Mr & Mrs G W Sear

Mount Pleasant Care Home

Inspection report

18 Rosemundy
St Agnes
Cornwall
TR5 0UD

Tel: 01872553165

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection of Mount Pleasant Care Home on 28 January 2016. Mount Pleasant Care Home is a residential care home, which provides care and support to older people, some of who live with dementia. The service is privately owned and can accommodate a maximum of 22 people.

On the day of the inspection there were 19 people living at Mount Pleasant Care Home. The service was last inspected in September 2014 when the service was meeting the regulations inspected.

Services are required to have a registered manager and at the time of our inspection the owner of the service was also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service manager had submitted a notice to the CQC that the registered manager would take a leave of absence from the service for three months. Management arrangements during this time were the responsibility of the office manager.

Risk assessments and personal emergency evacuation plans (PEEP's) were not always updated when people's needs and capabilities had changed. People's needs were not always assessed and their care plans did not give enough guidance to staff on how people wanted to be supported. People and their relatives were not routinely involved in the on-going reviews of their care.

Premises were not properly maintained. The front porch, which was also the main entrance to the service, was damp and had black mould patches on the walls and ceiling. Cleaning of equipment such as manual handling equipment was not routinely carried out. People's rooms were personalised and decorated to suit their needs.

Appropriate systems were in place to order, store, administer and dispose of people's medicines. However, there was no system in place to record medicine errors. There was no medicines auditing used to ensure processes were accurate and following best practice. Not every staff member who administered medicines had been fully trained in safe medicines administration.

Staff and management did not have a good understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and were not knowledgeable about the requirements of the legislation. This meant people did not have their capacity to make decisions appropriately assessed or receive the legal protections offered by the Deprivation of Liberty Safeguards.

The quality assurance management systems were not sufficiently robust in detecting when people's needs had changed and care plans were in need of updating. The service did not use audit processes to check that procedures were carried out consistently and to a good standard. This was evident in equipment cleaning processes and in medicines management.

While the culture of the service was essentially caring it was not always personalised to the individual and did not encourage people to make choices about their lives. People were not always treated with dignity and respect when choosing how independent they wanted to be while living at the service. For example, people were discouraged from having a key to their room. People could not choose when to have a bath as there was a rota in place for people to have a bath once a week. People's dignity was not respected because communal net underwear was used.

On the day of our inspection there was a calm and relaxed atmosphere in the service. We observed people had a good relationship with staff and staff interacted with people in a caring and respectful manner. One person said, "It's good as far as I am concerned. Staff are very ready to help you when you need it and there is always a nice atmosphere." A relative said, "Staff are very helpful and friendly."

Relatives and visitors were made welcome. A relative said, "The staff are all so friendly, lovely and helpful. We pop in whenever we want and they're always very welcoming." People had opportunities to take part in a range of social activities offered at the service. There was a complaints procedure in place and the provider had responded appropriately to complaints.

Staff employed at the service were familiar with the safeguarding and whistleblowing procedures. There were sufficient numbers of staff available to meet people's care and support needs. Recruitment processes for care staff were robust. However, checks were not completed for volunteers working in the service.

People told us they thought the staff had the right skills and knowledge to meet their care needs. The service provided regular supervision and an appraisal system to support staff. This did not extend to senior staff such as the office manager and deputy manager in charge of care, who did not receive supervision.

We identified breaches of the regulations You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. Risk assessments and personal emergency evacuation plans (PEEP's) were not always updated as and when people's capabilities had changed. Some risk assessments were not clear in the actions required to manage the identified risks for people.

Not all staff had been fully trained or assessed as competent to administer medicines. Audit processes to check the quality of the medicines management systems were not completed.

Some areas of the premises were not maintained to an appropriate standard and some equipment was not adequately cleaned.

Recruitment processes for care staff were robust. However, checks were not completed for volunteers working in the service.

Is the service effective?

