appropriately and found people were cared for by "kind" staff.

## Is the service caring?

### Our findings

People told us that staff were, "Nice and friendly" and would assist them with all their care needs promptly. A relative told us, "This place suits mum, she's settled in well. She's happy which makes me happy."

At this inspection we spent time in the communal areas of the service to observe how care was delivered and received. We observed people were comfortable in their surroundings. Staff were kind, respectful and spoke with people considerately. Throughout the inspection staff were observed to stop and engage with people when moving through lounge area. Staff spoke to us about people fondly. There was a calm and relaxed atmosphere at the service.

We reviewed people's daily logs which recorded how people had been that day, the care they had been provided with and any issues in relation to their health and wellbeing. The majority of these records were completed satisfactorily and were respectful of the person they had been supporting.

People's privacy was respected. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on bedroom doors and waited for a response before entering.

Care files and information related to people who used the service was stored securely and accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines.

Staff supported people to maintain contact with friends and family. Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in one of the communal areas or in their own room. We observed staff talking with visitors on arrival and making them feel comfortable.

## Is the service responsive?

### Our findings

People had a care plan. We reviewed three people's care records. We found that the majority of the care plans reflected people's personal care needs. However as detailed in the safe section of this report the care plans did not provide guidance to staff about when people may become confused or anxious. The service employed agency staff due to low staffing levels. They did not know the people they were supporting well and were not provided with guidance in how to support or approach people in a consistent manner. It is important people have an up to date care plan in place so that staff are knowledgeable on how they are to provide consistent support to the person at all times in order to protect their health and well-being. We concluded that people's care plans did not provide staff with sufficient accurate information to enable them to meet people's current care needs.

We concluded that there continued to be a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff acknowledged that the level of planned activities had reduced. They felt the reason for this was due to permanent staffing levels being reduced. However we saw staff spend time talking with people in the lounge.

Staff understood the importance of people maintaining relationships with those who mattered to them. During the inspection, we saw that relatives were treated respectfully and made to feel welcome and there were no restrictions on visiting times. A relative said, "There are no visiting restrictions. The staff make me feel so welcome".

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. Some people told us they knew how to raise a concern and they would be comfortable doing so. Staff told us they felt able to raise any concerns with the deputy manager. However they felt the registered provider was not available to respond to concerns and this is detailed in the 'well led' section of the report.

The service did not provide end of life care at the time of the inspection.

# Is the service well-led?

## Our findings

At our inspections in September 2015, February 2016, September 2016, January 2017 and April 2017 we found systems were not being operated effectively to assess and monitor the quality of the service provided. Due to the repeated breach of regulation 17 of the Health and Social Care Act, we issued a warning notice in September 2016. We reviewed this warning notice in January 2017 and found there was still no robust system of effective auditing in place and therefore the provider and manager were unable to identify or address any areas of concern. We then issued an urgent letter asking the provider to respond immediately to inform us how they would address the shortcomings of the service. The provider did respond and assured us, using their action plan, that all issues would be addressed by the 27 February 2017.

However at this inspection we found that the provider had failed to effectively address the repeated concerns and continued to be in breach of a number of regulations. There remained failings in the overall management of this service. We have reissued breaches of regulations in the areas of management of risk to people that use the service, the poor facilities, inadequate care planning and support for staff. Due to continuing failures since 2015 we have no confidence in the provider's ability to address the issues raised and establish an effective and robust system of auditing..

It is also of serious concern that areas that did have a breach in regulations in the past, including medicines (September 2016), which were later compliant (January 2107), have again been found in breach of the regulations.. This raises concern that the provider had not been able to maintain an adequate standard consistently, in order to both ensure the safety of the people that used the service and to ensure compliance with the regulations over a period of time.

Staff told us they felt the registered provider had 'no interest' in how the service was being run. For the last eleven months the provider hoped that the service was going to be sold. Staff were aware of the potential sale of the service as were relatives and people who live at the service. The provider had therefore not invested in the service, for example in its staff or its environment. Following the inspection we were informed the sale was not proceeding. Due to the continued breaches as identified in this report we will continue with our enforcement process.

The deputy manager had one shift allocated a month to undertake management responsibilities. They told us, "Being on the floor and doing managers tasks, I just can't do it." They also told us, "I have spoken to the new buyers more than I have (Providers name) and they have supported me." We spoke to the provider following the inspection who agreed that the deputy manager could increase their office hours so that they could undertake management responsibilities.

We discussed with the provider at the last two inspections, the need to oversee the running of the service, for example by holding regular meetings with the management team. Two of the staff who had delegated responsibilities told us they still did not have meetings as a managers group to discuss their roles, the development of the service and any concerns. They commented that conversations 'occurred as needed.' There were no written records of discussions so there was no audit trail of how they planned to monitor and

improve the service. This meant that there continued to be no formal process for a management overview of the service.

The deputy manager had met with staff but the provider had not had regular contact with the staff team. Discussion around the rating of the service or what action needed to be taken to improve the standards at the service had not occurred with the provider. Therefore staff were not aware of what actions they needed to take to ensure that the failings identified at previous inspection reports could be addressed. There is no evidence the provider is pro-actively involving the staff team and other stakeholders in any effort to improve the service.

These examples demonstrated quality assurance processes were either not in place at all or not operated effectively and that the provider and manager had failed to identify areas of significant concern. There was a lack of clear oversight of the service which had resulted in failings in the quality and delivery of care.

The evidence above demonstrated the provider's on-going breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

The service is required to have a registered manager in post. The service had not had a registered manager in post since January 2014. To date we have not received a valid registration application for registration for a registered manager at Tolverth house.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>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</p>

### The enforcement action we took:

NOD to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users. Including: Assessing the risks to the health and safety of service users of receiving care or treatment. All premises and equipment used by the service must be properly maintained.</p> <p>The proper and safe use of medicines</p>

### The enforcement action we took:

NOD to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs</p> <p>The registered person must ensure that there is sufficient food available for people at all times.</p>

### The enforcement action we took:

NOD to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good



personal care

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.

**The enforcement action we took:**

NOD to cancel registration

**Regulated activity**

Accommodation for persons who require nursing or personal care

**Regulation**

Regulation 18 HSCA RA Regulations 2014 Staffing

There must be sufficient numbers of suitably qualified and competent staff deployed to meet people's needs. Staff should receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties.

**The enforcement action we took:**

NOD to cancel registration