Mr & Mrs G W Sear

Mount Pleasant Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

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 12 people living at the service at the time of our inspection.

We carried out this unannounced inspection of Mount Pleasant Care Home on 30 May 2017. At this comprehensive inspection we checked to see if the service had made the required improvements identified at the inspection of 7 and 8 December 2016 when the service was rated as inadequate. At this time seven breaches of regulations were found overall.

The services was put into Special Measures because we judged people were at risk from harm because the provider's actions did not sufficiently address the on-going failings in the service and we had found there was insufficient management oversight regarding how the service was run.

The registered manager was also the provider and had 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.

At this inspection we found the registered manager had re-established themselves in more direct day to day control of the service. Work had been carried out in conjunction with Cornwall Council's quality assurance team to address the concerns highlighted from the last inspection. An action plan had highlighted areas for improvement and progress had been made with this although there remained areas that required further work.
At this inspection, we had concerns about some aspects of how the service was operating. For example, in the morning we found two pots of paint stripper and a scraper with a razor blade attachment had been left unattended on a garden table. As people were free to access this area, this posed a risk to people's safety. We also saw a boiler room door with a clear sign stating it should be kept locked. This was left open and unlocked throughout the day. Staff were unaware of these two potential hazards. We have made a recommendation regarding making sure the premises is kept safe from potential hazards.

Medication administration was safe and but some records (MAR) had not been appropriately completed and

medication audits were not being completed.
The service had sufficient capable staff on duty to meet the needs of the people that used the home. People commented that they were attended to in a timely way. Comments included, "They always make sure my call bell is within reach", "Nothing is too much trouble for the staff" and "It's just a lovely, quiet, warm atmosphere around the home."

Care planning processes had been improved. Care plans and risk assessments had been re-written for everyone supported by the service. However, we found that diabetes care management plans remained vague and unclear with no clear guidance for staff about appropriate dietary options for people with this condition. We have made a recommendation about the management of long-term conditions.

There was little evidence that people had begun to be involved in the process and review of their care planning. We observed that staff always verbally checked that people consented to care and support before providing this. However, there was no documentation in place to evidence that the service were working in line with the Mental Capacity Act (2005). People were not supported to have maximum choice and control of their lives; the policies and systems in the service do not support this practice.

The three most recent staff employed did not have records of a formal induction and the Care Certificate, or any equivalent process, was not implemented by the service. Staff confirmed there were limited induction processes in place.

Staff training was not up to date for all staff for first aid and fire training. We found no evidence of practical manual handling training. Staff confirmed they were shown by a senior staff member how to use equipment such as hoists.

A formalised system to provide staff with regular supervision had been implemented. At the time of inspection there was no evidence of recent staff appraisal procedures. Staff confirmed they had not received appraisals but had begun to receive supervision. This was not consistently being recorded.

The premises and the general environment were maintained to a good standard. Fire extinguishers and smoke detectors were located throughout the building. Equipment such as wheelchairs were appropriately maintained and wheelchairs previously identified as missing foot rests had been replaced.

There were no malodours present. New carpets in communal areas and some bedrooms had been replaced.

We found water temperature records were not routinely being recorded for baths and only one bath thermometer was in use across two bathrooms.

There were a limited amount of activities offered to people who lived at Mount Pleasant. The service user guide stated that people would be offered 'a wide range of leisure activities to enable each resident to express themselves as a unique individual'. There was no evidence that this was occurring. The service provided some structured activities to people such as weekly armchair exercises and skittles. People told us there were few activities offered on a regular basis. Comments included, "There's not much activities going on" and "I sleep a lot because there's nothing much to do". People told us they enjoyed watching television, reading, crosswords and word searches.

We found little understanding from staff about what meaningful activities might be for a person living with dementia. The service had a number of people living with dementia who were unable to regularly engage in

the few activities offered. We observed little social interaction for people who were unable or chose not to leave their rooms. The service did not support people to attend activities outside of the service.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe. We saw potentially hazardous situations such as paint stripper and an unprotected razor blade stripper left unattended in a communal area.

Medication administration was safe and but some records (MAR) had not been appropriately completed and medication audits were not being completed.

Risk assessments were in place and had been updated when people's needs had changed.

Personal emergency evacuation plans (PEEP's) were in place for everyone living at the service.

There were sufficient staff to meet peoples' needs.

Is the service effective?

Requires Improvement

The service was not entirely effective. Care staff had begun to receive appropriate support for their role but there was a lack of recording evidence to support this and effective induction processes were not followed.

There was no staff appraisal system in place.

The service had not undertaken mental capacity assessments and best interest discussions had not been recorded as having taken place when necessary and in accordance with the Mental Capacity Act.