Requires Improvement

The service was not entirely effective. Staff did not have a good understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and were not knowledgeable about the requirements of the legislation.

Advice had not been sought about how to meet the needs of people who had special dietary requirements.

People received care from staff who had the knowledge and skills to meet their needs. Care staff received regular supervision and support. This did not extend to senior staff.

People saw health professionals when they needed to, so their health needs were met.

Is the service caring?

Requires Improvement

The service was not entirely caring. Care plans did not record in any detail what people's choices and preferred routines for assistance with their daily living.

People's dignity was not always respected because some items

of personal clothing were shared. The opportunity for people to make choices about their daily lives was limited in some areas.

People were treated with kindness and compassion and their privacy was
respected.

Relatives and visitors were made welcome and had privacy to meet together privately.

Is the service responsive?

Requires Improvement

The service was not responsive. People did not always have a needs assessment or care plan put in place on admission to the service.

Information in some people's care plans had not been updated and lacked clarity on how their current needs were being met.

People and their relatives were not involved in the on-going reviews of their care.

The service had an effective complaints procedure in place. There were appropriate systems in place for responding to complaints.

Is the service well-led?

Requires Improvement

The service was not well led. The culture of the service was essentially caring but it did not have a clear vision and set of values to ensure people had choice and control over all areas of their lives.

The designated service manager did not have oversight into all areas of the service.

Records in relation to people's risk, care and treatment were not robust.

The service did not have an effective quality assurance process in place to regularly assess and monitor the quality of service that people received. There was a lack of any audits to monitor the running of the service and the care provided to people.

Mount Pleasant Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced inspection took place on 28 January 2016. The inspection was carried out by two inspectors.

We reviewed the information we held about the service such as notifications of incidents. A notification is information about important events which the service is required to send us by law. We also looked at the last inspection.

We spoke with a range of people connected with Mount Pleasant Care Home including eight people who lived at the service, four relatives of people who used the service and five staff members. We also spoke with the office manager, who had been designated as overall service manager for a three month period, the deputy manager and a district nurse who visited the service. Following the inspection we contacted three health and social care professionals to gather their views, which are reflected in the report.

We looked at four sets of records relating to people's individual care and nine staff handover records We also looked at three staff recruitment files, staff duty rosters, staff training records and records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

During the inspection we observed medicines being administered to people and found they were given to people safely following the medicines policy guidelines. Staff asked people for their consent before their medicines were given to them.

The deputy manager had responsibility for all medicines processes such as stock control, recording and returns of unused medicines. Medicines were stored appropriately and records seen demonstrated that people's medicines were safely managed. However, there were no audit processes carried out to check the quality of the medicines management systems. There was no system in place for recording medicines errors. The deputy manager said there were rarely any medicine errors to record. However, we found a recording error had been made about the amount of stocks held of one medicine. This meant management were not aware of areas were improvements to the medicines systems could be made.

Not all staff who were handling medicines had received full training in medicines administration. The service did not operate a competency based screening of staff to help make sure staff knew what they were doing and felt confident when handling medicines. Medicine Administration Records (MAR) records were accurate; however, eye drops/ointments had not been dated on opening. This is good practice as some medicines lose effectiveness once opened.

Personal emergency evacuation plans (PEEP) were not in place for people using the service. This meant there was no documented plan of how people would be evacuated safely if there was a fire or other emergency at the service. The deputy manager told us it would be staff's responsibility to evacuate people safely. However, no analysis of people's ability to move around independently or changes to their mobility had been carried out. This meant there was a lack of accurate information to make sure people could be safely evacuated from the building in an emergency.

Risk assessments were in place to promote and protect people's safety. Staff said they knew the risks for people they cared for, as they knew people well. Some risk assessments were not clear in the actions required to manage the risks. For example, one person had displayed aggressive behaviour towards others. A note on a slip of paper had been inserted inside their care plan stating they had been placed on 15 minute observations. Their risk assessment documentation did not explain why the observations had been put in place and gave no detail of the risks to the person or to others and how they were to be managed.

