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?	**Requires Improvement**
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 14 people were living at the service. Some of the people at the time of our inspection had physical health needs and some mental frailty due to a diagnosis of dementia.

We carried out this unannounced comprehensive inspection of Tolverth House on 9 January 2017. At this visit we checked what action the provider had taken in relation to concerns raised during our last inspection in September 2015, February 2016 and September 2016. At that time we found repeated breaches of legal requirements related to the service such as: a lack of training and supervision for staff, recruitment records were not robust, and ineffective auditing systems. We issued a warning notice as part of our enforcement process.

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

There had been no registered manager in post since January 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had submitted a valid application which is being considered by the Commission.

The manager told us they had less time at Tolverth House to undertake their managerial duties as they were now managing both Tolverth House and the provider's sister home which is approximately one hundred miles away. The consequence of this was that the manager had doubled their day to day managerial responsibilities and needed to divide their time equally between the two services. However, there remained failings in the overall management of this service which again resulted in breaches of regulations being identified.

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, at the September 2015 inspection we found that care plans were not in place for all people at the service. This was found again for two people at this inspection. We also found that risks were not identified or assessed formally. Therefore there was no action agreed on how any risks could be minimised. This meant staff did not have information, direction or guidance on how to support a person's care needs.

Likewise we found at the inspections in September 2015, February 2016 and September 2016 that recruitment processes were not followed consistently. The manager showed us they had introduced a new audit trail for recruitment of staff following the last inspection. However, we found that the new system was not being implemented consistently.

The registered provider had introduced new job specifications for the manager and deputy manager. Due to this change the manager had delegated some tasks to the deputy manager and a specified care worker. The provider and manager acknowledged that no written records of these discussions had occurred so that there was no audit trail of how they planned to monitor and improve the service.

We had identified that the provider had not been notifying us of significant events in the September 2016 inspection. The provider is required by law to submit notifications to CQC of significant events such as injury or any safeguarding concerns. We found the service had not submitted statutory notifications as required since the September 2016 inspection. This demonstrated the provider continued to not act in accordance with their legal responsibilities.

Following each inspection we requested that the provider submit an action plan on how they would address the shortfalls of their service. To date we have not received any action plan. From the issues highlighted in previous reports and in this report, it is of concern that the management team have not openly shared with us how they intend to address the failings of the service.

These examples evidence that the service's quality assurance processes are not operated effectively and the provider and manager has failed to identify areas of significant concern.

We received mixed views from people about how safe they felt and about the care they received. One person and a relative told us that "The care during the day is 100%. It's the night time that isn't." Another person told us they were content. We also saw a letter of thanks from a relative about the service their family member received.

We had received concerns about staff practices from an emergency health care agency, a person using the service and relative. We also noted in records that the language staff used to describe people was not always respectful. We concluded that safeguarding allegations had not been investigated thoroughly by the service and that the reporting procedure for safeguarding had not been followed. We have made a safeguarding alert to the local authority in this regard.

We found that there continued to be a lack of oversight from the management team in the running of the service. Staff were now being provided with training and some support, to give them the knowledge and skills to carry out their roles safely. We concluded that whilst some progress had been made in the provision of staff training and supervision there had not been sufficient time to analyse if the actions taken in this area had been 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. We found that there were some restrictions in place such as pressure alarm mats and that further assessments and applications in respect of these restrictions needed to be completed.

We noted that there had been some improvements to the service. For example, the medicine system was now robust and the premises were clean and tidy. Staff meetings were occurring which allowed the staff the opportunity to share their views on the running of the service. The registered provider said they visited the service approximately fortnightly which the staff viewed as supportive. The manager told us they had received support from a 'mentor' who works within the care sector.

The overall rating for this service is '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 fully safe. Allegations of abuse were not investigated and safeguarding protocols were not followed.

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

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.

Medicine management systems were robust

Is the service effective?

Requires Improvement

The service was not entirely effective. Staff supervision had commenced however, there was limited documentary evidence to support this.

The registered 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 supported people to maintain a balanced diet appropriate to their dietary needs and preferences.

Is the service caring?

Requires Improvement

The service was not always caring. People who used the service their relatives and health care services raised staff practice issues which were then not investigated.

