Mr & Mrs G W Sear

# Mount Pleasant Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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 13 people living at the service at the time of our inspection; this included 10 permanent residents and three people who were staying at the service for periods of respite care.

This was an unannounced inspection, carried out on 4 October and 9 October 2017. The service was last inspected in May 2017 when it was rated as 'Requires Improvement'. The rating from this inspection is 'Inadequate'.

There was a history of the service failing to meet the requirements of the Regulations of the Health and Social Care Act Regulations 2014.

There have been on-going concerns with the management of Mount Pleasant Care Home. The provider of the service is also the registered manager and at previous inspections we found the management arrangements and oversight of the service, had not ensured that people were being provided with quality care that met their needs. Enforcement was taken against the service in August 2016 and following this, a proposal to cancel the provider's registration was made in January 2017 and the service was placed into Special Measures after a rating of Inadequate.

As part of the Commissions on-going monitoring process, CQC continued to inspect the service; with the knowledge that the service had been supported by Cornwall council's service improvement team, we re-inspected in May 2017 and judged the service had made progress on the issues previously identified. In May 2017 the service was rated as Requires Improvement. As part of the service action plan, CQC received assurance from the provider that they intended to return to an active leadership role at the service.

Following this inspection it is clear that management oversight of the service has not been sustained.

Despite significant issues with the leadership of the service that had been highlighted over successive inspections, the provider had not prioritised the management of the service. The provider was not present at the beginning of the inspection and made it clear to inspectors that it was not convenient for her to attend the inspection due to another appointment. The importance of a management presence at the inspection was stressed to the provider who rearranged appointments to be available during the inspection.

Arrangements for managing the service were not effective. No-one working at the service could operate the computer system in the absence of the office manager. The provider was in breach of the Data Protection Act 1998 which is designed to protect personal data stored on computers or in a paper filing system, by permitting a person who was not employed by the service to access the computer system.

Staffing arrangements at the service had not ensured sufficient, competent and skilled staff were available

at all times to meet people's needs. Two staff were employed from 7am to 9pm each day to meet the needs of 13 people. Two people required two care staff to assist them with mobilising when being supported for personal care. This meant when the two staff on duty were helping one of these two people there were no staff available to support the remaining 12 people. People told us they did not feel staff had time to spend with them or always supported them in a timely fashion.

The service had experienced a high turnover in staff and had resorted to regular use of agency staff to cover shifts. The service relied on three senior staff and two care staff to cover all day time shifts and two night staff who shared the waking night shift between them. This meant the service did not have a consistent core staff group to work at the service. The office manager also helped with care shifts when necessary. We were told recruitment for new staff was on-going.

We had concerns about the level of competency and skills of staff available to meet people's needs. For example, on one occasion there was no senior carer available and a recently employed member of staff and a member of agency staff were responsible for the care of 13 people. This included administering medicines, which neither staff member was trained to do.

During the inspection we had concerns about the conduct of a senior staff member concerning information they were supposed to have passed to management and other staff about the inspection. We discussed these concerns during the inspection feedback. However though the provider had serious concerns about this member of staff no disciplinary action had been taken.

There was no induction policy or process in place for temporary staff. Induction to the service for permanent staff was considered ineffective and did not provide staff with the knowledge of policies and procedures required to do their job. For example, staff told us they were not given time to familiarise themselves with people's care plans and were expected to follow the lead of more experienced staff without the knowledge of the specific care plan and any associated risk assessments. Staff comments included "I don't recall anything that could be called an induction really. I was straight into two shadow shifts. I wasn't given an opportunity to read policies and procedures or to read people's care plans. I've been told about people's needs as I've gone along."

Training was provided but was not always effective. For example, despite repeated reassurances from the provider, about making practical manual handling training available to staff, this had not been done. All other training was conducted using a social care television package. Staff commented, "They could do with more hands on training because e-training isn't always effective."

Recruitment processes were not robust. Records were disorganised and did not always contain necessary documentation such as a full employment history. One member of staff did not have recruitment records including relevant recruitment checks to evidence they were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

There were little meaningful activities available for people. People told us they were 'bored stiff' and we saw the majority of people stayed in their rooms with no social stimulation.

Three people had moved into the service for a period of respite care. One person had no care records available and a second person's records reflected a previous respite stay; and were not up to date.

