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 12 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.

Two inspectors carried out this unannounced comprehensive inspection on 25 April 2017. At this visit we met with the manager, staff and people who use the service. We also spoke with relatives. We revisited the service on the 3 May 2017 to meet with 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 and January 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 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 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

We received five anonymous concerns about the service prior to this inspection. Some of the concerns were in relation to the attitude and approach of the manager, staffing, premises and activities. They felt the manager had not taken on board their concerns or felt anxious that if they raised concerns there might be repercussions for their relative's care or their employment. Staff raised serious concerns about the attitude and approach of the manager.

These examples demonstrated that some people and staff had little confidence in the management of the service. We discussed this with the provider who stated they had confidence in their manager. 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 2017 inspection and remains inadequate at this inspection due to continued failings.

We found at this inspection from the concerns raised, that there was no operating central heating in the older part of the home and staff told us this had been the case for "3 to 4 years". Standalone electric heaters had been installed around the service. We found generic risk assessments were completed about aspects of the premises, for example use of standalone heaters, however staff were unaware of them and therefore were not taking the appropriate action to ensure that potential risks were minimised. We also found that the call bell system equipment was not monitored. On the second day of our inspection a fault with the call bell

system occurred. No regular monitoring of the call bell system equipment was evident to ensure that it was regularly checked so that it could be relied on when people called for assistance. This meant that 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. We also found that a stair lift did not work effectively or reliably on both days of our inspection visit. This meant that people who needed to use this stair lift were unable to move around the service independently.

We found continued inconsistencies in records. For example some people had risk assessments in areas of care such as being supported to move around the service and others did not..

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 which again resulted in breaches of regulations being identified. For example we have reissued breaches of regulations in the areas of management of risk to people that use the service and, the poor facilities, as cited above.

We have also reissued breaches in the area of inadequate care planning and records. We found that when peoples care needs had changed these were not amended on the persons care plan. For example a person's night care plan said they were being cared for in a bed, however we found that the person was for their safety being cared for on a mattress on the floor. Therefore care plans did not provide staff with up to date guidance in how to support a person consistently.

In addition there was no documentary evidence to support why or how this decision had been reached or if the person, their family or other health or care professionals from outside the service was involved in this decision. When we returned to the service on the second day of our inspection, a week later, the person was now sleeping in a bed in another bedroom. Again no documentary evidence was available to show how this persons care needs had been assessed and what support the person needed. For example, previously the person had bed rails fitted to their bed prior to using the mattress on the floor, but no bed rails were now in place. No explanation was provided as to why bed rails were no longer needed. We concluded that there was no documentary evidence to show that an appropriate decision making process had been carried out involving all those with an interest in the person's care and safety.

We found there continued to be no robust system of effective auditing in place and therefore the provider and manager were unable to identify or address any areas of concern. For example, care plans were not up to date, equipment in the service including the stair lift and call bells were not working effectively and the heating system did not work.

We also identified new breaches at this inspection for example in relation to complaints and medicines. It is of serious concern that areas that did have a breach in regulation in the past, such as medicines (September 2016) which were later compliant (January 2107) have now been issued with another breach of regulation. This raised concerns that the provider had not been able to maintain the consistent standards needed to ensure compliance with regulations over a period of time. These examples showed that the service's quality assurance processes were not operated effectively and the provider and manager had failed to identify areas of significant concern.

The manager told us they had delegated responsibilities to the deputy manager, administrator and a specified care worker. However they did not have meetings as a managers group to discuss their roles and their findings. The provider and manager acknowledged that no written records of discussions had occurred so that there was no audit trail of how they planned to monitor and improve the service.

Staff told us they had no discussions with the manager about the latest inadequate rating of the service. A staff meeting was held with the provider but staff felt it was not discussed in depth. The minutes did not evidence that a discussion around the rating of the service or what action needed to be taken to improve standards at the service had occurred. Therefore staff were not aware of what actions they needed to take to ensure that the failings identified at previous inspections could be addressed. There was inadequate leadership in place to support the staff team to work to improve the delivery of care.