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

People and their families were involved in their care and 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. Some people's needs had not been
thoroughly and appropriately assessed. This meant people did not always
receive support in the way they needed it.

People were able to take part in a range of activities of their choice. However, the recording of the activities provided and their value was inconsistent.

Information about how to complain was readily available. Some people told us they would be happy to speak with the management team if they had any concerns.

Is the service well-led?

Inadequate

The service was not well-led. The service did not have a registered manager and the acting manager had been tasked to provide leadership to two services some distance apart. Management of the service was not delivering a good quality service.

There were systems in place to assess and monitor the quality of the service provided to people. However, audits had not identified some areas where improvement was required.

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 9 January 2017 and was unannounced. The inspection was carried out by one inspector

The inspection was planned to check if the service had met specific needs identified following previous inspections in September 2015, February 2016 and September 2016. Before the inspection we reviewed these inspection reports and other information we held about the service. 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 four people who were able to express their views of living in the service and one relative. We spoke with two commissioners about their views of the service. We looked around the premises and observed care practices.

We spoke with three care staff, the deputy manager, catering staff, the administrator, the manager and the registered provider. 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.

Inadequate

Is the service safe?

Our findings

We received a mixed view from people about if they felt safe in the service. One person and their relative told us that "The care during the day is 100%. It's the night time that isn't." In talking with the person and their relative further they highlighted concerns about their care and safety during the night time. They had raised this with the manager but felt their concerns were not taken seriously. We had also received concerns from an external health agency regarding the care that another person at the service received during the night time.

We reviewed the accidents records for one person at the service and found that a large number of incidents occurred at night. The deputy manager said they had noticed that there were more incidents at night and had discussed this with the manager. We spoke with the manager who told us they had received allegations about care practice at night but acknowledged that they had not investigated or reported this under their safeguarding responsibility. The manager and staff were aware of the safeguarding reporting procedure but had not followed it. Therefore we referred this matter to the Local Authority safeguarding team so that a further investigation could be undertaken.

We concluded that safeguarding allegations had not been investigated thoroughly by the service and that the reporting procedure for safeguarding had not been followed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments identify different ways of working so appropriate measures can be 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 three care plans we reviewed, two had no risk assessments in place. The third person was at high risk of falls and there was no risk assessment in respect of this issue. From our conversations with staff it was clear they were knowledgeable about the care needs of people living at the service but there was no guidance so that staff could ensure that they approached people's needs in a consistent manner. We concluded that risks were not identified or assessed adequately. Therefore there was no action agreed on how any risks could be minimised.

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.

During the tour of the premises we checked the temperature of water coming from taps. We found that the water temperature was too hot. For example, in a communal bathroom and two people's bedrooms the temperature of the water was too hot to be able to wash yourself safely without the potential risk of

scolding. In a third bedroom the hot water tap did not work. We spoke with the maintenance person at the service who said they were aware of the issue and a plumber had been arranged to place thermostatic values on all taps, and mend the hot water tap in one bedroom, the following week. Following the inspection we received an e mail to say that a plumber was at the service undertaking the work. However, while the service was waiting for repair work to be carried out no action had been taken to prevent people from using water where there was a scalding risk.

Therefore we concluded that this is 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 and September 2016 we found recruitment processes were not followed consistently. The manager showed us they had introduced a new audit trail for recruitment of staff following the last inspection. However we found that the new system was not being used consistently. Whilst the manager had ensured that application forms and Disclosure and Barring checks were now obtained, when we reviewed the files of the two newly recruited staff there were no references present. This meant that the provider did not ensure that people employed by the service were of good character or have the qualifications, competence skills and experience which are necessary for the work to be performed by them.

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

The manager divided her time between the two care services that they managed. The managers availability in the service was not recorded on the staff rota, neither was the designated person who was on call. We were made aware from records that on two occasions staff had tried to contact the manager to alert them to incidents at the service and the records stated "I tried to contact (managers name) but couldn't get hold of her." On these occasions staff had not been adequately supported by the management of the service. We advised that the staff rota needed to reflect who was working at the service at all times to ensure accountability for all staff. The manager stated this would be addressed immediately.

People felt that there were sufficient staff on duty. The manager regularly reviewed staffing levels. For example, recently a person's health had deteriorated and more staff were allocated on shift so that there were sufficient staff to meet all people's needs in the service.

