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Mount Pleasant Care Home

Inspection report

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Date of inspection visit:
07 December 2016
08 December 2016

Date of publication:
25 January 2017

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

Mount Pleasant Care Home provides accommodation for up to 22 people who require care and support. The service mainly provides support for older people and people living with dementia. There were 16 people living at the service at the time of our inspection.

The registered manager is also the provider and has worked in this role for many years. 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 and associated Regulations about how the service is run.

We carried out this unannounced inspection of Mount Pleasant Care Home on 7 and 8 December 2016. At this comprehensive inspection we checked to see if the service had made the required improvements identified at the inspection of 27 and 28 July 2016.

Following the inspection in July 2016 it was agreed that the provider would take a more active role as the registered manager at the service. Prior to July 2016 the provider had taken a leave of absence from the position of registered manager. This period of absence had extended from January 2016 until the July 2016 inspection. CQC did not agree that the alternative management arrangements put in place for the first six months of 2016 had been adequate. During this inspection we were told the provider was still not working as an active registered manager.

The Head of Care for the service, who had taken the role of deputy manager during the provider's absence, had stepped down from this role following the July 2016 inspection. The provider had requested a member of care staff support the service with a review and updating of certain processes at the service. This arrangement ended in November 2016. The service did not have adequate management arrangements in place for the period from the January 2016 through to the December 2016 inspection and the CQC continues not to have been informed of suitable management arrangements being put in place. This meant that in the absence of the provider, there was no clear management accountability for how the service was run.

During this inspection we found the provider had failed to undertake most of the identified actions required from our previous inspections in order to become compliant with the breaches of regulations identified in July 2016.

The service did not have enough staff on duty to meet the needs of the people that used the home. There were periods when there were not enough staff on duty to meet the needs of all of the people at the same time. People commented that they at times had to wait long periods for a staff member to be available to meet their needs.

The role of activities coordinator had not been filled when the last coordinator left the post. There was little structured activity being supported in the home and people commented on the lack of stimulation. The

activity that was supplied was not chosen by people according to their interests. We found little understanding from staff about what meaningful activities might be for a person living with dementia. The service had a number of people living with dementia who were unable to regularly engage in the few activities offered. The service did not have enough staff available to support people to go out of the home.

Premises and equipment were not appropriately maintained. For example we found wheelchairs were being used without foot rests because the footrests had gone missing and one of two ovens used to cook all the meals was broken. The carpets in the service were heavily worn, stained and were in an unacceptable condition. Staff were unclear about when repair and replacement of these fittings and equipment would take place and the provider was not available to tell us when repairs and replacement would happen.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Mount Pleasant Care Home and has been rated as Requires Improvement at both of the inspections carried out in July 2016 and January 2016. At the inspection in July 2016 we had serious concerns about the lack of adequate management of the service and the well-led section was rated as Inadequate. At each inspection there have been breaches of the regulations and we issued two Warning Notices after the inspection in July 2016.

At the inspection in July 2016, we had concerns about the management of medicines. At this inspection we found continued concerns about how the service managed medicines. We found not all staff who worked over-night at the service had received appropriate training and assessment to administer medicines safely.

Medication administration records had been amended without written authorisation from a medical professional (MAR) and safe recording practices, such as double signing hand written entries as an accuracy check, had not been followed.

We found a stock of controlled drugs (CD) had been received into the service but had not been recorded into the CD record log. This meant requirements for handling CD drugs were not being adhered to. There was a medicines audit system in place; however, this had failed to pick up errors and omissions in medicines management.

At the inspection in July 2016, we found management were not operating a supervision or appraisal system to support staff; and there were no staff meetings or opportunities for the staff team to meet together to discuss working practices at the service. During this inspection we found the situation remained the same. No action had been taken to begin a formalised staff support system.

At the inspection in July 2016 we found the service was not operating an effective quality assurance process to regularly assess and monitor the quality of service people received. At this inspection we found some action had been taken to gather people's views of the service. However, no appropriate action had been taken to assure every person had an up to date care plan or monitor errors on medicine administration records. This meant there continued to be an ineffective quality assurance system in operation at the service.