We saw a record of incidents and accidents for the service entitled a 'falls record'. This detailed when people had fallen. One person had fallen nine times over a six week period. Management had not identified any patterns or trends in accidents and incidents which could be corrected, and subsequently reduce any apparent risks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of the premises were not were properly maintained. The entrance porch had a leak in the roof which had resulted in black mould staining on the walls and ceiling. The office manager told us the service had tried to secure a builder to carry out the required work but had not yet arranged a definite date when this work would be carried out. The environment was mainly clean but equipment used by people to help with their mobility had not been cleaned.

A maintenance person worked part-time at the service to carry out regular repairs and maintenance work to the premises. Records were kept of tasks that had been carried out. We saw a number of wall mounted soap dispensers that were no longer used, one of which had been taped to the wall to keep it in place. These had not been identified as needing to be removed as a maintenance task.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us that they enjoyed living at Mount Pleasant Care Home. We saw people were relaxed and at ease with staff, and when they needed help or support they turned to staff without hesitation.

People were safeguarded against the risk of being cared for by staff that were unsuitable to work in a care home. We saw evidence that staff recruitment procedures included checks on previous employment and written references had been obtained from previous employers. We also saw that checks had been carried out through the government body Disclosure and Barring Service (DBS) that included checks for any criminal convictions. The service did not apply the same safe recruitment processes when contracting staff from outside the service. For example, a volunteer worker provided weekly social activities with people who lived at the service. While they did not work unsupervised with people, management had not carried out a DBS check to find out if it was safe for them to work in a care environment.

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and knew what action they should take. Staff told us if they had any concerns they would report them to management and were confident they would be followed up appropriately. Staff received safeguarding training as part of their initial induction and this was regularly updated. There had been no recent safeguarding referrals made to the local authority.

People told us they thought there was enough staff to support their needs. A relative said, "I have never had any reason to think it's been short staffed. There's always someone around to help people and they are quick to come if a call bell is rung." Call bells were answered quickly on the day of inspection.

People who were at risk of developing pressure sores were seen regularly by the district nursing team. We saw that pressure relieving equipment had been put in place to minimise the risks of further tissue damage.

There was a system of health and safety risk assessment being used. There were smoke detectors and fire extinguishers in the premises. Fire alarms were checked by staff, the fire authority and external contractors, to ensure they worked effectively. Management said a recent fire safety check had been carried out and a report had been issued. This was not available for inspection as it was not kept on the premises. We requested a copy of this report be provided after the inspection. However, this was not received.

Requires Improvement

Is the service effective?

Our findings

The management and staff at the service did not have a working understanding of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLs). Staff had received training in this area but did not recognise when it was appropriate to carry out capacity assessments and introduce best interest meetings in order to make sure people's legal rights were upheld under the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLs).

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. At the time of our inspection the service had not carried out capacity assessments for people who lacked the capacity to make certain decisions for themselves and had not made the required DoLS applications for people who required a DoLs authorisation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people had a diagnosis of diabetes. This meant they were advised to follow specific dietary menus. Care records recorded each person, 'should follow a diabetic diet' but provided no further details about what this should consist of. Staff told us there were always a low sugar option dessert available for people with specific dietary needs if they chose. However, there was no specific guidance for staff about what a 'diabetic diet' would consist of. We saw no evidence that the service had worked with diabetes specialist services or nutritionists to develop best practice guidelines for people who lived with diabetes. This meant people were at risk of not having enough choice of appropriate low carbohydrate and low sugar foods to meet their dietary and health needs.

We recommend that the service seek advice and guidance from a reputable source, about supporting people's dietary requirements when they have been diagnosed as having diabetes.