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.

The service is required to have a registered manager in post. At the time of our inspection the manager in charge had not been registered with the commission. The service had not had a registered manager in post since January 2014. The present manager was appointed in January 2014 and they had day to day responsibility for running the service. In June 2016 the provider informed us that they had appointed the same manager to also manage the registered provider's other care service, which is in another county and a considerable distance from Tolverth House. An application to the commission was received by the manager to register for both services in October 2016. However in February 2017 the manager withdrew their application to manage both services. The manager has not submitted an application to manage Tolverth House and to date we have not received a valid registration application for registration of the manager at Tolverth house.

We noted that there had been some improvements to the service. For example, people told us they were supported by staff who showed genuine care. In addition we noted that supervision was occurring and training had increased.

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.

Recruitment processes were inconsistently followed. Therefore the provider could not ensure people were protected from staff that may be unsuitable for work with vulnerable individuals.

Some of the premises and equipment, such as the heating, call bells and stair lifts, 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.

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 increased to enhance staff skills and knowledge.

Staff supported 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?

Requires Improvement

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.

People were able to take part in a range of activities of their choice.

Information about how to complain was available.

Is the service well-led?

Inadequate

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.

Concerns were raised from a number of sources about the manager's approach. This meant that people, relatives and staff were reluctant to raise issues with the manager.

We found a number of concerns during our inspection which had not been identified by the provider or manager. 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.

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 25 April 2017 and was unannounced. The inspection was carried out by two inspectors. We met with the manager, staff, people who used the service and spoke with a relative. We received further phone calls from staff following this inspection visit to share their views on the service. We revisited the service on the 3 May 2017 to complete the inspection and meet with the registered provider to share the findings of our inspection visits.

The inspection was planned to check if the service had met specific needs identified following previous inspections in September 2015, February 2016, September 2016 and January 2017. Before the inspection we reviewed these inspection reports and other information we held about the service. We spoke with local commissioners and a district nurse about their views on the service. We had received five concerns from different sources since the last inspection in January 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 seven care staff, the deputy manager, catering staff, domestic staff, the administrator, the manager and the registered provider. We looked at four 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.

Inadequate

Is the service safe?

Our findings

At our previous inspection 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 found there were still no care plans in place to guide staff on how to support people when they were distressed. This meant staff may have been inconsistent in their approach to people which could have resulted in them becoming increasingly confused and anxious.

For example, we saw that a person's mattress was placed on the floor. Care staff told us they had made this decision with the GP and family, as the person kept getting out of bed during the night and was at risk of falls. There was no care plan in place to show the reasoning behind this or how to support the person if they became anxious during the night. The care plan in place for sleep stated "Since residing at Tolverth house (person's name) sleep pattern has changed and on most occasions appears to be asleep. Has wandered a few times at night.' This did not reflect what staff told us about this person's night time routine or the fact that the person was to be supported by their mattress being placed on the floor.

We also noted from the same person's daily records that, on at least six occasions, the person was found to be sleeping on the floor and not on the mattress. There was no evidence that this had been discussed or any action taken to ensure that the person slept on their mattress. We discussed our concerns with the deputy manager and manager about the person sleeping on a mattress on the floor and the lack of evidence of about how this decision was made or that their wellbeing was being ensured. This meant that the person's care needs were not being monitored or reviewed on a regular basis to ensure that appropriate care was provided at all times. Although records had identified the person was not being cared for in a way which helped ensure their comfort and well-being, no action had been taken to address this.

When we returned on our second day of inspection we found that the person had moved bedroom, and was now sleeping on a divan bed in another bedroom on the ground floor. When the person had slept in a bed previously, bed rails had been put in place to prevent them from falling out of bed. There were no bed rails in place on their new bed. We asked how and why the decisions had been made to move the person's bedroom, change from using a mattress on the floor to a bed, and not to put any bed rails in place to stop the person from falling out of the bed. We were concerned that the risks associated with this particular person sleeping in a bed had not been considered or action taken to protect them from avoidable harm. There was no documentary evidence to support why or how these decisions had been reached or if the person, their family or other health or care professionals from outside the service were involved in this decision,. We did not receive information to show that an appropriate decision making process had been carried out involving all those with an interest in the persons care. Therefore we were not assured that the person was not at risk of falling from their new bed.