At this inspection we found the service did not have robust records and data management systems. This was identified as a concern at inspections in July 2016 and January 2016. This extended to multiple areas of the running of the service including risk assessments, care planning, medicines management recording, infection control recording and the lack of quality assurance recording. This meant the service could not evidence that good practice was followed.

Five people who lived at the service did not have a care plan in place. This meant people did not have documented, individualised plans of care designed to meet their specific needs. Care plans are a means of communicating and organising the actions of the staff team. Other care plans were found to be in need of review and did not reflect the current needs of the people they were about. Four care plans, including risk assessments had been rewritten. However, where risk assessments were in place they were not updated when people's needs and capabilities changed. People's needs were not always assessed and care plans did not give enough guidance to staff about how people wanted to be supported. People and their relatives were not routinely involved in on-going reviews of their care.

The service was not operating a safe and robust recruitment system. For example we found one staff member had begun working at the service without any references being taken to verify they were of good character. This meant the provider could not be assured new employees were appropriate to begin working in the care sector.

During the inspection we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from harm because the provider's actions did not sufficiently address the on-going failings in the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Services placed in special measures will be inspected again within six months.

• The service will be kept under review and if needed could be escalated to urgent enforcement action.

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. Risk assessments were not always in place or updated when people's needs had changed. Some risk assessments were not clear about action required to manage identified risks for people. This lack of recording and assessment was putting people at risk.

Personal emergency evacuation plans (PEEP's) were not in place for everyone living at the service.

There were insufficient staff to meet peoples' needs at all times.

Medication administration records (MAR) were not accurate and Controlled Drugs were not appropriately recorded when received by the service.

Equipment was not being properly maintained to ensure people were supported safely.

Is the service effective?

Requires Improvement

The service was not effective. Care staff had not received the appropriate support for their role. There was no staff supervision or appraisal for any of the grades of staff working at the service.

Not all staff had received the training required to safely carry out their role. People did not always see health professionals when they needed to, so their health needs were not consistently met.

Is the service caring?

Requires Improvement

The service was not entirely caring. The majority of care plans had little detail of people's choices and preferences or how they were to be assisted with their daily living.

People were generally treated with kindness and compassion but their privacy was not always respected.

Relatives and visitors were made welcome at all times. There was private space for people to meet with visitors and relatives if they chose to.

Is the service responsive?

Requires Improvement

The service was not responsive. People did not always have a needs assessment or care plan 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 care needs were to be met.

People and their relatives were not routinely involved in their reviews of care.

Is the service well-led?

Inadequate

The service was not well led. The provider who was also the registered manager, was mainly absent from the service. There was no management accountability within the service to address the areas highlighted at the last inspection.

Records in relation to people's risks, care and treatment were inadequate.

The service did not have an effective quality assurance process in place, to regularly assess and monitor the quality of service that people received.

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 inspection took place on 7 and 8 December 2016 and was unannounced. The inspection was carried out by two adult social care inspectors on 7 December and one inspector on 8 December 2016.

We reviewed previous inspection reports and also looked at notifications sent to the Care Quality Commission. A notification is information about important events which the service is required to send us by law.

During the inspection we looked at four people's care plans, 16 people's Medicine Administration Records (MAR), four staff files, staff training records and other records in relation to the running of the service. We spoke with the Head of Care and five other members of staff. We spoke with ten people who lived at Mount Pleasant Care Home and two professionals who visited the service. We also spoke with two relatives of people who lived at the service. Following the inspection we received feedback from two external professionals familiar with the running of the service.

Inadequate

Is the service safe?

Our findings

Following the inspection in July 2016, we had issued the service with an enforcement action Warning Notice regarding a breach of regulatory requirements about providing care and treatment in a safe way. We had concerns about the management of medicines at the service. In particular there were concerns that pain relief medicines were not available to people overnight. There were also concerns about the safety of recording practices regarding medicines administration.