Staff training was not up to date for all staff in mandatory training areas. There was no evidence of practical manual handling training.

People's health needs were consistently met. Arrangements for people to see health professionals when they needed to were in place.

Is the service caring?

Good

The service was caring. Care plans provided detail of people's choices and preferences and how they were to be assisted with their daily living.

People were treated with kindness and compassion and 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 entirely responsive. Care plans had been rewritten and were improved. However, more detailed care planning in regard to long term conditions was missing.

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.

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

Is the service well-led?

Requires Improvement

The service was not entirely well led. Records regarding the running of the service were improved since the last inspection. However, there was still work to be done in this area to be assured of a robust record management system overall.

The provider who was also the registered manager had returned to day to day control of the service. There was management accountability within the service to address the areas highlighted at the last inspection.

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

Mount Pleasant Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 May 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

During the inspection we looked at five people's care plans, 12 people's Medicine Administration Records (MAR), six 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 three other members of staff. We spoke with six people who lived at Mount Pleasant Care Home and two professionals who visited the service. Following the inspection we received feedback from one external professional familiar with the running of the service.

Requires Improvement

Our findings

Following the last inspection in December 2016 we found the service was not safe and rated this domain as inadequate. We identified issues regarding unclear risk assessments and a lack of recording and assessment which was putting people at risk. We also found emergency evacuation plans were not in place for everyone living at the service. We had concerns about the numbers of staff being sufficient to meet people's needs. There were also concerns about the safety of recording practices regarding medicines administration.

Following a review of evidence we reviewed at this inspection we judged the service had met the requirements of the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we had concerns regarding the management of medicines. The identified issues were in relation to how staff were recording the administration of medicines and changes to medicines and dosages to be administered. This had led to a breach of regulations.

At this inspection there remained issues with recording practices around Medicines Administration Records (MAR). For example, staff had handwritten entries on to the MAR following advice from medical professionals about two people. These handwritten entries had not been signed by a member of staff or witnessed by a second member of staff. This meant there was a potential risk of errors and people might not receive their medicines safely.

Also one person had no photo ID or summary sheet which is used by staff to check medicines are being administered to the right person with the correct details including whether they have any allergies. We spoke with the provider about this and she confirmed regular checks on the quality of medicine recording "should be happening."

Medicines audits which had been developed and were being used at the time of the last inspection were no longer being used. The provider and Head of Care told us regular checks of medicine stocks and ordering and returns processes were undertaken. However, the lack of regular auditing of MARs remained a cause for concern and had failed to highlight issues around the recording and monitoring of medicines provided to people.

Accidents and incidents that took place in the service were recorded by staff in people's records. However,

such events were not being audited by the registered manager. The registered manager told us that they had a process in place for recording all incidents and accidents. However, the lack of auditing procedures meant that common trends were not identified to help to reduce future events.

The failure to satisfactorily monitor medicines management procedures and accidents and incidents is a contributory factor to the continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored appropriately and, other than for the two people discussed, Medicines Administration Record (MAR) charts were completed appropriately. Medicines which required stricter controls by law were stored correctly and records kept in line with relevant legislation. A lockable medicine refrigerator was available for medicines which needed to be stored at a low temperature. Records demonstrated medicine storage temperatures were consistently monitored and demonstrated. This meant medicines were stored correctly and were safe and effective for the people they were prescribed for.

Staff were competent in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record. Staff who administered medicines were up to date with their training.

We had concerns about some aspects of how the service was operating. For example, in the morning we found two pots of paint stripper and a scraper with a razor blade attachment had been left unattended on a garden table. As people were free to access this area, this posed a risk to people's safety. We also saw a boiler room door with a clear sign stating it should be kept locked. This was left open and unlocked throughout the day. Staff were unaware of these two potential hazards.

It is recommended the service ensure the premises are safe from hazards which could pose a risk to people.

People's care plans contained risk assessments for a range of circumstances including moving and handling, weight loss and the likelihood of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk. For example, where people had been identified as losing weight they received a weekly weight check and their food and drink intake was monitored using a chart record. Some people had been identified as being at risk of skin damage due to pressure. Staff were directed to check their skin regularly and complete records to show if there were any red areas or broken skin.

At the last inspection we found recruitment procedures were not robust. We saw two members of staff were working without a record of previous employment references. We looked at this area during this inspection and again found the service did not have previous employment references for the most recently employed staff members. We alerted the registered manager to the fact that appropriate employment references were not on file for two members of staff. These records were made available to inspectors following the inspection.

Recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks. A member of staff commented; "We've recruited really well. We've got some good people." We were satisfied that the service now operated a safe recruitment process to help ensure staff had the appropriate skills and knowledge required to provide care to meet people's needs.