We saw people's rooms had been personalised and decorated to suit their needs. People could choose their own décor and bring personal items of furniture to the service if they chose to. Living areas such as the lounge were clean and well looked after. Outside, there was a secure garden area and this was maintained to a good standard.

The design, layout and decoration of the building met people's individual needs. Corridors and doors were wide enough to allow for wheelchair access and there was appropriate equipment such as hoists, in use

where required for safe moving practices.

People had mixed views on the menu choices and quality of food offered at Mount Pleasant. Some people said the choice of foods offered was good, others thought the choice was limited and repetitive. One person told us, "The food is beautiful every day", while another person commented, "The food is mixed. There isn't much choice." Daily menus showed people had a choice between two main options at lunch time. Staff told us people could ask for something else if they wanted to. One person with specific food requirements said, "They provide me with what I need. If I want something special I can ask."

People told us they were able to access drinks when they wanted and we saw that staff offered drinks throughout the day. People said the meal time experience was enjoyable, and they could choose where they ate their meal. The dining room was well laid out and nicely decorated. On the day of the inspection the meal was served on time and the staff provided help to people who needed assistance to eat and drink. They ensured that each person had sufficient quantities to eat and drink. Some people said they chose to eat their meals in their rooms, or in the lounge area.

One person had been identified as at risk of not eating and drinking sufficient amounts. This person had their daily food and drink recorded and was regularly encouraged by staff to have snacks. The manager told us that no one currently resident at Mount Pleasant needed a dietary assessment by a speech and language therapist (SALT).

People told us they thought the staff had the right skills and knowledge to meet their care needs. The service had an induction policy in place and staff told us when first taking up employment at the service they were provided with induction training. They told us this included areas such as, moving and handling, confidentiality, fire safety, food hygiene, choice, dignity and independence. The service had not updated their induction in line with the Care Certificate. The Care Certificate replaced the Common Induction Standards in April 2015. This is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector. Management told us the service had not needed to put any staff through an induction since the Care Certificate came into place.

Staff told us they were also provided with training that covered health and safety, infection control, behaviour and risk management. Training was provided, in the main, by a television based training package along with some computer based training provided by the Local Council.

The service had good working relationships with other healthcare professionals who also provided support as needed to meet people's specific needs, such as GP's, district nurses and social services. For example, where people had specific health conditions such as diabetes they were supported to access specialist services. This included having their blood sugar levels monitored daily and eye and foot checks to make sure associated health conditions were regularly monitored.

Staff told us they were provided with the opportunity to obtain a recognised accredited care qualification such as a Diploma in Health and Social Care. We also saw records of training, which demonstrated that staff training was on-going. All care staff were qualified or were working towards a Diploma in Health and Social Care. The service had a training calendar to make sure staff received relevant training that was kept up to date. The service provided training on conditions that affected people who lived in the service, such as dementia awareness and diabetes care.

People's needs were met by staff that were appropriately supported and supervised. Staff said management and senior staff were approachable and always willing to offer advice, support and practical help. This gave

staff the opportunity to discuss working practices and identify any training or support needs. Staff also said there were regular staff meetings which gave them the chance to meet together as a staff team to discuss people's needs and any new developments for the service. Senior staff such as the deputy manager and office manager did not receive regular supervision but confirmed the provider of the service was supportive when required.

Requires Improvement

Is the service caring?

Our findings

Care plans did not record in any detail people's choices and preferred routines for assistance with their personal care and daily living. We were told people chose to take a bath once a week and there was a bath register in place for when this would be. However, some people living in the service had not been assessed to check if they had the mental capacity to agree to this arrangement. Although, seven people had en-suite facilities to use, an additional 12 people used one bathroom because the second bath was not in use. This arrangement did not meet people's preferences to bathe when they chose to rather than by a rota.

