Mr & Mrs G W Sear

Mount Pleasant Care Home

Inspection report

18 Rosemundy
St Agnes
Cornwall
TR5 0UD

Tel: 01872553165

Date of inspection visit:
27 July 2016
28 July 2016

Date of publication:
23 May 2017

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?	**Inadequate**

Summary of findings

Overall summary

The last unannounced comprehensive inspection of this service was on 28 January 2016, at which we identified seven breaches of the legal requirements. This was because the service had not made sufficient assessment of needs for people or appropriately assessed the risks of people using the service. In addition, certain practices operated by the service did not uphold people's dignity. We found legal guidelines of the Mental Capacity Act (2005) were not being met at this time. There was also an issue with cleanliness and maintenance of the premises. We found the provider did not have an effective quality assurance process in place to regularly assess and monitor the quality of the service that people received.

The inspection report and findings were published in March 2016 and the provider has a legal requirement to display the ratings of the report for the public to see no later than 21 calendar days after it has been published on CQC's website. The provider failed to do this. We were told by the provider that they were aware of this requirement.

After the January 2016 comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches. We undertook a second two day comprehensive inspection on 27 and 28 July 2016 to check that they had followed their plan and to confirm that they now met legal requirements. Prior to this inspection we received information of concern about medication handling practices at the service.

This report covers our findings in relation to the topics outlined above and a full report on all key lines of enquiry completed during this inspection.

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 18 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.

Prior to our inspection on the 28 January 2016, we had been notified that the provider had taken a three month leave of absence from the position. At the inspection on 27 and 28 July 2016 we were informed that the provider/registered manager had not returned to the post. The service was being managed by the Head of Care. CQC did not receive a notification regarding an extended absence of the registered manager from the expiry of the last notification in June 2016. Significant periods of absence from a service must be notified, reviewed and a proposed date for return or alternative and acceptable management arrangements put into place.

CQC had received an action plan outlining the action the service would take to improve the areas identified at the inspection on 28 January 2016. During this inspection we found the provider had failed to undertake most of the identified actions, which they had confirmed in writing as being completed.

Prior to this inspection CQC had received information of concern regarding the service's ability to provide appropriate pain relief to a person living at Mount Pleasant. This had resulted in a safeguarding referral to the Local Authority being made by CQC. The service had not followed their own policy regarding when incidents should be reported to the local authority as safeguarding and also failed to notify CQC regarding the incident.

During this inspection we looked at how the service managed medicines and the arrangements for providing appropriate medicines during the night. We found allegations that staff could not access required medicines for pain relief for one person, following an event when paramedics requested that pain relief be made available, were substantiated. This was because night-staff were prevented from accessing people's medicines which were locked in the office. Staff were unaware of the procedure for accessing medicines by contacting a senior member of staff when required.

We found there was a system in place to order, store, administer and dispose of people's medicines. However, the service did not have a system to record and handle medicine errors and there was no medicines auditing systems to ensure accuracy. On two occasions, staff found administered medicines, which had not been taken, in a person's possession. Staff, who worked overnight at the service and were responsible for people's care, had not received medicines training while working at Mount Pleasant Care Home and did not have access to medicines when they were required. Medicines records did not follow best practice advice and were without photographic ID to aid staff in identifying medicines were administered to the correct person.

Amendments to medicine records did not follow best practice guidance to ensure changes were witnessed by two members of staff and signed to evidence this.

We found risk assessments and personal emergency evacuation plans (PEEP'S) had not been completed. Where risk assessments were in place they were not updated when people's needs and capabilities changed. We found fire doors where the alarm had been switched off and could be easily opened to access the outdoors. Staff confirmed that people who did not have the mental capacity to keep themselves safe, had been able to use the fire door to go outside unsupported by staff. There was no risk assessment to keep people who were independently mobile and living with dementia safe from leaving the premises unseen. The provider refused to re-alarm the doors stating that it would restrict the movement of staff and others from easily accessing the outside.

People's needs were not always assessed and 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 on-going reviews of their care.