The provider had reviewed staffing levels and the care staffing level had been increased to three care staff from 9am to 1pm. One of the care staff was also the activity coordinator and after completing care tasks they then undertook providing activities to people who used the service. After 1pm two care staff were present through until 7pm. From 7pm to 8pm one care member of staff and the two waking night staff were on shift. The two waking night staff were then on duty from 8pm to 8am. A cook was available each day to prepare the main meal and teas and snacks. Administrators were also employed for the service. Care staff were happier with the increased number of care staff in the mornings and felt they had more opportunity to undertake care tasks and spend time with people.

At the last inspection in September 2016 we found the premises were not clean in all areas. On the day of this inspection we toured the whole premises and found it to be clean and tidy. We spoke with the cleaner who told us that the issue with the pets in the service was now monitored more closely. We were reassured from our discussion with them that a regular cleaning schedule of the service was now taking place.

At the last inspection, in September 2016, we found the systems in place for the storage, administration and

recording of medicines were not robust.

Following the previous inspection a new medicines system had been introduced. The deputy manager was now the delegated person for ordering and reviewing the medicines system. They had received an independent review from the Clinical Commissioning group who provided guidance and advice in how medicines should be managed in care home settings. From this the deputy manager had put in place new medicine auditing tools so that each month she reviewed all medicines to ensure that there were no discrepancies.

We reviewed two people's medicines and found that the system for recording medicines was robust. Medicines Administration Records (MAR), were completed appropriately. They recorded the amount of medicines that were received into the service as well as medicines carried forward to the next month. A disposal of medicines log was also completed. This meant that all medicines in stock corresponded with the person's records. We therefore found that the service had complied with the breach of regulation in that systems in place for the storage, administration and recording of medicines were robust.

Requires Improvement

Is the service effective?

Our findings

At the last 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.

The manager told us, that they had met with all the staff and held supervision sessions with them and completed an annual appraisal. The manager told us they planned to undertake four supervision sessions with each member of staff a year. We reviewed eleven staff supervision records and found that a formal record of staff supervision had occurred for all eleven staff on 15 August 2016. However we found that there were either no action plans for future developmental needs for staff, or it only commented that the person was undertaking NVQ training. All the records stated that the next planned supervision was to be held on the 15 November 2016 but there were no records of these sessions taking place. Staff confirmed they had met with the manager. However, we had concerns about how meaningful these sessions had been for each staff member and the manager, when eleven meetings took place on the same day. Also there was no evidence that further supervision sessions had taken place since.

We also noted that annual appraisals for six staff had last occurred on the 18 December 2015 and there were no updated appraisals since that time. The manager said that she continued to provide all supervisions and appraisals. The provider had completed an in-depth appraisal of the manager in 2016 but this was not dated or signed.

The manager continued to divide their time between managing the provider's two care services, which are of a distance of 101 miles apart. The manager spent two days a week at Tolverth House and three days a week at the other care service. The manager acknowledged that this had an impact on when they could undertake certain managerial tasks, such as staff supervisions as it was dependent on their availability. Staff said that they could approach the manager however they commented that they felt she was under a significant amount of pressure managing two services and would try to manage situations themselves. This demonstrated that staff were hesitant to contact the manager if they needed support.

From both discussions with staff and reviewing staff files it was evident that staff had attended training since our previous inspection. Records confirmed staff had recently attended safeguarding and mental capacity training. However, it is of concern that when issues regarding safeguarding happened staff did not follow the guidance given in their training.

We concluded that while some progress had been made in the provision of staff training and supervision these had not yet been effective. Therefore this contributes to a repeated 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). The manager had carried out two assessments to see if there were any restrictions in place for people, that might mean an application under DoLS would need to be made. Where restrictions had been identified, appropriate DoLS applications had been submitted and the service was waiting for assessments to be undertaken.

However the front door of the service had a chain, two door locks and a dead lock fitted on it due to previous incidents of two people who were at risk if going out alone, leaving the service without staff being aware. All exterior doors were now fitted with locks and window restrictors were in place. We were told these have all been approved by the fire authority. However, all the people at the service were now restricted within the building as they could not leave the property freely due to the security in the service. So the people who were not at risk, if going out on their own, could not now do so when they wished. In addition we found that there were other restrictions of peoples' rights which had now been put in place, such as pressure alarm mats. However no assessments had been carried out to identify that these restrictions were in peoples' Best Interests. In talking with the deputy manager she acknowledged that further mental capacity assessments, Best Interest agreement processes and DoLS applications were needed in respect of the restrictions in place for people at the service.