There was no evidence of capacity assessments or best interest discussions taking place for people who lacked capacity to make certain decisions for themselves. Systems for recording consent were not robust. It

was not always clear when Lasting Power of Attorney (LPA) arrangements were in place. We saw records signed on behalf of people by relatives who did not have appropriate LPA authority to do so. Management did not have a clear understanding of the requirements of the Mental Capacity Act 2005.

Accidents and incidents that had taken place since the last inspection had not been audited to identify any patterns or trends. There was no record of specific action that had been taken to address any incidents. This meant the risk of re-occurrence was not reduced.

There were inadequate governance arrangements in place to monitor and assure the quality of the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this time frame, and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and is no longer rated as inadequate for any of the five key questions it will no longer be in special measures .

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe. The provider was aware of potentially unsafe staff practices but had not taken disciplinary action to safeguard people from harm.

The service had not ensured there were sufficient, competent and skilled staff available at all times to meet people's needs.

Safe medicines management procedures were not consistently followed.

The service was not consistently following safe recruitment practices.

The provider had not ensured the privacy and safety of people's personal records.

### Is the service effective?

**Requires Improvement**

The service was not effective. Management did not have a clear understanding of the requirements of the Mental Capacity Act 2005.

The service was not operating effective staff support systems including appropriate induction, supervision and appraisal.

Staff had not received effective training in manual handling practice. There was no assessment of staff capability to undertake this safely.

### Is the service caring?

**Requires Improvement**

The service was not entirely caring. Relationships between staff and people were predominantly task orientated and there was little capacity for people to develop meaningful relationships with staff.

People were not actively involved in making decisions about their care and support.

People made day to day decisions about how they spent their time.

## Is the service responsive?

**Requires Improvement**

The service was not responsive. The service was not providing adequate social activities to meet people's needs. People did not have access to activities that were important and relevant to them and were not protected from social isolation.

Opportunities for people to share their thoughts on how the service was operating such as a residents meeting were not offered.

People saw health professionals such as GP's and district nurses when they needed to and records evidenced this.

## Is the service well-led?

**Inadequate**

The service was not well led. There was a history of the service failing to meet the requirements of the Regulations of the Health and Social Care Act Regulations 2014.

There were multiple and repeated breaches of Regulations. This demonstrated the provider was unable to ensure a consistent quality service was provided to people.

The leadership of the service did not promote a positive culture that was person-centred, open and inclusive.

# 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 4 and 9 October 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. Their area of expertise was in older people's care.

Before the inspection we reviewed information held about the service including previous inspection reports and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spent time with 11 of the 13 people who lived at Mount Pleasant Care Home. We also received feedback from one representative of a person living at the service. Following the inspection we spoke with two external professional who had experience of the service.

We looked around the premises and observed care practices. We also spoke with the provider, office manager, four care staff and two staff responsible for preparing food. We looked at five records relating to the care of individuals, staff recruitment files, staff duty rosters, staff training records and records relating to the running of the service.

Inadequate

# Is the service safe?

## Our findings

People had mixed views about whether they felt the service was safe. When asked if they felt safe one person commented, "Feel safe? Not a lot. I don't know all the staff; some are strangers to me. I am always glad when my [relative] comes." Another person said, "I feel safe here. I have been here a few years now."

During the inspection we had concerns about the conduct of a senior staff member concerning information they were said to have passed to management and other staff regarding the inspection. We discussed these concerns during the inspection feedback.

Despite the provider's concerns there had not been any formal disciplinary action taken.

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

Staffing arrangements at the service had not ensured there were sufficient competent staff available at all times to meet people's needs. The service had experienced a high turnover in staff and had resorted to regular use of agency staff to cover shifts. The service relied on three senior staff and two care workers to cover all day time shifts and two night staff who shared the waking night shift between them. This meant the service was short of a consistent core staff group to work at the service. The office manager also helped with care shifts when necessary. Recruitment for new staff was on-going.

Two staff were employed from 7am to 9pm each day to meet the needs of 13 people. Two people required two carers to assist them with mobilising when being supported for personal care. This meant when the two staff on duty were helping one of these two people, there were no staff available to support the remaining 12 people. People told us they did not believe there were enough staff available to meet their needs, comments included, "I never see staff. They don't talk to me. The cleaner opens my door and talks to me."

People told us they did not feel staff had time to spend with them or always supported them in a timely fashion. People told us, "There are not as many [staff] as there used to be" and "They take a long time to get to you even when you ring the bell." One person commented, "They are short of staff sometimes especially when someone is on holiday or off sick." Staff commented, "I don't think there are enough staff for doing baths and everything for 13 people, there are only two staff".