The provider, management and 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. 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 service did not have a functioning quality assurance system. This meant the service were not sufficiently robust in detecting when people's needs had changed. Care plans were not in existence for some people

and where they were they were in need of updating and inconsistent in the information they provided. The service did not use audit processes to check that procedures were carried out consistently and to a good standard. This was evident in the care planning and review process and in medicines management.

The culture of the service was essentially caring and it was clear staff were committed to providing good care. However, staffing levels were relatively low and there was not always time for staff to do more than basic care for people.

The service was not personalised to the individual and did not encourage people to make choices about their lives. For example, although there was no longer a 'bath rota' in place as seen at the last inspection, instead staff were told by senior staff who would need a bath that day. People's personal care, particularly toileting was done on a time rota rather than when people chose to go to the bathroom. We were told this was due to time constraints and the limited number of staff on duty to support such choice.

The service did not provide staff supervision or appraisal to support staff. We found significant gaps in staff training, including infection control and medicines management. Management said this was due to insufficient funds having been available to provide required training.

Over the course of the two day inspection, there was a calm and friendly atmosphere in the service. It was clear staff were busy but they took the time to encourage people to independently walk around areas of the building and interacted with people in a caring and respectful manner. People and their relatives who we spoke with said they were happy with the service.

Relatives and visitors were made welcome. A relative said, "We are always made very welcome when we come. The staff are lovely and my [relative] has told us they are happy here, so what more can you ask for?" People had opportunities to take part in a range of social activities, such as armchair exercises and religious services. However, we found little understanding from management 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 activities offered.

Work had been completed to repair the entrance porch, which had been in a poor state of repair at the last inspection. Cleaning schedules had been developed, to ensure consistent standards of cleanliness at the service. However, the cleaning schedules had not been used. We found poor standards of cleanliness in the kitchen. Throughout the rest of the service we found a generally good standard of cleanliness. People's rooms were personalised and decorated to suit their needs.

There was a complaints procedure in place and the provider had responded appropriately to complaints.

During the inspection we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulations 2009 (Part 4) People were at risk from harm because the provider's actions did not sufficiently address the on-going failings in the service. 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?

Requires Improvement

The service was not safe. Risk assessments were not always in place or updated when people's capabilities had changed. Some risk assessments were not clear about action required to manage identified risks for people.

Personal emergency evacuation plans (PEEP's) were not in place.

Medicines were not available for administration throughout the night. A safeguarding concern had been upheld by the local authority. Care staff working during the nights had not been trained to administer medications.

The standard of cleanliness in the kitchen was not maintained to an appropriate standard. Safe food management system recording practices were inconsistent.

Is the service effective?

Requires Improvement

The service was not effective. Management did not have an effective understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The provider and management were not knowledgeable about the requirements of the legislation and had not met the requirements to safeguard people's rights under this legislation.

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

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 had little detail of people's choices and preferences or assistance with their daily living.

People were treated with kindness and compassion and their privacy was 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 involved in on-going reviews of care.

Is the service well-led?

Inadequate

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

The provider who was also the registered manager, was absent from the service; management accountability was unclear within the service to address the areas highlighted at the last inspection. The designated service manager did not have oversight into the operation of all areas of the service.

The service had not followed their own policy about when incidents should be reported to the local authority, such as safeguarding alerts. The service failed to notify CQC regarding such incidents.

Records in relation to people's risks, 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 audits to monitor the running of the service and 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 inspection took place on 27 and 28 July 2016 and was unannounced. The inspection was carried out by two adult social care inspectors on 27 July and one inspector on 28 July 2016.

Prior to this inspection CQC had received information of concern regarding the running of the service. We reviewed previous inspection reports and the action plan provided by the provider. We 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 six people's care plans, 18 people's Medicine Administration Records (MAR), three staff files, staff training records and other records in relation to the running of the service. We spoke with the provider who is also the registered manager, the Head of Care and five other members of staff. We spoke with ten people who lived at Mount Pleasant Care Home and one professional who visited the service. We also spoke with two relatives of a person who lived at the service. Following the inspection we received feedback from two external professionals familiar with the running of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection CQC had received information of concern regarding the service's ability to provide appropriate pain relief to a person living at Mount Pleasant. This had resulted in a safeguarding referral to the Local Authority being made by CQC.