Staff received training in safeguarding adults when they joined the service. This was refreshed at regular

interviews to help ensure staff had access to the most up to date information. Staff told us they had no concerns about any working practices or people's safety. They would be confident to report any worries to the manager and believed they would be dealt with appropriately. If staff felt their concerns were not being taken seriously they knew where to go outside of the organisation to report concerns. "Say no to abuse" leaflets were available for people, relatives and staff on request. These contained the number for the safeguarding team at Cornwall Council.

The environment was clean and hygienic. The home was visibly clean, with hand sanitising gel, gloves and aprons available throughout the building which we saw staff using appropriately during the inspection.

The premises and equipment were maintained. Records showed that manual handling equipment, such as hoists and bath seats had been serviced. It was brought to the attention of staff that two light bulbs were not working in the corridor and these were immediately replaced to help ensure people's safety when moving around the building.

There was a system of health and safety risk assessments. However, we found only one of the two bathrooms used a temperature thermometer to gauge the warmth of the water. No temperature records were seen in either bathroom. This was brought to the attention of the provider who assured us this would be rectified immediately.

Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. There was a record of regular fire drills. Personal emergency evacuation plans (PEEP's) were in place for everyone living at the service.

Requires Improvement

Our findings

There was no effective induction process in place for newly employed staff to complete when they began working at the service. We saw there was no completed induction checklist in place for the last three most recently employed staff. The service also did not have a process in place for the induction of agency staff.

The service had not updated their induction in line with the Care Certificate or equivalent induction process and therefore the existing induction did not give staff members new to working in the delivery of care basic skills training. This is designed to help ensure care staff have a wide knowledge of good working practices within the care sector.

The service had an induction policy in place. This dealt with the organisational working practices such as action to take if the alarm bell sounded and accident and hazard reporting procedures.

The provider told us management were operating a staff supervision system. However, three out of six staff files we looked at did not have supervision dates or records. The provider and staff confirmed that discussions had taken place but these were not recorded or minutes kept. The service did not have a staff appraisal system in place.

A staff training record was in place and had identified required training. However, this was not effective and staff training was not up to date for all staff for first aid and fire training. There was no recorded evidence of practical manual handling training. Staff said they were shown by a senior staff member how to use equipment such as hoists. The registered manager told us a practical manual handling training course was being arranged. The majority of other training such as safeguarding were completed as distance learning and were up to date.

Though progress had been made this continued to be a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings had begun taking place and provided a formalised opportunity for staff to discuss working practices and identify training and support needs.

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

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for DoLS authorisations had been made to the local authority.

There was little evidence that people had begun to be involved in the process and review of their care planning. We observed that staff always verbally checked that people consented to care and support before providing this. However, there was no documentation in place to evidence that the service were working in line with the Mental Capacity Act (2005). People were not supported to have maximum choice and control of their lives; the policies and systems in the service do not support this practice.

The service had not undertaken mental capacity assessments and best interest discussions had not been recorded as having taken place when necessary and in accordance with the legislation. For example, one person who lived with dementia was restricted from eating certain foods due to a health condition. The care plan stated the person chose from the menu themselves but went on to state that certain foods were unsuitable for the person. There were no records to substantiate that a mental capacity assessment had been carried out or that a best interest process had been followed regarding this. The provider showed us a new format agreed with Cornwall council Quality Audit team to record such discussions to be used going forward.

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

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

We observed the lunch time period in the dining room. We saw that staff were available to help people who required assistance. Staff worked to help people maintain their dignity. It was clear from the chatter and laughter at lunch time that mealtimes were relaxed and informal. People told us, and we could see for ourselves, that they could choose what to eat from a choice of freshly prepared food.

Interactions between staff and people during lunch were friendly and we saw staff encouraging people to eat. People and relatives told us the food was usually of a good standard and the portions were generous. They told us there was always a choice of meals and if anyone wanted something other than that offered it could be provided. One person told us; "The food is home cooked and very nice. There is a choice of meals at lunch and dinner." We saw people had chosen different options for their meals and it was clear staff were familiar with people's preferences. We spoke with the cook on duty who said they were aware of people's dietary needs and preferences. They commented; "I like to see people enjoy their meals and I speak with people every day so I know what they want". The kitchen was well equipped and clean.

People had access to external healthcare professionals such as dentists, chiropodists and GP's. Care records contained records of any multi-disciplinary notes and any appointments. We spoke with a GP who visited the service during the inspection. They told us they had no concerns and staff made timely and appropriate referrals for medical care when required on behalf of the people who lived at Mount Pleasant.

The building was in a good state of repair and free from odours. We found the environment to be clean and bathrooms were well equipped with hand wash and paper towels.