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 not robust. For example, as reported in the previous paragraph, there was no risk assessment on how a person was to be supported to get in and out of bed whilst their mattress was placed on the floor. In one file we found moving and handling risk assessments had not been reviewed since 20 February 2015, yet on another we noted that when a person's mobility needs had changed that this had been updated. This showed that there was an inconsistent approach to risk assessments for the safety of the people supported at the service. The accuracy or relevance of the assessments in place could not be relied upon. Risks were not adequately or consistently identified or assessed and there were not always actions agreed on how any risks could be minimised.

From a tour of the premises we saw that there were 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 was left on and the room temperature had become very hot. We asked a staff member if this was safe and they switched the heater off. In addition staff told us the central heating system had not worked for "some years" in the older part of the service. This was later confirmed to be true by the manager.

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 the heater was 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.

A concern was raised around the stair lift. The stair lift on the lower stair case worked, however staff were unable to operate the upper level staircase stair lift on the day of the inspection. The maintenance person later inspected the stair lift and managed to get it working, but acknowledged that a key, which is required to operate the stair lift, was missing. Despite the stair lift having a recent service staff told us the stair lift was "temperamental" And often did not operate. This meant it could be difficult for people to get up to their rooms independently if they were not able to negotiate the stairs independently. Four people were using the upstairs bedrooms and we were told that they were able to manage the stairs safely. However, we were told by an anonymous source that one of these people had a visual impairment and another had mobility difficulties and both needed to use the stair lift. On our second visit to the service the deputy manager told us one person had been moved to a downstairs bedroom because they had found it difficult to manage the stairs.

During the second day of the inspection we found the upper stairs lift was again not working. No attempt had been made by the manager or provider to address the issue, although they had been informed of the inspectors concerns at the end of the first visit. Three people remained on the upper floor of the service. We observed a staff member supporting a person to come down the stairs to the first landing where they were able to use the operational stair lift to the ground floor. There had been no additional risk assessment put in place to manage the level of risk to those people who had been affected by the broken stair lift.

Although the service had responded to some of our concerns during the inspection they had failed to

identify the potential hazards themselves, at an earlier stage. We concluded people were not supported to move around the home with safe and appropriate equipment. People who were at risk had not been identified and action taken to protect them. As some people were dependant on staff to operate the lift or assist them upstairs they were not supported to maintain their independence and autonomy when moving around the premises.

We tested the services call bell system. We found that on first pressing a call bell it did not work. On the second attempt it did and staff were quick to respond. However the call bell system then sounded again and staff were unable to identify who had operated it. The monitoring pad was alerting them to a specific area but the call bell had not been alerted from that area. The monitoring pad then indicated that it was not a bedroom but the front door where the call bell had been used. At this point the call bell system had been ringing for 25 minutes and we suggested to staff that the batteries in the hand held call bell pads might need changing. This turned out to be correct. Although there were different views as to which hand held call bell the batteries needed replacing in. Care staff eventually were able to tell us that the call bell which had been sounding for 25 minutes was from a person's room and the manager told us it was a spare call bell pad which was in a cupboard. The situation was very confused and staff were not able to quickly identify if anyone needed support. Had anyone needed urgent assistance, for example, if they had fallen, there could have been a considerable delay before staff reached them. There was no audit of call bells to check they were all working and to ensure batteries were replaced regularly. This meant that the call bell system was ineffective and could place people at risk of not receiving staff attention promptly.

We had identified previous breaches of regulations in this area at previous inspections and found at this inspection that little progress had been made. Therefore we concluded risks to people's health and welfare had not been consistently identified, assessed and monitored and there was a lack of sufficient guidance to help staff safely manage risks. Although this had been highlighted to the provider in earlier inspection reports no action had been taken to address these failings.