Records demonstrated the provider was aware of the necessity of both staff on duty being visible at the service. Senior staff meeting minutes directed staff, "On days when someone is in the office please spend minimal time in the office. Please complete as much paperwork as possible in the coffee lounge/dining room so as you're apparent on the floor." This meant the staffing of the service was not adequate to provide staff with protected time to ensure appropriate records were kept.

We heard of occasions when there was a lack of appropriately skilled and competent staff available to meet people's needs. A representative of a person living at the service told us about a recent incident when they visited the service and found no senior staff member in charge and two staff, one of whom had worked at

the service only a matter of weeks and the second an agency staff member who was not familiar with people or their needs. The person told us they had to explain the complexity of a medical condition to the staff and the need for the person's medication to be given at specific times throughout the day. They commented, "In my view this place is an accident waiting to happen." Staff confirmed a recent occasion when due to a senior staff member being absent due to illness, there were two staff with limited knowledge of people's needs working on a 14 hour shift. Staff commented, "There was no senior on site. I don't think that was right."

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

Recruitment processes were not robust. Recruitment records were dis-organised and did not always contain necessary documentation such as a full employment history. We found some staff had changed roles within the service and this was not reflected in their employment records. Staff did not have a contract of employment. This is important because it regulates the behaviour of an employee in the workplace.

One member of staff did not have recruitment records including relevant recruitment checks to evidence they were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks. This meant people received support from staff without the appropriate pre-employment checks in place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

It was observed that due to a lack of storage space at the service items such as wheelchairs and commodes were kept in people's rooms. One person commented, "I don't know why it is [commode] in the room as I like to use the toilet in my room." We observed the person had to lift their walking aid into the air and over a commode in order to access it to go to the toilet. The hazard the commode was causing was pointed out to a staff member who removed it from the room. However, the provider intervened and said there was nowhere else to store such items. The lack of appropriate storage available to people meant their accommodation was not providing a pleasant or suitable space for them and potentially put them at risk.

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

People told us they could not always call staff to support them. One person told us, "I can't get at my call bell as it is jammed down by the bed so I can't get hold of anyone. If something happens I feel I would have to wait until someone comes. The alarm keeps going off so I don't take any notice of it. I have no idea what it is or what it's for". A visitor to the home also told us they had observed and reported to staff that one person was unable to access their call bell because they could not reach it due to it being placed down the side of a bed. This meant there was a risk that people would be unable to summon staff assistance when they needed it.

Care plans included risk assessments that identified what level of risk people were at from various events such as falls and trips, bathing and showering, choking and aggression. Where someone had been identified as being at risk there was a description of the action staff should take to minimize it. This information lacked detail and provided little guidance for staff. There was no description of the likely triggers or diversionary techniques. This meant staff who were not familiar with the person would not have known how to support them well.

When an accident or incident occurred an accident form was completed and routinely, it was recorded in people's daily logs. However, we found an instance where a person had had an accident that was not recorded in their daily records. This meant there was not an accurate and contemporaneous record of

events experienced by a person living at the service. In addition, the accident form had not been filed appropriately and was identified because of a comment made in the night carer's book. This meant there was a lack of appropriate recording to ensure incidents and accidents were identified and audited to allow management to carry out audits of these events and identify any patterns or trends.

Medicines were not safely administered. We observed a senior carer sign for medicines as administered before they were given. This meant records reflected medicines had been taken before they actually were. This is unsafe practice because in the event that a person was not able to take their medicine this would not be accurately recorded. The provider told us they had permitted an unqualified carer to administer medicines due to a staff shortage. This meant people were not assured of safe and effective administration of their medicines by qualified and competent staff.

We had a concern about how people were supported with their mobility needs. The service had not provided practical manual handling for staff. Training provided about how to safely move people was undertaken by watching training on television. Staff told us they did not believe this was an appropriate way to train staff in this area. Despite assurances given by the provider at the last inspection that practical manual handling training would be prioritised, this had not taken place. This meant new staff were reliant on being shown how to use equipment by other staff and there was no evidence of an assessment of their capability to do this safely.

A representative of a person living at the service told us staff had used a large fitting handling belt to mobilise a person when it was clear the equipment was too big for the small framed person. A safeguarding referral was made by CQC to Cornwall council about this.