This in a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014.

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. However, consent forms were not consistently signed or an explanation recorded if it was not possible to obtain written consent.

People were able to make choices about what they did in their day to day lives. For example, when they went to bed and got up, who they spent time with and where, and what they ate. A person told us, "I'm content."

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.

Staff cooked on a domestic cooker for approximately 20 people. The small size of the cooker and the demands of the service had been discussed with the registered provider at the previous inspections. At this inspection the registered provider, after further discussion, went out during the inspection and purchased a larger cooker that met the demands of the service.

People had access to healthcare services and received on-going healthcare support. Specialist services such as occupational therapists and community psychiatric nurses were used when required.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people about the care they received. One person and a relative told us that "The care during the day is 100%. It's the night time that isn't." Another person told us they were content. We also saw a letter of thanks from a relative about the service their family member received.

As detailed in the safe section of this report concerns had been raised about staff practices. This had initially been raised from an emergency health care agency. In talking with a person and relative they raised concerns regarding particular staff care practice to us. We also noted in records that the language staff used to describe incidents was not always respectful. For example '(Person's name A) was good. (Person's name CB) was on one'. The manager told us that they had spoken with staff regarding the use of language and the provider recognised this was a training issue. However, as noted in the effective section of this report no records of these conversations had been made in the staff members supervision records. Therefore no action on how to address this had been agreed between the manager and staff.

Therefore this contributes to a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoke to us about people fondly and went out of their way to support people. For example, a person told us they wished to have a daily newspaper. The staff member spoke with the person, listened to their request and responded immediately by arranging for a paper to be delivered from the next day. A staff member responded promptly when a person was calling out and gave appropriate reassurance and spent time with the person until their anxiety levels had reduced.

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.

Requires Improvement

Is the service responsive?

Our findings

We had received concerns from the ambulance service about when they were called to the service to assist a person, and staff did not have access to the person's care plan or any contact details. This meant that staff did not have access to, or any knowledge of, the person's medical needs to share with the paramedics in an emergency situation. Neither could contact be made with the persons next of kin to alert them to the situation. The manager and deputy manager told us that the next of kin contact details were available, but the night staff could not locate them. It is of concern that information was not accessible to staff at all times so that it could be shared with other agencies in a timely manner to ensure that the person received the appropriate support. This has been raised as part of a safeguarding issue.

We reviewed three people's care records. We found that two people who had been resident at the service for the last month did not have a care plan. Basic contact information was written on a 'All about me" sheet. In respect of meeting peoples care needs it was recorded on this sheet, "needs help with full personal care by two carers'. This did not provide staff with information, guidance or direction on what the person's needs were or how staff were to provide their care. There was no assessment of the individual's needs from which a comprehensive care plan could be developed to describe how care should be delivered to meet their assessed needs. Staff said they felt they were able to meet the person's needs by getting to know them.

The manager told us that they had not written the care plans for these two individuals as they originally had been admitted to the service as a respite placement. It had since been agreed they would remain at the service permanently. However, all people who are using the service must have a care plan in place so that staff are knowledgeable in how they are to provide consistent support to the person at all times irrespective of the status of their stay.

At the inspection of September 2015 we found that a person who had been at the service for five months did not have a care plan and we issued a breach of regulation. Following that inspection the manager ensured that care plans were present for all people using the service by February 2016. It is therefore a serious concern that we have identified that this inspection had not completed care plans for newly admitted people to the service. Therefore the breach of regulation has been reissued.

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

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. As detailed in the safe section of this report a person and a relative told us they had raised a concern but felt they were "not taken seriously." They also worried that if they raised concerns there maybe repercussions for the family member's placement at the service.