On the morning of the 3 May 2017 we reviewed the medicines systems at the service. Medicines records were not accurate. For example, we found one person's record showed two medicines had been signed for in advance. A medicine, Laxido, was prescribed for administration at 21:00hrs but had been signed for in advance, for that day. Likewise Phenytoin Sulphate was to be administered at 21;00hrs but had been signed as given for on the 3 May 2017 at 21:00hrs, although we were inspecting the records in the morning of 3 May 2017. The deputy manager told us these medicines had not been given.

We noted that one person was to have three medicines administered at 8.00am, Ferrous Sulphate, Folic Acid and Levothyroxine, but they had not been signed as being administered for that morning. Another person was prescribed Ferrous Sulphate to be prescribed each day. However the records showed the person had received only one administration during the three day period, from the 28 to 30 April 2017.

The stock balance for two prescribed medicines was not accurate. One balance showed a balance of 58 Venlafaxine tablets when it was calculated there should have been 67. In another instance records showed nine tablets had been administered but this did not tally with the amount in stock. One person had been prescribed Lorazepam medicine to be taken as needed (PRN). This meant it should be administered only when required and not on a regular basis. However, records showed that the medicine was being administered daily. 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.

On the first day of inspection we looked at the contents of a first aid medicine box kept in a shared

bathroom and for general use. The checklist for the contents of the medicines box was last completed on 25 April 2004. A trauma dressing package had been opened and left in the box, this meant it was no longer sterile and should have been discarded. Other products in the first aid box had also passed their expiry date. For example, wound care packs had an expiry date of December 2014. We raised this with the manager who said she would address this immediately. During the second day of inspection, a week later, we checked to see what action the manager had taken and found no action had been taken. The first aid box contents were not suitable for use and people were at risk from harm if treated with these products, which could have been contaminated or no longer effective.

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

At the inspections in September 2015, February 2016, September 2016 and January 2017 we found recruitment processes were not followed consistently. The manager had introduced a new audit trail for the recruitment of staff. No new staff had commenced employment at Tolverth House since January 2017. However we reviewed the staff recruitment files to ensure that information which was lacking previously had been added. The manager had reviewed some staff files to ensure the information was included, although not all had been looked at. We found that some information required when employing new staff was still not present in some files. For example in some recruitment files there was no form of photographic identification for staff on file. The service checklist to ensure that all recruitment checks had been completed was not accurate. For example Disclosure and Baring checks (DBS) had been applied for but there was no date recorded as to when they were valid from to evidence that the staff concerned had only begun working with the vulnerable adults that used the service following a full DBS check. There was no evidence the manager had asked staff members about any gaps in employment during the interview process. In addition not all employees had received two references before starting work. This was contrary to the service's auditing process. This meant people were not protected from the risk of being supported by staff who were not suitable for the role.

Therefore we concluded that this is a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the previous inspection we checked the temperature of water coming from taps and found that the water temperature was too hot and people were at risk of scalding. The provider contracted a plumbing service to arrange for thermostatic values to be fitted to all taps. On this inspection we saw that thermostatic valves had been put in place and that the water temperatures were now being monitored monthly. A risk assessment had been implemented on 6 February 2017 which directed staff on what action to take if the water temperature went above 44 degrees centigrade. This meant staff were now aware of the potential risks of scalding for people and what action they must take to ensure people's safety.

At the previous inspection we received a mixed view from people about how safe they felt in the service and we identified a breach in regulations. This was particularly in relation to the care people received during the night time. Since the previous inspection the manager had undertaken some night time shift observations and we saw documentary evidence to support this. The manager told us discussions had taken place with particular members of staff about their individual care practice. For example it had been agreed they would spend some time on day shift so that the manager could observe their care practice and identify if additional support for them was needed such as additional training. However there was no documentary evidence to show this had happened. This is discussed further in the well led section of the report.

People and a relative told us, at this inspection, that they felt staff supported them well. Comments

included, "Always treats them (people) well", and "Very happy with the care they have."