People were able to make limited choices about their daily lives. For example, people could choose to meet with others in the lounge, stay in their rooms or take part in arranged social activities. They could not, however, choose to take a trip into the local town. This was because only one person could independently access the community. One other person was supported by a friend to go out on trips. Everyone else was limited to activities inside the service as there was no appropriate transport available to support people to leave the service. Management told us, trips had been offered in the past but this was no longer possible.

Some people had asked to have a key for their room and this was discouraged. They told us, "we aren't allowed to have locks on our door." We asked management about this and were told it was because of safety concerns in case people locked themselves in their rooms. We were told one person had requested a key and this had been provided but it was preferred if people did not lock their doors. We also found people did not have access to any lockable storage facilities in their rooms. This meant people who wanted their valuables locked up had to give them to management who locked them in the main service safe. One person was reluctant to do this because they wanted their valuables close at hand. They had used a lockable suitcase which they kept in their room. This did not provide people with an effective choice about areas of their life they felt were important to them, such as the freedom to lock their door.

Some people had been assessed as requiring specialist close fitting net pants to help secure their specific continence pads. We saw these pants were shared communally and were not named for each person's individual use. Sharing equipment and underwear does not respect people's dignity.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection there was a calm and relaxed atmosphere in the service. We observed people had a good relationship with staff and staff interacted with people in a caring and respectful manner. One person said, "It's good as far as I am concerned. Staff are very ready to help you when you need it and there is always a nice atmosphere." A relative said, "Staff are very helpful and friendly."

Staff were positive about their work and told us they thought people were well cared for. Staff told us, "I love working here. The most important thing for me is that residents are happy, clean, comfortable, tidy and safe." We saw staff took the time to speak with people as they supported them and we saw many positive interactions between staff and people who lived at the service. For example, staff were patient, kind and

encouraging when supporting one person to have lunch because they needed encouragement. By interacting and encouraging the person it helped to ensure the person was able to have some nutrition.

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 the lounge or in their own room. Visitors told us, "The staff are all so friendly, lovely and helpful. We pop in whenever we want and they're always very welcoming" and "We are made to feel very welcome when we visit. The staff are lovely and we're offered a cup of tea. It's a nice place."

People told us they could talk to staff at any time about what was important to them, although this was not always recorded in their care plans. For example, on the day of inspection a staff member took time to sit with a person to discuss their health needs following some test results. People had an opportunity to make their views of the service known in the annual quality assurance questionnaire.

Requires Improvement

Is the service responsive?

Our findings

People said they were not involved in the assessment of their needs. We found people did not always have their needs assessed before moving into the service. This meant management could not be confident the service was able to meet people's needs and expectations before they moved into the service.

Where people had moved into the service, for a period of respite care, an assessment of needs for the person had not been carried out. Management told us this was usual practice for respite care because people were living at the service for a short period. However, we saw a number of people had moved into Mount Pleasant as respite and then stayed. In these cases an assessment of needs was not completed. This did not enable people to understand the care or treatment choices available to them or support them to make decisions about their own care. Relatives also confirmed they were not invited to be part of the review process. Management said people and their relatives could speak to staff and management informally whenever they wanted to. However, people did not feel they were expected or had permission to be part of the care review process.

People's care plans were not personalised to the individual because they did not give clear details about each person's specific needs and how they liked to be supported. Care plans were out of date and did not reflect the current situation for the person they were about. For example, one plan stated a person was more independently mobile than other medical records stated they were. In another care plan a person's partner was referred to throughout the plan when the person was deceased.

Care plans were not updated as people's needs changed and did not provide clear direction and guidance to staff in order to meet people's needs and wishes. There were records that showed some care plans had been reviewed. However, these reviews had not been robust enough to assess people's needs or reflect on any changes that would need to be updated in an individual's care plan. Management confirmed that people's care planning needed to be updated.