The information of concern received concerned staff inability to administer pain relief medicine to a person during the night following advice from South West Ambulance Trust. This meant medical advice about making a person comfortable was unable to be followed because staff could not access medicines, which were locked in an office. From conversations with staff, the deputy manager and the provider who is also the registered manager, we found conflicting accounts of events regarding why this happened. The service policy provided no clear direction about how medicines would be administered in the event of an emergency. Staff confirmed they had not been informed of the procedure for accessing required medicines during the night. The provider told us that medicines were not available to staff once the office was locked for the night. In the event of medicines being required overnight staff, were directed to call the Head of Care and/or the provider who would provide further guidance about administering medicines. This meant people did not have timely access to their medicines throughout the night. Staff told us that following the incident and investigation by social services, paracetamol was now available and kept in a box outside the locked office for use by night-staff when required.

This measure does not meet the requirement that people have access to their prescribed medicines in a timely way when they need them. For example, one person who needed prescribed medicine for a stomach condition, was unable to have this when they required it because night-staff could not access it and needed to obtain the medicine from another member of staff who had access to the office . Staff who work during the night are reliant on contacting the sleeping in member of staff or an on-call staff member to get access to medicines. This meant people were not receiving their medicines in a timely way throughout the night. Care staff who worked over-night had not received medicines training.

Medication administration records (MAR) did not contain personalised protocols for 'as required' administration of commonly used medicines, such as simple pain relief. There were numerous handwritten additions to MARs which were not 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 to the amount of medicines to be administered with no explanation to explain the change. This meant the service could not evidence why or on whose authorisation these changes to prescribed medication had been made.

The service did not have an audit process for checking the quality and consistency of medicines administration processes. There was no system for recording medicine errors. We saw two entries in the senior's diary which mentioned medicines being found with a person for no reason that could be accounted for. This meant the service could not be sure people had taken their medicine.

Medication administration records (MAR) did not have photographic ID to help staff to accurately identify

that medicines were administered to the correct person.

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

We also found the service had not followed their own policy regarding when incidents should be reported to the local authority as safeguarding and the service failed to notify CQC regarding the incident when medicines were not made available to a person when required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4)

The Head of Care was designated as deputy manager in the absence of the registered manager. The deputy manager had responsibility for all medicines processes such as stock control, recording and returns of unused medicines. Medicines were ordered and stored appropriately in a lockable cabinet kept in the office. There were appropriate arrangements for medicines which required stricter controls and medicines requiring cold storage were appropriately kept.

We found 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 last inspection in January 2016.

During this inspection we found a continued lack of appropriate risk assessments. Where risk assessments were in place, they were not updated when people's needs and capabilities changed. For example, one person was stated as being at risk of medical complications due to diabetes. However, there was no explanation or direction for staff about what this would look like or what action should be taken to mitigate the risk of this.

Environmental risk assessments were not consistently completed. We saw three fire doors where the alarms had been switched off and easily opened. Staff told us one person who had dementia had independently left the service by way of the un-alarmed fire door. We spoke with the provider about the lack of risk assessments and the dangers posed to people who lacked capacity to keep themselves safe, who could potentially leave the service unsupervised. The provider told us the fire doors would remain un-alarmed in order to allow free access to people who chose to go outside.

Not all staff were confident to report concerns to management because when they had done so previously they felt that appropriate action had not been taken. Staff reported that handover reports about one person who vigorously scratched themselves to the point of breaking their skin, had resulted in no action being taken. 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 during the last inspection in January 2016. We saw no work had been carried out to produce these. This meant there was no documented plan about how people would be evacuated if there was a fire or other emergency at the service. No analysis of people's needs and 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.