At this inspection we found the service had made changes to both the availability of medicines overnight and also to how medicines were recorded. Staff told us night staff now had access to the office where medicines were stored. However, there continued to be areas of concern regarding the management of medicines by the service.

Medication administration records (MAR) did not contain personalised protocols for 'as required' administration of commonly used medicines, such as simple pain relief. We found some handwritten additions to MARs were not consistently double signed to indicate two staff members had checked the accuracy of the added medicines. This is important as it acts as a check on the details recorded for the administration of this new medicine.

We saw amendments had been made to the amount of medicines to be administered to people with no explanation to explain these changes. For example, one person had their medicine dosage doubled without explanation or authorisation recorded on their medicine administration record. This meant the service could not evidence why or on whose authorisation these changes to prescribed medication had been made.

A stock of controlled drugs (CD) had been received into the service and had not been recorded appropriately. Some prescription medicines are controlled under the Misuse of Drugs legislation; these medicines are called controlled drugs. Stricter legal controls apply to controlled medicines. We found the service had not complied with the regulations for the recording of CDs as outlined by the Misuse of Drugs Act 1971.

The service had introduced an audit process for checking the quality and consistency of medicines administration processes. However, this had failed to identify errors and omissions in medicine recording.

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

The Head of Care had responsibility for all medicines processes such as stock control, recording and return of unused medicines to the pharmacy. Medicines were ordered and stored appropriately in a lockable cabinet kept in the office. Medicines requiring cold storage were appropriately kept.

Risks in relation to people's care were not being adequately managed. The provider had not ensured appropriate risk assessments had been completed for people who lived at Mount Pleasant Care Home. This

issue had resulted in a breach at the inspections in January and July 2016.

At this inspection, we saw one person had been assessed as being at low risk of choking but we were told this was actually a high risk if the person was unsupervised when eating. This was not clear in their risk assessment. In addition, a control measure which was included on the risk assessment was to monitor the person's intake of food. Staff confirmed no food intake chart was being used to monitor this risk.

One person had diabetes, for which they had previously being hospitalised, but had no medical or dietary risk assessment in place. This meant there was no guidance for staff about the risk of medical complications due to their diabetes or what action was required to ensure the person's condition was properly monitored.

Another person was at risk of malnutrition and was continuing to lose weight. No risk assessment had been completed to assess if a referral to an appropriate health professional would help to stop this person losing weight and what action was needed to ensure the person did not become ill. Food intake monitoring records were not being kept to assess how much the person was eating.

We were told that staff were not confident to report concerns to management, because when they had done so previously, they felt that appropriate action had not been taken. A staff member told us, "I know a member of current night staff who hasn't had any manual handling or first aid training and I did report this but nothing was done." Staff felt their concerns were not being taken seriously but showed a good understanding of where to go outside the organisation to report concerns.

Personal emergency evacuation plans (PEEP) were identified as being required for all the people that used the service during the inspections in January and July 2016. We saw thirteen out of sixteen plans had been carried out and appropriate plans produced. This meant three people did not have documented plans about how they would be evacuated if there was a fire or other emergency at the service.

Incidents and accidents were recorded. However, there were no audits used to identify patterns or trends in incidents or accidents which could be corrected, and subsequently reduce apparent risks. This meant the risks continued to impact on people.

The provider had not appropriately assessed the risk to the health and safety of people living at the service, by ensuring appropriate food safety practices were followed. We found incidents of infection control concern because cooked food was being refrigerated without expiry dates. This meant there was a risk of food going beyond safe limits for use.

This further contributed to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a continued breach from the last inspection.

Environmental risk assessments were not consistently completed. We saw loose wiring trailing along a corridor attached to a portable heater. We were told this was a temporary measure, but there was no risk assessment in place.

We saw manual wheelchairs were being used without footrests. It is important that people's feet are well supported when using a wheelchair. There were no risk assessments completed for using wheelchairs without the support of a footrest. Staff told us the wheelchairs without footrests had become broken and had not been replaced. Staff confirmed this had been brought to the attention of the provider and no action to repair or replace the faulty wheelchairs had been taken. We were told the service did have three wheelchairs fitted with footrests but these were kept only for use when people had to leave the building.