The staff team told us that they had all undertaken recent safeguarding training and they were able to tell us who they would contact if they had any suspicion of abuse taking place. The manager and provider had attended a multi-agency safeguarding course, and had arranged to attend the next safeguarding course in the future. The manager told us that they felt the course was beneficial and had "Opened my eyes to what is, and is not safeguarding."

Since the inspection the registered provider was monitoring the number of accident reports monthly. We looked at the accident reports and found accidents were reported in February but none for the month of March or April 2017. 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. The provider agreed to address this.

Since April 2017 the manager was no longer dividing their time between two care services owned by the provider, which meant they were now available at Tolverth full time. The manager was now included on the staff rota so that staff could see when the manager was available. Likewise the rota now showed who was on call outside of daytime hours. This meant staff now knew what management cover arrangements were in place at all times.

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. Staff continued to be satisfied with the staffing levels and felt it was sufficient to meet people's current care needs. These showed staffing levels were felt to be appropriate and were being delivered consistently.

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. We were reassured from our discussion with them that a regular cleaning schedule of the service was now taking place.

Requires Improvement

Is the service effective?

Our findings

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).
At the January 2017 inspection we identified that people's liberty was restricted as they were not able to leave the service without support. The correct legal process had not been followed to authorise this restriction. We identified a breach of regulation in this area. At this inspection we found that the deputy manager had submitted ten DoLS applications for the people living at the service in this regard only, as it was deemed that no person at the service had the capacity to decide if they could leave the service without support. Therefore the restrictions in respect of leaving the service had now been identified, appropriate DoLS applications had been submitted and the service was waiting for assessments to be undertaken by Cornwall Council.

We noted, as discussed in Safe section of this report, that one person was sleeping on a mattress on the floor. Staff were able to explain the reasons why they had come to this decision and stated it had been discussed with the GP and the family. A daily record note by care staff recorded 'GP called. Blood taken. Mattress to be put on bedroom floor. Alarm in-situ.' This did not provide sufficient detail as to how the decision had been taken and why. There was no reference to family being involved in the decision. There was no further documentation provided to evidence that this decision had been made using an appropriate 'best interest' process. Therefore the service could not show that an assessment had been carried out to ensure the manner in which they were providing care was in the person's best interests and legitimate.
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.

This continues to be a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014.

At the inspection in September 2016, we found staff had not received regular training or support to provide them with the knowledge and skills to carry out their roles safely. Supervision sessions with the manager

had not occurred. This meant staff had not received effective support and their on-going training needs had not been addressed.

At the inspection in January 2017 we found that the manager had met with all the staff and held supervision sessions with them and completed an annual appraisal. From the eleven staff supervision records we found that a formal record of staff supervision had occurred for all eleven staff on one day. However we found that there were either no action plans for future developmental needs for staff, or the record was limited to the person was undertaking NVQ training.

We reviewed two supervision records at this inspection. We noted that supervision session times were now regular and did not all occur on the same day, meaning the manager had more time to support staff in a meaningful way. Some staff said they had received supervision sessions since the inspection in January 2017, others said they had not. We also noted that annual appraisals were occurring and that an action plan for individual staff members was being developed, for example further training needs had been identified.

We saw the service's new induction procedure. We also saw a record of staff completing their induction. This induction involved the employee and manager working through 54 health and safety checklists in one day. This did not demonstrate the staff members understanding of certain procedures and indicated a blanket 'tick box' approach to completing the process. This meant people were at risk of being supported by staff who did not have the relevant skills or knowledge.

Staff told us they had attended recent training in the areas of medicines and safeguarding and that more training had been arranged. Evidence of notices to staff to alert them to new training courses were on display. Staff were pleased that there was more access to training. From both discussions with staff and reviewing staff files it was evident that some staff had attended both meetings with the manager and training, since our previous inspection. Records confirmed staff had recently attended safeguarding, and medicines training.

We concluded that further progress had been made in the provision of staff training and supervision and therefore in this area the provider was now compliant with this part of the breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) 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.