The service had undergone a fire safety audit visit from the Fire Brigade in April 2016. This had resulted in a number of breaches of fire safety regulations being identified. Following the inspection we requested a copy

of the fire safety audit and action plan, which was received. This demonstrated that required actions had been met.

Incidents and accidents were recorded. However, there was no audit 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.

This 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.

We noted the service had put cleaning schedules in place for deep cleaning of the service. However, while the majority of the service was clean, the kitchen was not satisfactorily cleaned or maintained. We saw one kitchen cabinet had expanded due to water damage and had a sign on it stating it was not to be used. We looked at record management for ensuring safe food handling practices and found these were inconsistently completed. The cook explained that the service were currently short-staffed in the kitchen, which had resulted in jobs such as deep cleaning of appliances not taking place as regularly as needed.

People and their relatives told us they thought there were enough staff to support people's needs, although it was commented that, "staff are always very busy". There were two care workers and one senior care worker available in the morning to assist people and one care worker and a senior available in the afternoon and evening. The senior care worker was responsible for administration of people's medicines, which took place up to four times per day. Overnight one waking night care worker and one other care worker who slept at the premises, and was available to be called on, cared for 18 people. Staff commented that there were usually enough staff available to carry out the work. However, we saw that three people stayed in bed due to ill-health and required the assistance of both care workers to provide for their needs. Staff told us that under such circumstances the current level of staffing was the minimum number to meet people's needs; "Things can get tight to be truthful especially when people are in bed, it is manageable when no-one is in bed. Currently we have three people in bed requiring two to one care and this is a stretch with need to do regular turns and pad changes."

Staff told us they had not had time to take their scheduled breaks during the inspection due to the amount of tasks that needed to be attended to.

Following the inspection we spoke with the deputy manager about how the service determined the amount of staff needed to meet people's individual needs. We were told there was no formal assessment of needs used and the current staffing level had remained the same for at least the last thirteen years. This meant the service were 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.

At the last inspection in January 2016, we had identified areas of the premises which were not properly maintained. This included the entrance porch which had a leak in the roof. During this inspection we saw refurbishment work had been carried out to the porch, which was now in good condition. A maintenance person worked at the service and carried out regular repairs and maintenance to the premises. Records were kept of required work and when this had been completed.

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 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).

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). We checked whether the service was working within the principles of these safeguards, and whether any conditions on authorisations to deprive a person of their liberty were being met. During the last inspection in January 2016, we found the service had not made appropriate authorisation requests for people who required these safeguards.

After a further week following the inspection, the provider still had not taken the necessary action to meet their legal obligation to assess mental capacity for six people they knew to require assessment. We then told the provider that they must make applications for urgent authorisations from the local supervisory body responsible for upholding DoLS legislation.

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. They were at risk of not having their health care needs met. Care plans were unclear in directing the appropriate care to be provided for these people. For example, records stated 'should follow a diabetic diet', but provided no further details about what this 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. One person who was recorded as having Type one, insulin dependent diabetes, had no detail of required monitoring of their blood sugar recorded in their care plan. Records noting the potential risk of experiencing low blood glucose levels leading to hypoglycaemia. However these records gave no information to staff about symptoms to be aware of and what action should be taken in the event of this happening. The same care records noted a 'choke risk' for the person but provided no further risk assessment or direction to staff about how to keep the person safe. No specialist advice or assessment had been carried out regarding the person's difficulties with eating and drinking.

This contributed to the breach of Regulation 12 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. We shared a meal with people living at Mount Pleasant Care Home on the first day of the inspection. We experienced, and people told us, that the quality of the meals provided was good. One person told us, "I like the food here. We usually get a choice for our main meal and the puddings are always 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. We spoke with the cook about how specialist diet requirements were organised and were told 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.

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.

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 sounds and accident and hazard reporting procedures. 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 practices within the care sector. Management showed confusion about what the Care Certificate was and how it could be used by the service.

The service training matrix demonstrated areas of training that needed to be completed. For example 'medication handling' had been completed by three care staff. Neither member of night staff had received training in the safe administration of medicines. The Head of Care told us this was personal choice by staff members not to undertake this training. This meant there were occasions overnight, when the service was without any trained staff to manage medicines. The provider told us staff were requested to telephone the 'out of hours' contact if people required medicines during the night.