The kitchen was not satisfactorily maintained. We saw one oven had an out of order notice on it. We were told the oven had not been working for the last three weeks. We were told that the service was struggling to deliver food appropriately due to the lack of this oven facility.

Carpets in communal areas were very worn. We were told the provider was aware of this and had made arrangements for the replacement of worn carpets.

This contributed to the breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mixed views from people and professionals about whether there were enough staff available to meet people's needs. People and their relatives said they thought there were enough staff to support people's needs, although it was commented that staff are "always very busy". Staff confirmed, "We have been very short staffed recently. We lost two staff members who we have got replacements for but they haven't started yet. We are lucky that the staff we do have been willing to cover any gaps in the rota."

There were three care workers available in the morning to assist people and two care workers available in the afternoon. Overnight one waking night care worker and one other care worker who slept at the premises, and was available to be called on, to support 16 people.

We were told that one person required three care workers to assist them with their mobility and personal care in the morning and this often took up to 45 minutes. This meant that during this time all the staff were occupied with the care of one person and there was no support available for any of the other 15 people that lived in the home during this period of time. One professional commented, "In general it's a nice home but I think it's understaffed. There are quite a lot of people who use wheelchairs and it would be difficult for between two to three staff to safely evacuate people if there was an emergency."

There was no formal assessment of needs used to determine staffing numbers and the current staffing level had remained the same for at least the last thirteen years. This meant the service was not assessing staff requirements based on the personalised needs of the people living at Mount Pleasant.

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

The service had undertaken fire safety improvements following a fire safety audit visit from the Fire Brigade in April 2016.

Requires Improvement

Is the service effective?

Our findings

Recruitment procedures were not robust. We saw two members of staff were working without a record of previous employment references. This meant the provider could not be confident they were employing people suitable for the role. Another staff member told us they had not received a contract of employment despite working at the service for several months.

The service had an induction policy in place. This dealt with the logistics of working at the service such as action to take if the alarm bell sounded and about accident and hazard reporting procedures. The service had not updated their induction in line with the Care Certificate and therefore the existing induction did not give staff members new to working in the delivery of care basic skills training. The Care Certificate replaced the Common Induction Standards in April 2015. This is designed to help ensure care staff have a wide knowledge of good working practices within the care sector. Two staff had no record of having undertaken any induction.

Training records demonstrated areas of training that needed to be completed. For example, training was required in the areas of safeguarding, manual handling and first aid for the most recently recruited staff members. There were also gaps in the completion of training for other staff.

Since the last inspection in July 2016, staff who required training in the safe administration of medicines had been assessed as competent by the head of care. However, this process did not follow the service' medication policy and the head of care was not trained or qualified to provide training to staff. Therefore staff had not received appropriate medication administration training. In addition one member of night staff had not received medication training. This meant there were occasions overnight, when the service was without any trained staff to manage medicines.

Staff confirmed the training they received was mainly done by electronic learning on the computer. Some staff questioned the value of this type of training. Comments included, "Manual handling training should be physical rather than e-learning. I don't believe it is anywhere near as effective to do this type of training as e-learning." The head of care confirmed they would demonstrate the use of equipment when needed although they were not qualified to provide manual handling training but told us, "I have experience of being here."

Staff were not appropriately supported and supervised. This had been raised with the provider at the last two inspections and no action had been taken to address this. Staff told us they had not received supervision or appraisal of their work since 2015 and said, "There's been zero improvement in this." The Head of Care told us they also did not receive supervision. Staff told us they did not feel supported by the provider. This meant people's' needs were not met by staff who were appropriately supported and supervised. Staff did not attend regular meetings and there was no formalised opportunity for staff to discuss working practices and identify training and support needs.

This contributed to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack the 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 people 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 it 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). The service had made appropriate DoLS applications, and were awaiting assessment by the Local Authority Supervisory Body responsible for these.