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

Medicines were stored appropriately. A lockable medicine refrigerator was available for medicines which needed to be stored at a low temperature. Records showed the temperature was consistently monitored. Medicines which required stricter controls by law were stored correctly and records kept in line with relevant legislation. The amount of medicine held in stock tallied with the amount recorded.

Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. They were aware of the whistle blowing and safeguarding policies and procedures which were held at the service. However, some staff were not aware that the local authority were the lead organisation for investigating safeguarding concerns in the county or how to contact them should they wish to.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We found no evidence of any capacity assessments or best interest discussions taking place. Systems for recording consent were not robust. It was not always clear when Lasting Power of Attorney (LPA) arrangements were in place. We saw records signed on behalf of people by relatives who did not have appropriate LPA authority to do so. Management did not have a clear understanding of the requirements of the Mental Capacity Act 2005.

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

At the last inspection in May 2017 we found new staff were not completing a satisfactory induction. Staff new to care were not required to complete the Care Certificate as part of their induction. Although this is not mandatory it is important care staff cover the 15 fundamental standards included in the Care Certificate by some means. This was not occurring. There was no introduction to the organisational policies and procedures or working practices. We found the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the service had an induction policy in place which dealt with the organisational working practices, such as accident and hazard reporting procedures and which required staff new to care to complete the Care Certificate. However, there was no appropriate induction system in place for agency staff and this meant this staff group were not familiar with the people they supported. Staff told us they did not feel the current induction system was effective.

Staff recently employed by the service told us when they began to work at the service they were shown around the building and completed some shadow shifts with more experienced staff. Staff comments included "I don't recall anything that could be called an induction really. I was straight into two shadow shifts. I wasn't given an opportunity to read policies and procedures or to read people's care plans. I've been told about people's needs as I've gone along." The service did not have an induction policy in place for the induction of agency staff.

The service did not have an effective staff supervision system in place. Staff told us they had not received supervision. Comments included, "I haven't had any supervision to do" and "I can't remember the last time I had supervision". Staff files did not evidence that supervision was taking place.

A staff training record was in place and had identified required training. Some training was not effective. For example, most staff had undertaken safeguarding training but were not confident to answer questions on the subject.

Mandatory training was completed. Staff told us the majority of training was completed via electronic modules and distance learning. Staff told us, "I think training should be practical. I just think training by watching it on TV isn't great. You should be doing it. Like first aid – if you actually need to do it, are you going to be able to" and "They could do with more hands on training because e-training isn't always effective." This meant people were at risk of receiving care from staff who were not effectively trained. There was no system in place to monitor if staff had gained the relevant competencies from training courses to ensure they had the skills to meet people's needs.

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

People saw health professionals such as GP's and district nurses when they needed to and records evidenced this. A healthcare professional we spoke with said they received appropriate referrals and were happy that people were receiving appropriate care and support. The service had organised an onsite eye examination visits for people who required this.

Requires Improvement

# Is the service caring?

## Our findings

We observed that relationships between staff and people were predominantly task orientated and time pressures left little capacity for people to develop more than fleeting relationships. Staff told us, "I think the care that is provided is good".

People told us, "I never see staff. You're the first other than the cleaning man to speak to me. No one has come to see me. Staff don't talk to me neither do residents. I went in the lounge twice but didn't stay more than half an hour as no one speaks to you and there is nothing to do."

People did not feel they were actively involved in their plan of care; the majority of people told us they were not aware they had a care plan. Comments included, "I didn't know I had a care plan in the four years I have been here. I get on well with the staff and they listen to me"; "I don't know if I have one. I have not heard of a care plan in all the years I have been here. I feel I am well looked after."

People liked the staff who supported them but told us they did not feel listened to and that their opinions mattered. For example, in relation to their food choices, people told us they did not feel they had a choice about the meals they were served. People's comments included, "I like the food. It is generally home cooked and fresh but I don't think there is a lot of choice. I eat what I am given pretty much." We spoke with one of the cooks about this and looked at the menu options recorded in the kitchen diary. We saw a number of instances when options had been changed at short notice. No reason was provided about why this happened. This meant people could not be given a consistent, clear choice about meal options because this could be changed without notice. For example, we were told that a cook had been asked to provide a pasty lunch for people on a Sunday during the inspection period. This would not be the normal meal choice on a Sunday and the cook told us they refused to do this, instead preparing a Sunday roast.