People were complimentary about the food. The catering staff had a good knowledge of people's dietary needs and catered for them appropriately. The cook prepared the main meal, snacks and tea, bought stock locally, and had an appropriate budget to buy all the foods needed. Catering staff had attended relevant training. 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.

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.

Good

Is the service caring?

Our findings

At the previous inspection we received mixed views from people about the care they received, especially at night time. The manager and deputy manager reviewed the night time care system, and as referred to in the Safe and section of the report, addressed the areas of concern.

At this inspection people told us that they felt well cared for by caring staff at all times. We saw staff greet people in the morning with a smile, a touch and in some cases a kiss when asked for by the person receiving it. This was given with affection by the staff member and received positively by the person. We heard appropriate humour and laughter between people and staff and also saw staff provide people with comfort if they became distressed or anxious.

Staff spoke to us about people fondly and went out of their way to support people. For example, we saw a member of staff place a blanket on a person as they were cold. The person said "Thank you dear that's just what I needed. I think I'll stay here for a while now."

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 service 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 maintain their dignity and independence. As we were shown around the premises staff knocked on people's doors and asked people 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.

We saw that some people had completed, with their families, a life story which covered the person's life history. Relatives 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.

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.

We therefore found that the service was now complying with the breach of regulation18 of the Health and Social Care Act 2008

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we identified that two people did not have a care plan. There was no evidence they had received formal assessments prior to admission to the service to ensure that the service could meet their care needs. As there was no assessment or care plan this also meant that staff were not provided with information, guidance or direction on what the person's needs were or how staff were to provide their care. There was no other documentation to evidence how the people needed or wanted their care to be delivered.

We were told at this inspection that every person at Tolverth House had a care plan. We reviewed four people's care records. We found that one care plan had been updated, showing for example that the person's health had deteriorated and the new information about the person's reduced level of mobility had been added to the updated care plan, so that staff knew what support was needed.

In contrast we saw two care plans that were not up to date. One is detailed in the safe section of this report regarding the person sleeping needs, as their mattress was placed on the floor. This was not included in the person's care plan. This meant that the person's care needs were not accurately reflected in their care plan.

Another example was in respect of supporting a person with their diet and nutrition. The service had identified that a person was losing weight and had contacted dentists and a Speech and Language Therapist (SALT) to discuss possible reasons for weight loss. A care worker had written in the multi-agency record sheet that the SALT team had provided advice on 7 April 2017 stating, "when eats have a carer prompt and tell (person's name) to swallow and after drink water and check her mouth. To give (person's name) lots of cream milkshakes ½ and ½ food so that (person's name) is not dropping weight." The person's nutrition care plan had not been updated with this information and still stated, "has no difficulties chewing and swallowing." The last dated review of this section of the care plan was on 2 August 2016, yet there had been significant changes for the person in this area of care. This meant staff might not be aware of the need to give this additional support, putting the person at risk of poor nutrition and deteriorating health. 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 found the provider was in continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received five concerns about the service and all stated they did not feel comfortable raising concerns with the manager. This is discussed in further detail in the well led section of this report. A staff member told us the information on how to raise concerns or complaints was displayed in the entrance to the service. However when we looked the information was not there. A member of staff told us, "Some residents move things and I think that's what's happened." We were later told that the information was now in the entrance hallway. One family member told us they would approach the homes manager or Cornwall Council if they were not happy about the care and treatment of their relative.

An activity coordinator was employed five mornings a week. People were pleased with the level and range of activities on offer. People had recently been on an outing and told us they had enjoyed it. Activities were provided five times a week in the mornings. The service's activities coordinator told us people participated more in the morning activity. Records of the activities, who participated, and how people responded to the activity, were now being kept. This helped the activity coordinator to consider what future activities people would like to participate in so that they could cater for their needs. They had also held a residents' meeting which discussed activities and what people would like to see occur at the service. Outside entertainers, the local minister and a group of school children had visited the service recently.

Inadequate

Is the service well-led?