Daily records and staff handover documents did not provide a clear picture of how people had spent their time or what their current needs were. These records were repetitive, often did not state clearly what a person had been doing or how they were and tended to be task focused. For example, "All personal care given, seems well." This meant vital information about people's care needs was not recorded so any changes to people's needs could not be communicated to staff or used to update people's care plans.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people required medical attention, staff responded appropriately and made arrangements for treatment as quickly as possible. On the day of inspection we met an audiologist who had been called in to see a person who had begun experiencing problems with their hearing.

People had access to a range of social activities throughout the week. Activities included physical activities,

games and creative pursuits such as painting and drawing. People were free to attend activity sessions or not as they chose. A hairdresser provided a service fortnightly. There was also a weekly opportunity for bible reading with members of a local church and a twice monthly church service held at Mount Pleasant. One person chose to worship with another church denomination and this had been supported.

People and their families were given information about how to complain and details of the complaints procedure were given to people and displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. One person said, "I have no complaints. When I have had any concerns I have spoken with staff and have been reassured." A relative of a person who lived at the service told us they had never had to make an official complaint to management. They said when they spoke informally about any issues these were always resolved quickly and to their satisfaction.

Requires Improvement

Is the service well-led?

Our findings

The service provider was also the registered manager of Mount Pleasant Care Home. The provider had taken a three month break from the service and had appointed the office manager as overall service manager in their absence. Throughout the inspection we found the interim service manager was unable to provide certain documentation such as financial checks of people's personal monies and a fire safety report. This was because they did not have access to these records. This meant interim management of the service did not have complete oversight into all areas of the running of the service.

The service did not have a clear vision and set of values particularly in relation to the equality of choice for people who lacked the mental capacity to make certain decisions for themselves. Management and staff had a focus on care for people but showed an unclear understanding of the legal obligation of the provider to meet the requirements of the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards.

While the culture of the service was essentially caring it was not always personalised to the individual and did not encourage people to make choices about their lives. Some people had asked to have a key for their room and this was discouraged. People could not choose when to have a bath as there was a rota in place for people to have a bath once a week. People's dignity was not respected because communal net underwear was used. Care planning processes such as needs assessments, care plans and reviews were inconsistent. As a result the service was missing essential good practice such as person centred care planning.

The service did not have an effective quality assurance process in place to regularly assess and monitor the quality of service that people received. The quality assurance policy stated the service take, "a pro-active approach, to introduce quality systems that incorporate audits and feedback so that every part of the home and its services can be evaluated to ensure improvements are continuous." We found management were not meeting the procedure in the policy because quality audits were not taking place. For example, management had not identified that schedules for the cleaning of hoists were not being consistently carried out and some areas of the premises were not maintained to an appropriate standard. Patterns or trends in relation to accidents and incidents had not been analysed to identify how any risks to people could be reduced. Recruitment processes when using external contractors were not robust. The lack of medicines audits meant that recording errors in the administration of medicines had not been identified. This meant there was no management oversight into the quality of service provided at Mount Pleasant.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the service and their relatives received an annual quality satisfaction questionnaire. We looked at the questionnaire responses from the last questionnaire in 2015 and saw comments from people were positive. Relatives of people who used the service said they were kept informed informally of what was happening in the service. Some people who lived at Mount Pleasant expressed a wish to be more involved

with menu planning.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not carried out, collaboratively with the relevant person, an assessment of the needs and preferences for the care and treatment of people. Regulation 9(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People must be treated with dignity and respect which supports their autonomy and independence. This relates to people's choice to have a lock on their doors and the practice of sharing communal personal clothing. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment must only be provided with the consent of the relevant person. The legal guidelines of MCA (2005) had not been followed. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed the risks to the

health and safety of people using the service. The provider taken appropriate action to mitigate any risks to people in relation to the proper and safe management of medicine. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment All premises and equipment used by the service must be clean and properly maintained. This relates to the required maintenance of the front porch at the service and the cleaning of equipment. Regulation 15(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective quality assurance processes in place to regularly assess and monitor the quality of service that people received. Regulation 17(1)