We saw people were offered the pasties for lunch on Monday. We asked the provider why this had happened and were told they had proposed the cook conduct some cleaning duties in the home on the Sunday so the pasty option was made available to save time. This meant dedicated cooking staff were being asked to undertake other work at the service at the expense of their principle responsibilities to provide a choice of fresh, nutritious meals to people who lived at Mount Pleasant Care Home.

Care provided to people during lunch time was minimal. Seven people chose to eat their meal in the dining room. No staff were available to assist people while they were dining. We observed one person was unhappy because they did not have sugar available to put in their tea and there was no staff available to ask. The person used a sweetener which belonged to another person and did not like this so did not drink their beverage.

Generally people felt they were treated with respect by staff. However, we observed a staff member administering medicines at lunch time who did not provide a person with choice about taking their medicine. The person queried if this had to be done while they were eating and staff confirmed that it did. The person told us, "I don't have much choice about how or when I get my medication. I usually take it after

my meal as that is my preference. I don't know why today they made me take it mid mouthfuls." This did not uphold the person's dignity and choice to take their medicine after they had finished their meal.

People did not feel that staff always showed concern for their well-being in a caring and meaningful way and responded to their needs at the time they need it. People told us, "I am happy living here but sometimes I get fed up and want to go back home. My memory is letting me down as I don't talk enough to other people so I get muddled. When I first came here it was full up now it is half empty and lots of people stay in their rooms. In the lounge it used to be busy and there was always someone to talk to but not now. Even when people are there they don't speak much; I use to walk around the garden but now I can't walk very far, staff don't take you out around the garden. I have a commode in my room but prefer during the day to use one of the toilets for residents but when I ring the bell they don't always come quick enough so I end up using the commode." This meant people were not consistently having their needs met and clearly expressed a sense of frustration and social isolation because of their experience of not being cared for as an individual at the service.

People told us they were able to make day to day decisions about how and where they spent their time. People told us they had choice about what time they got up in the morning and retired to bed. People told us, "I have been here a long time but remain in my room. I don't have any family and my friends are now like me, unable to get out and about to visit me. I don't know about a care plan but I have my needs met although there is nothing else to do but watch TV."

The service did not support people to express their views and be actively involved in making decisions about their care, treatment and support in any meaningful way. We saw people had been asked to complete a tick box questionnaire about their experience of living at the service but the results of this did not resonate with people's feedback when we spoke with them in person.

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

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection in May 2017 we found the service was not providing adequate social activities to meet people's needs. People did not have access to activities that were important and relevant to them and were not protected from social isolation. There was no attempt to provide social activities that were personally meaningful to individuals who were living with dementia. We found the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and issued a requirement notice.

At this inspection we found little progress had been made in this area. People commented, "I have only been here for a few days but it feels like weeks. I am fed up and bored. In fact I have gone to bed sometimes it is that bad. I did go to the lounge a couple of times but no one spoke to me so came back to my room. No one comes to see you and the staff don't talk to you either".

Another person said, "There is nothing to do here and no choices given. I don't go out. In the past I might have gone out in the summer but I don't now. I don't have anyone to visit me or take me out either" and "I don't go into the lounge. There is not enough interaction. I like listening to my radio I prefer classical music and Opera. The activity I like I can't do" And "I am bored stiff."

Staff showed little understanding of the challenges faced by people living with dementia or what would make an activity meaningful for a person. We were shown a corner of the lounge which had a number of knitted hand muffs with buttons sewed onto them and an artificial fish tank which a person told us," it makes an awful noise when it's been on a long time and it's very distracting and annoying." We were told this was an attempt to provide a stimulating activity for people living with dementia.

An activity folder had been put together to record the activities people were doing. We reviewed seven people's records which were incomplete and recorded seeing the hairdresser and nail care as activities.

Opportunities for people to share their thoughts on how the service was operating such as a residents meeting were not offered. People told us they did not generally share their feelings about their care because there was no regular means for them to do so other than by raising a complaint.

The policy of the service was that people who wished to move into Mount Pleasant had their needs assessed to help ensure the service was able to meet their needs and expectations. In practice we found this was not consistently followed. Two people receiving respite care at the service had no care records available for review. This meant it was not always possible for the provider to be clear that the service could meet people's needs.