Staff were not appropriately supported and supervised. Staff told us they had not received supervision or appraisal of their work since 2015. The Head of Care told us they also did not receive supervision. 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.

People's rooms were personalised and decorated to suit their needs. People could choose their own décor and bring personal items of furniture to the service. Living areas such as the lounge were clean and well looked after. Outside there was a patio and garden both maintained to a good standard.

The design and layout of the building was easily accessible as the building was on one level. Corridors and doors were wide enough to allow for wheelchair access and there was appropriate equipment available, such as hoists, where required for safe moving practices. The service did not use methods, such as photographs, to assist people living with dementia, to find their way around the building. Staff told us people were familiar with the lay out of the building and would be assisted by staff if they required it.

Requires Improvement

Is the service caring?

Our findings

At our last comprehensive inspection of this service in January 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. The provider told us what action they were going to take and we found some improvements had been made. However, more could be done to support people's choice over their lives.

At the inspection in January 2016 we found the service was using a rota to allocate which days people would be offered a bath. Six people lived with dementia and had not been assessed as having capacity to consent to these arrangements. At this inspection staff told us there was no longer a written rota for bathing, instead baths were allocated according to decisions made by the Head of Care. There was no written information in care plans about how the Head of Care made these decisions. We asked people about the arrangements for having a bath and everyone we spoke with confirmed they were told the day when they would have a bath. In addition, staff told us the majority of people who lived at Mount Pleasant used continence aids and were routinely offered 'pad changes' after meals. This practice does not foster dignity and respect for people who use the service.

Care plans provided inconsistent and sometimes conflicting information. For example, one person's medical information stated they suffered from a condition that limited their ability to communicate fluently. The care plan stated the person had 'good verbal communication' and then directly contradicted the information by stating the person's communication skills were 'repressed'. We found no details about how staff could promote the person's communication abilities. Some of the language used in writing care plans was not person centred and could sound judgemental. In the case of one person who had significant incontinence needs and lived with dementia it was stated, "…does not make any effort to take [themselves] to the toilet, although able to walk there independently."

There was no social history included in 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. Relatives said they thought it would be "helpful to be able to give a history."

This contributed to a breach of Regulation 9 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 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.

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, "Staff seem very caring. They always tell us if there is anything wrong and they have a doctor in when it's needed."

Requires Improvement

Is the service responsive?

Our findings

At the January 2016 inspection 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.

Following the January 2016 inspection the provider sent us an action plan stating that care plans were being reassessed and updated to reflect the individual needs of each person. This action plan stated that all care plans would be reviewed monthly and at least twice a year families or advocates would be invited to attend these re-evaluations.

At this inspection we found evidence that people's needs were not always assessed and 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 on-going reviews of their care. One relative told us, "I think it would be a really good idea to be part of reviews."

Five of 18 care plans had been reviewed by the Head of Care. Two people did not have a written care plan. Information provided by the local hospital stated the person used a catheter, inhalers and used hearing aids. There was also a comment made by the hospital about the person which mentioned 'cognitive impairment' and 'falls risk'. However, there was no further information, risk assessments or care planning to show the service had assessed this person's needs or had a plan to meet their identified needs.

The deputy manager confirmed that no families or advocates for people had been invited to reviews. Staff told us people had not contributed in any meaningful way to the planning of their care.

Care plans did not capture people's views about their strengths or levels of independence. This meant care plans did not reflect how people would like to receive their care, treatment and support. There was no personal history or details of their individual preferences. This meant it was difficult for staff to ensure people were offered as much choice and control as possible over their lives.

Although there were a small number of social activities available to people, such as skittles and baking, 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.

Monthly reviews of care plans were not consistently happening. Long gaps between reviews were seen. When reviews were completed they were short and often repetitive and did not capture people's individual needs. For example, one person's review commented only on continued use of a walking frame and one other comment about 'drinking well and eating.' The following review completed four months later commented that the person 'has not changed' and went on to contradict information about the person's interest in activities from information recorded in the care plan. This meant the care plans did not reflect the

most recent information about the person.