Our findings

At our inspections in September 2015, February 2016, September 2016 and January 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 continued to be in breach of a number of regulations. There remained failings in the overall management of this service which again resulted in breaches of regulations being identified. For example 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 recruitment, as discussed earlier in this report. 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.

It is also of serious concern that areas that did have a breach in regulation in the past, including medicines (September 2016), which were later compliant (January 2107), but have now been found in breach of regulation. The reasons for the breach related to the issues that were found in the past, i.e. that the systems for the management of medicines were not robust. This raises concern that the provider had not been able to maintain an adequate standard consistently, in order to both maintain 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 had not had any discussion with the manager about the latest Inadequate rating of the service. They said they had met with the provider in a staff meeting in March 2017, but felt it was not discussed in depth. This meeting discussed the impact of the media at Tolverth House as the service had an inadequate report rating. The minutes did not evidence that a discussion around the rating of the service or what action needed to be taken to improve the standards at the service had occurred. 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.

In the January 2017 inspection the manager told us they had delegated responsibilities to the deputy manager, administrator and a specified care worker. We discussed with the manager and provider, the need to oversee the running of the service, for example by holding regular meetings with the management team. At this inspection two of the staff who had delegated responsibilities told us they 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." The provider and manager acknowledged that no written records of discussions had occurred so that 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.

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 ongoing breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

Following the previous inspection the provider and manager were required to investigate some care practices with staff. We were shown a letter stating that a record of the findings would be kept on their file. However on looking at staff records there was no documentation of how the provider or manager investigated the concerns raised, what actions were taken or how they would support staff in the future. The manager and provider acknowledged that they did not take notes of the meetings held with staff. This meant there was no appropriate process evident that the investigation was completed in a fair or transparent manner.

We received five anonymous concerns about the service before this inspection. Some of the concerns were in relation to the approach of the manager. We were told the manager had not taken on board concerns raised. Staff and relatives were anxious that if they raised a concern there maybe repercussions for their relatives care or their employment. We were told they were aware that since the previous inspection a person who raised a concern had been asked to leave the service and were fearful this would happen to them if they raised issues.

Staff raised with us concerns about the attitude and approach of the manager. Some comments in respect of the manager included: "There is a divide between manager and staff", "All I wish for is for people to be spoken to properly, for people to be valued and praised," "People deserve to be spoken to with respect", "Everyone else is to blame" and that the managers approach was "aggressive" and they were a "bully."

This demonstrated a lack of confidence in the management of the service. Members of the public and the majority of staff we spoke with during the inspection told us they were unwilling to raise concerns as they felt "intimidated" and were concerned by the response they would receive if they raised any issues. It is important that staff, people and relatives are supported to raise concerns about the quality of the service in an open and transparent manner to enable the provider to work to improve and develop the service. We discussed this with the provider who was aware that at times the manager's approach could be viewed negatively. However the provider stated they had confidence in their manager. We spoke with the provider about the management structure and our increasing concerns that since September 2015 there have been consistent failings in the service. The service was rated inadequate at the January 2017 inspection and remains inadequate at this inspection due to continued failings at the service. Due to this we will review what further enforcement action we will be taking.

The evidence above demonstrated a breach of Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014.

The service is required to have a registered manager in post. At the time of our inspection the manager in charge had not been registered with the commission.

The service had not had a registered manager in post since January 2014. The present manager was appointed in January 2014 and they had day to day responsibility for running the service. In June 2016 the

provider informed us that they had appointed the same manager to also manage the registered provider's other care service, which is in another county and a considerable distance from Tolverth House. An application to the commission was received by the manager to register for both services in October 2016. However in February 2017 the manager withdrew their application to manage both services. The manager has not submitted an application to manage Tolverth House and to date we have not received a valid registration application for registration of the manager at Tolverth house.

We had issued a breach of regulation as the provider had not been notifying us of incidents at the service as required to by law. Since the January 2017 inspection we were informed that no incidents had occurred and therefore no notifications were needed to be submitted. We therefore conclude that they were compliant with the breach of Regulation 18 HSCA 2008 (Registration) Regulations 2009.