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

Two people on respite care packages did not have care plans available, as detailed above. The remaining

care plans which had been completed were an accurate and up to date record of people's needs. Care plans were regularly reviewed to help ensure the information remained up to date and relevant.

People told us they were supported to maintain relationships with their friends and relatives. Visitors to the home were welcome to visit at any time. People told us, "My visitors do get the offer of a cup of tea. They take me out as staff at the home won't"; "My wife, grandchildren and the rest of my family are made very welcome and offered a cup of tea" and "My daughters always come weekends and are offered a cup of tea."

There was a complaints process available. People told us they would be comfortable in making a complaint if they wanted to. People told us, "I can always talk to staff if I am worried" and "If I saw a member of staff at the time [I would talk to them] but I don't see them very often. There is no particular member of staff I would talk to about my worries and I have nobody to visit me so no one else to speak to."

Inadequate

# Is the service well-led?

## Our findings

There was a history of the service failing to meet the requirements of the Regulations of the Health and Social Care Act Regulations 2014.

Enforcement was taken against the service in August 2016 and following this, a proposal to cancel the provider's registration was made in January 2017 and the service was placed into Special Measures after a rating of Inadequate.

As part of the Commissions on-going monitoring process, CQC continued to inspect the service; with the knowledge that the service had been supported by Cornwall council's service improvement team, we re-inspected in May 2017 and judged the service had made progress on the issues previously identified. In May 2017 the service was rated as Requires Improvement. As part of the service action plan CQC received assurance from the provider that they intended to return to an active leadership role at the service. Following this inspection it is clear that management oversight of the service has not been sustained.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider of the service is also the registered manager and at previous inspections we found the management arrangements and oversight of the service, had not ensured that people were being provided with quality care that met their needs. There have been on-going concerns with how Mount Pleasant Care Home has been managed since January 2016.

The provider has been unable to demonstrate leadership or management of the service. The lack of consistent management and leadership had resulted in poor outcomes for people.

We have determined the provider is unable to consistently meet the regulations of the Health and Social Care Act (2008) Regulations 2014.

We asked staff about how the service was managed, staff comments included, "If it wasn't for the office manager, the running of the service is diabolical" and "[Office managers's name] runs this place hands down. If it wasn't for her I don't know where this place would be to be honest." Staff told us there was little management input from the provider, "For the last couple of weeks we haven't really had any management to call upon. The owner pops down for an hour now and again but it isn't enough. We generally have to call and speak to her on the phone."

People who lived at the service commented, "[Provider/Registered manager] actually came into my room this morning and spoke to me. The last time I met the manager was just before I came into the home and that was a few years ago now" and "I don't know who the manager is and never see her."

Arrangements for managing the service were not effective. The provider or other staff working at the service

could not operate the computer system in the absence of the office manager. Staff commented, "Everything is kept on the computer; all the safeguarding information and the DoLS and the office manager has the password. So when she's not here none of this is available to be seen."

The provider breached the Data Protection Act 1998 which is designed to protect personal data stored on computers or in a paper filing system, by permitting a person who was not employed by the service to access the computer system.

Daily records were task orientated and provided little information about how people were as a whole nor did the records provide staff with clear information about people's needs or keep staff informed as people's needs changed. For example, we saw information about an accident that been recorded in a staff communication diary was not included in the person's daily records. There was also no accident form included with the person's care records. We later found an accident form had been completed but had not been appropriately filed. The lack of information about incidents of this nature meant it was difficult to be clear about what, if any action had been taken to monitor the person after the accident.

Accidents and incidents that had taken place since the last inspection had not been audited to identify any patterns or trends. There was no record of specific action that had been taken to address any incidents. This meant the risk of re-occurrence was not reduced.

We have found continuing breaches of the regulations about the provision of person-centred care, particularly as regards people's involvement in decisions about their care and how the service seeks to meet their wider social needs.

The provider had not ensured appropriate support, training, supervision and appraisal systems were operating for the benefit of staff. We found breaches of regulations regarding recruitment procedures; the provider's use of quality assurance to ensure the service was able to meet the quality standards required for a service of this type; records and data management systems were not effective. The service had not operated safe medicines management procedures. This put people at a risk of receiving care and treatment that was unsafe or inappropriate.

People were not actively involved in developing the service. There were not a clear set of vision and values that included involvement, compassion, dignity, independence, respect, equality and safety. The culture of the home was one of providing food and shelter for people rather than person-centred quality lives for the individuals who lived there.

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