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 mental capacity assessments. They also did not know when to carry out 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). For example, a professional we spoke with confirmed they had concerns about staff understanding of the appropriate use of the mental capacity act for people living with dementia. In addition, we found one person who did not have capacity to consent for themselves, that presented with consistently low mood and was at risk of malnutrition. The provider had not arranged a best interests meeting to discuss meeting the person's needs. An appropriate specialist referral for this person had not been considered or made by the service.

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

The provider was not meeting the specialist needs of people with conditions such as diabetes. One person with diabetes did not have a written care plan or any guidance for providing an appropriate diet. This person was noted as previously being admitted to hospital due to hypoglycaemia or low blood sugar. However, there was no monitoring of the person's blood sugar recorded, partly due to the person not having an up to date care plan. This meant there were no health records noting the potential risk of experiencing low blood glucose levels leading to hypoglycaemia. There was no information available to staff about symptoms to be aware of and what action should be taken in the event of the person becoming ill with hypoglycaemia.

There were no care records in place to direct staff about what an appropriate diabetic diet should 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 spoke with the cook about how specialist diet requirements were organised and were told there was no documented system but that if a person required a low sugar diet, a range of low sugar pudding options would be made available. However, there was no guidance available for managing individual's specialist and medical dietary needs.

Where people were identified as being at risk of poor nutrition and hydration, food and fluid charts did not contain sufficient information to accurately monitor if people were receiving adequate food and drink. Monthly weight records were kept but no action was taken to address identified concerns. We saw records that showed one person had lost over 5 kilogrammes in a six week period. No specialist referral had been made to investigate the causes of this.

This contributed to a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to access drinks when they wanted and we saw that staff offered drinks throughout the day. People told us, "The food is nice", "It's ok". "We get a choice for our main meal" and "the puddings are good." Daily menus showed people were offered a choice between two main options at lunch time. Staff told us people could ask for something else if they wanted to.

People said the meal time experience was enjoyable, and they could choose where they ate their meal. Some people told us they chose to eat their meals in their rooms, or in the lounge. Other people remarked that they enjoyed the social aspect of meeting with others to enjoy their meals in the dining room. The dining room was well laid out and nicely decorated.

Requires Improvement

Is the service caring?

Our findings

At the inspection in July 2016, we found that the service people experienced was not as caring as it should be. Staff did not support people in a way that was consistently respectful and promoted their dignity.

At this inspection, the majority of people said they liked the staff and felt they were treated with care. Comments included, "Staff are very nice, hardworking and kind. No-one shouts or is unkind", "Staff are patient and caring." A relative told us, "They know my [relative] well. Staff are patient and they take a genuine interest in her."

However, one person told us they did not feel their dignity was respected due to the length of time it took staff to support them with their personal care. They said, "I don't find it acceptable to be told someone will help me in five minutes and then they don't return for 25 minutes. I have had disagreements with them about how long I have had to wait for help." We raised this with staff who acknowledged that this had happened. ,

People's privacy was not always respected. A professional told us they had experienced staff walk into a person's room without knocking or asking the person's consent to enter; they commented that this was not the first time this had happened. This did not respect the person's dignity and right to have their personal space and have choice about when staff entered their room.

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

Five people who lived at the service did not have a care plan in place. This meant people did not have documented, individualised plans of care designed to meet their specific needs. Care plans are a means of communicating and organising the actions of the staff team. Other care plans were found to be in need of review and did not reflect the current needs of the people they were about.

Following the last inspection a staff member had begun working on care plans. Four care plans, including risk assessments had been rewritten. However, 12 people did not have appropriate risk assessments and three out of 16 people did not have a personal emergency evacuation plans in place.

Apart from the four newly written care plans, there was no social history included in any other peoples' care plans. This meant staff had no easy means of understanding the lives of people they cared for before they moved to Mount Pleasant. This was particularly important for people who lived with dementia who could not easily share their memories.

Daily records did not consistently record care interventions. For example, one person was recorded as having two baths over a four week period. This was a recording issue because the person told us they sometimes had two baths in a week. Staff confirmed that not all information about what happened during the day was recorded in the daily records.