Staff felt able to raise any concerns. They told us the management team were approachable and would be

able to express any concerns or views to them and felt they would be listened to. Staff told us they had plenty of opportunity to raise any issues or suggestions

An activity coordinator was employed five mornings a week. They also undertook some care tasks at the beginning of their shift. People were pleased with the level and range of activities on offer. People told us they were looking forward to an outing the next day. Nine people and three staff were going on the day trip and had organised transport so that they could all travel together. Activities were provided five times a week in the mornings. The service's activities coordinator told us people participated more in the morning activity. Outside entertainers, the local minister and a group of school children had visited the service recently.

Inadequate

Is the service well-led?

Our findings

The service is required to have a registered manager in post. At the time of our inspection, there was no registered manager in post. A valid application had been received by the Care Quality Commission in October 2016 which was being considered at the time of the inspection.

The service has not had a registered manager in post since January 2014. An acting manager was appointed in January 2014 who had the day to day responsibility for running the service. The provider informed us that they had appointed the manager to also manage their other care service, which is located one hundred miles away in June 2016. The consequence of this was that the manager had doubled their day to day managerial responsibilities and needed to divide their time equally between the two services. However, there remained failings in the overall management of this service which have resulted in breaches of regulations being identified.

At our inspections in September 2015, February 2016 and September 2016 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. We reviewed this warning notice and found the following. 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, at the September 2015 inspection we found that care plans were not in place for all people at the service, this was found again at this inspection. This meant staff did not have information, direction or guidance in how to support a person care needs.

At the inspections in September 2015, February 2016 and September 2016 we found recruitment processes were not followed consistently. The manager showed us they had introduced a new audit trail for recruitment of staff following the last inspection. However we found that the new system was not being implemented consistently. Whilst the manager had ensured that application forms and Disclosure and Barring checks were now obtained, in the two newly recruited staff files we reviewed, we found no references were present. We also found documentation relating to other staff members who are employed at their other care service, on other staff member's files. This did not follow the manager's recruitment audit trail. This demonstrated that the audit tool introduced by the manager was not effective as the gaps in records obtained had not been identified.

The registered provider had introduced new job specifications for the manager and deputy manager which were shared with us. The manager told us they felt that they needed to delegate further work and had discussed this with the provider. Due to this the manager had delegated some jobs from the deputy manager to a specified care worker. When we spoke with the care worker they were not aware of what role they were now responsible for. The provider and manager acknowledged that no written records of these discussions had occurred so that there was no audit trail of how they planned to monitor and improve the service.

Following each inspection we requested that the provider submit an action plan on how they would address

the shortfalls of their service. To date we have not received one. From the issues highlighted in the previous inspection report and in this report, it is of concern that the management team have not openly shared with us how they intend to address the failings of the service.

These examples evidence that the service's quality assurance processes were not operated effectively and that the provider and manager had failed to identify areas of significant concern.

The manager divided her time between the provider's two care services. Staff said they could contact the manager at any time. However we noted in daily records and from accident sheets that there were times when staff attempted to contact the manager in an emergency situation and were unable to do so. Staff then would 'phone around' until they spoke to another member of staff who lived locally to help them. Some staff said they felt the manager dividing the time between the two homes was "too much" and that this had an impact on the quality of service at Tolverth house.

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

At the September 2016 inspection we identified that the provider had not been notifying us of significant events. The provider is required by law to submit notifications to CQC of significant events such as injury or any safeguarding concerns. We found the service had not submitted statutory notifications as required since the September 2016 inspection. For example, when reviewing accident reports we noted that when a significant event had occurred, such as a person requiring emergency medical treatment following a fall, the service had still not notified us. This demonstrated the provider continued to not act in accordance with their legal responsibilities.

This in a breach of Regulation 18 HSCA 2008 (Registration) Regulations 2009

We were told that staff meetings now occurred, which allowed staff to share their views on the running of the service. Minutes of the August 2016 meeting were seen. We were told another meeting had occurred but minutes of this meeting were not available.

We were told that the service's policies and procedures continued to be reviewed to reflect current practices within the service.

The provider told us he now visits the service fortnightly. Staff spoke positively about the manager and provider and felt able to raise any concerns with them and said they were confident they would be listened too.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person must notify the Commission without delay of incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. All premises and equipment used by the service must be properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse.

There were restrictive control measures in place which had not been adequately assessed for or consented to.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure that people employed by the service were of good character or have the qualifications, competence skills and experience for the work to be performed by them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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