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 after meals. The provider confirmed that 'it makes sense' to provide this personal care support after people had eaten. 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 the 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.

Inadequate

Is the service well-led?

Our findings

At the January 2016 inspection we found that the service was not well led. While the culture of the service was essentially caring, it did not have a clear vision and set of values to ensure people had choice and control over their lives. The provider, who is also the registered manager of the service, had notified CQC that she was taking a leave of absence for three months and a designated manager was put in place. We judged that the designated manager was unable to have oversight into all areas of the service. This meant that in the absence of the provider, there was no clear accountability for how the service was run. At the last inspection, we judged records concerning risks to people and the care and treatment provided were not robust. We also found the service did not have an effective quality assurance system to assess and monitor the quality of the service that people received. There were no quality audits used to monitor the running of the service and the care provided to people.

We received an action plan from the service informing CQC of the actions that would be taken to meet the identified breaches of the Health and Social Care Act 2008. The service confirmed in writing that most of the action plan had been completed and outstanding actions would be completed by the end of July 2016. During this inspection held on 27 and 28 July 2016, we found some of the concerns from the last inspection had been addressed. However, the majority of actions had not been undertaken by the provider.

Following publication of the report in March 2016, the provider has a legal requirement to display the rating for the service for the public to see, no later than 21 calendar days after it has been published on CQC's website. The provider failed to do this. We were told by the provider that they were aware of this requirement.

CQC registration requirements, including the submission of notifications regarding an extended absence of the registered manager were not met. The provider had not informed CQC of their extended absence after mid June 2016. Significant periods of absence from a service must be notified, reviewed and a proposed date for return or alternative and acceptable management arrangements put into place.

This is a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

The service did not promote a positive culture that was person centred. People who lived at Mount Pleasant and their relatives were not actively involved in their own care planning. We saw from reviewing care plans that people did not participate in development or review of their care plans. Relatives told us they were unaware of the content of people's 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. Individual staff members told us they had raised areas of concern

about care practices, such as the need for mental capacity assessments, but these had not been dealt with.

In January 2016 the inspection had found the service did not have an effective quality assurance process to regularly assess and monitor the quality of service people received. The service action plan stated, 'We are going to assess the quality of service that people receive on a quarterly basis, to ensure good effective quality in all areas.' The action plan went on to state that 'residents/family members/advocates' would be asked to complete a questionnaire about their views of the service and 'action would then be taken to act on any recommendation.' Management confirmed no action had been taken to implement any quality assurance systems and questionnaires had not been used.

The provider told us they believed the actions from the action plan had been completed. This meant we could not have confidence in the provider to ensure necessary action would be taken to meet the identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, completion of cleaning schedules, medicines management recording and the lack of quality assurance recording. This meant the service could not evidence that good practice was followed. From discussions with the service's management, it was clear a lot of information about how the service was run and information about people's care was held in their mind but was not formally recorded. This meant that staff could not know some key information, such as care to be provided for the two people who were resident at Mount Pleasant and who did not have care plans, without direction from the service's manager.

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

The service worked in partnership with other agencies. Feedback provided by external agencies confirmed the service responded appropriately and requested specialist input when required.

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 14 Registration Regulations 2009 Notifications – notices of absence The provider did not give notice in writing to the Commission of their proposed continued absence from 15 June 2016 onwards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of (e) any abuse or allegation of abuse in relation to a service user. This was highlighted by the 111 service when a paramedic highlighted that inability to provide required pain relief was a safeguarding event.

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 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 18 HSCA RA Regulations 2014 Staffing The provider did not have appropriate support, training, professional development, supervision and appraisal necessary to enable staff to carry out their duties 18 (2a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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 had not taken appropriate action to mitigate risks to people in relation to the proper and safe management of medicine. Regulation 12 (1)

The enforcement action we took:

Warning Notice

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)

The enforcement action we took:

Warning Notice