This contributed to a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were happy living at Mount Pleasant. People said they liked the staff and were 'happy'. People could make limited choices about their daily lives. For example people could choose to meet with others to socialise in the lounge, stay in their room or take part in the minimal arranged social activities. They could not, however, choose to participate in events in the local town because only two people that lived at the service could independently access the local community and support from the service to go out was not being made available.

Staff told us they believed people were well cared for. This was also the view of relatives and professionals we spoke with. One relative told us, "We are happy with the home. Although it's not posh, it is genuinely really caring." Professionals commented, "While I am aware that there are on-going issues with the management of the home, I would have to say that my personal experience has been that the staff are very committed and caring, but I get the impression they are quite demoralised."

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 lounges or in their own room. We observed that staff greeted visitors on arrival and made them feel comfortable.

Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. We saw bedroom, bathroom and toilet doors were kept closed when people were being supported with personal care.

Requires Improvement

Is the service responsive?

Our findings

At the last two inspections in January 2016 and July 2016 we had concerns that people were not receiving personalised care that was responsive to their needs. This was because people said they were not involved in the assessment of their needs. People had not always had their needs adequately assessed before moving into the service, such as when a person came into the service for respite care.

At this inspection we found evidence that people's needs were not always assessed and care plans did not give enough guidance to staff about how people wanted to be supported. For example, one person who was living in Mount Pleasant for a period of respite care did not have an assessment of needs or care plan in place. We saw the service was reliant on the care plan that had been written by another community based care provider which had been brought in with the person when they came into the service. This meant the service did not have a current needs assessment or care plan in place to direct staff about how to meet this individual's needs.

People and their relatives were not routinely involved in on-going reviews of their care. Staff confirmed that no families or advocates for people had been invited to reviews and people had not contributed in any meaningful way to the planning of their care.

Social activities available to people were minimal. Information available to people about activities available at Mount Pleasant claimed there were, 'clubs, special events and trips out tailor made to our residents'. We confirmed with staff that these activities were not being offered.

People told us they would like to have a greater choice of activities available to them. Comments included, "There's nothing much, not that I have seen", "There's nothing to do. I'd try anything really, like crafts" and "TV most of the time. I just go to my room."
Since the last inspection in July 2016, the activities co-ordinator had left the service and had not been replaced. A staff member told us, "The activities lady we had a while ago was fantastic; she'd do really meaningful activities like individual art work and making bunting and floral displays with people who had a love for this. She was really active with the residents, but since she's gone, nothing much has been offered to the residents."

Currently the service had a church service monthly, bible reading once a week, and a hairdresser and arm-chair exercise session weekly. There was no attempt to provide social activities that were personally meaningful to individuals. In particular, people living with dementia were not catered for in terms of activities unless they could join in with organised group activities, which often they could not do.

The service did not provide care to people in a person centred way. For example, the majority of people used continence aids. Staff told us they routinely changed people's continence pads at the same times every day, such as after meals. This situation had remained the same since the last inspection in July 2016. Stating the time that people would receive their care was not person centred and did not support people's dignity or choice.

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

The service had a system for recording and responding to complaints. People who used the service told us they would be comfortable raising a complaint with staff if they needed to. Relatives said they were not routinely asked for their feedback about the service but would feel comfortable raising any issues that needed to be raised with management.

The service had completed a satisfaction questionnaire with people who used the service in November 2016. This indicated that people were generally satisfied with the service.

Inadequate

Is the service well-led?

Our findings

At the last two inspections in January 2016 and July 2016 we found the service was not well led. While the culture of the service was essentially caring, it did not have a clear vision, set of values, or ability, to ensure people were well cared for or had choice and control over their lives.

After the last inspection we met with the provider to discuss the seriousness of the situation and the publication of the issuing of two Warning Notices for breach of regulations. We were given specific assurances by the provider that management change would be undertaken at the service. It was agreed that the provider would address the changes needed to meet the regulation breaches and provide a good quality service. They also stated they would provide an action plan to CQC giving the actions they would take and the time frames within which these would be completed. Despite several attempts to contact the provider and further require the action plan to be sent, this was never received.

We spoke with Cornwall Council service improvement team and were told that a representative from service improvement had made two appointments to meet with the provider to discuss how best to support the service to meet CQC regulations and improve their service. On both occasions the agreed date for the appointment was cancelled at short notice and the service improvement team has not been enabled to support the service.

We had been given assurances that the provider, who is also the registered manager for the service would resume working at the service following an extended period of absence. During this inspection staff confirmed that the provider had not returned to the service in a working capacity. The head of care, who had previously deputised as manager during the provider's absence had stepped back from the position after the inspection in July 2016. This meant that in the absence of the provider, there was no clear accountability for how the service was managed.

People we spoke with who lived at Mount Pleasant and relatives all said they would speak with the head of care or another staff member if they had a problem and told us they did not have regular contact with the registered manager/provider. Professionals commented, "I don't think I've ever met the owner. I just thought [the head of care] was the manager."

Staff commented that it had been difficult to engage the provider to take action. Comments included, "There has been no structure in place. No leadership or accountability for things that need to be done because [the provider/RM] isn't here to make the decisions" and "I really think we need a better management system. A full time registered manager is needed. There is no support whatsoever."

The provider had not ensured that safe and robust recruitment procedures were in place. Two members of staff were working without a record of previous employment references. This meant the provider could not be confident in employing people suitable for the role. Another staff member told us they had not received a contract of employment and despite working at the service for some time, had never met the provider. They commented, "It's rather strange. I've never worked in a place quite like it."

At the last inspection we found the service did not have an effective quality assurance system to assess and monitor the quality of the service that people received. At this inspection we found some progress had been made with this aspect but that this quality assurance system had not caused the problems in the service to be addressed.

The head of care had worked with another carer to produce a medication audit. This was carried out monthly to check stock levels and the quality of recording practices. However, as outlined in the safe domain of this report, we found continued issues with medicines management at the service that the audit process had not found. This meant the thoroughness of the medication audit was not effective or reliable.

Cleaning and infection control schedules were completed. However, we found food safety safeguards were not followed with regard to the safe storage of cooked foods as we saw covered plates of refrigerated food without any expiry dates.

The service did not have robust records and data management systems. This extended to multiple areas of the running of the service including risk assessments, care planning, recruitment records, medicines management recording and the lack of quality assurance recording. Only the office administrator could operate the computer system used by the service. This meant the service could not evidence that good practice was followed.

The service did not promote a positive culture that was person-centred. With the exception of three people who had taken part in the review of their care plan, otherwise people who lived at Mount Pleasant and their relatives were not actively involved in their care planning. We saw that people did not routinely participate in the development or review of their care plans. People and relatives we spoke with told us they were unaware of the content of care plans and they had not been invited to be part of the care planning or review process. This did not provide people with care that met their individual needs and was based on their personal choices.

Staff were not supported to question practice at the service. Management were not operating a supervision or appraisal system and there were no staff meetings or opportunities for the staff team to meet together to discuss working practices at the service. Staff comments included, "I don't feel confident in the support that I have because there is no management accountability behind it" and "All the staff work well together to make this a lovely home but it essentially fails because we just haven't got the structure of any management behind it." Individual staff members told us they had raised areas of concern about care practices, such as training requirements and no action had been taken.

The provider has overall responsibility for the quality of management in the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Mount Pleasant Care Home and has been rated as Requires Improvement at both of the inspections carried out in January 2016 and July 2016. At the inspection in July 2016 we had serious concerns about the lack of adequate management of the service and the well-led key question was rated as Inadequate. At each inspection there have been multiple breaches of the regulations and we issued two Warning Notices after the inspection in July 2016.

The provider/registered manager was requested to attend a meeting at the end of our visits to the service to receive immediate feedback from this inspection. They did not attend or make contact with inspectors to discuss our immediate findings from this inspection.

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