Good

Our findings

People we spoke with were complimentary about the care they received and told us they were treated with kindness and compassion in their day to day care. Comments included; ""I enjoy the people who look after me", "Staff here are nice and friendly" and "We can have a laugh and staff are really caring." An external health care professional told us; "You are struck by the genuine affection which most of them [staff] seem to have for the residents."

Call bells were observed in people's rooms and were answered promptly when people called for assistance. One person commented, "They always make sure my call bell is within reach."

Staff clearly knew the people they supported well. Care plans contained information about people's personal histories. This is important as it helps staff gain an understanding of the person and enables them to engage with people more effectively.

People told us they were supported to express their views and were actively involved in making decisions about their care, treatment and support. For example, in one person's care plan it was recorded, '[Person's name] has requested that they are checked every two hours throughout the night by care staff'. In another person's care plan it was stated, '[Person's name] would like to be asked if they would like to stay in their room or go to the main lounge'.

People had completed satisfaction questionnaires regarding their views of the service. We saw people were comfortable to approach staff about aspects of their care. For example, one person checked with staff what time they were due to receive a visit from the GP. Formalised residents meetings did not take place because the service was relatively small and people did not feel regular meetings of this type were required telling us they preferred just to speak with staff when they wanted to.

We saw that people's privacy and dignity were respected. For example, when people were supported to go to the bathroom, staff were patient and did not rush people. Staff knocked on people's doors before entering and ensured bathroom doors and curtains were closed when providing personal care to ensure privacy. People told us staff were mindful of ensuring their privacy and dignity and we saw this was reflected in people's care plans. For example, in one person's care plan it was stated, 'Allow [person's name] time to wash areas they can manage themselves. Continue to allow [person's name] the dignity of maintaining as much independence as possible for as long as possible.'

People's bedrooms were decorated to reflect their personal tastes and preferences. People had photographs on display and personal ornaments in their room. Some people had chosen to bring their own furniture and bedding into the service. This meant they were able to arrange their bedroom to satisfy their own preferences. Staff were aware of what was important to people and supported them accordingly when people had lost the ability to do so for themselves.

People's relatives and friends were able to visit without undue restriction and were free to spend time with people in both communal areas and more private areas such as the small lounge or people's own rooms.

Most care plans contained details of people's expressed preferences and choices for their end of life care were clearly recorded and acted on.

Requires Improvement

Our findings

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. We found little understanding from staff about what meaningful activities might be for a person living with dementia.

The service had a number of people living with dementia who were unable to regularly engage in the few activities offered. We also observed little social interaction for people who were unable or chose not to leave their rooms. The service did not support people to attend activities outside of the service.

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

The service provided some structured activities to people such as weekly armchair exercises and skittles. The service invited in representatives from local churches and a hairdresser offered their services weekly. On the day of inspection a group skittles game was held in the lounge. We saw that people who could join in with activities took pleasure in doing so and commented, "I enjoy the bowling and the skittles" and "I love to join in the activities, I enjoy the bowling." However, people told us there were few activities offered on a regular basis. Comments included, "There's not much activities going on" and "I sleep a lot because there's nothing much to do".

People told us they enjoyed watching television, reading, crosswords and word searches. One person commented, "I enjoy going to the Bible readings, they give me great comfort ."

People received care, treatment and support when they needed it. For example, people saw health professionals such as GP's and district nurses when they needed to. 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 visit for one person who required this.

We saw people were supported appropriately with their mobility needs. The service had purchased five new wheelchairs to replace others which had been found to be faulty. People told us, "I had a problem with walking but they have now given me a walking frame and it's wonderful."

There were a limited amount of activities offered to people who lived at Mount Pleasant. The service user

guide stated that people would be offered 'a wide range of leisure activities to enable each resident to express themselves as a unique individual'. There was little evidence to indicate this was taking place.

Each person had a care plan and overall these were personalised to the individual person. Care plans contained appropriate assessments, for example, about the person's physical health, personal care needs, and moving and handling needs. Before moving into the service the administrator visited people to carry out an assessment of their needs to check if the service could meet their needs and expectations. Copies of pre-admission assessments were kept on people's files and were used to develop a care plan for the person. Any changes to people's needs were recorded as part of the monthly review process.

We found care records did not always provide guidance for staff about how to meet the needs of people who lived at Mount Pleasant. For example, there were no care records in place to direct staff about what an appropriate diabetic diet should consist of. For example, in one person's care plan it was stated, '[Person's name] is a diabetic which is controlled by medication and diet'. In another person's care plan it stated, '[Person's name] is now diabetic so we are changing [their] diet accordingly'.

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 might not have enough choice of appropriate low carbohydrate and low sugar foods to meet their dietary and health needs and personal preferences. We spoke with the cook about how specialist diet requirements were organised and were told there was no documented system but that if a person required a low sugar diet, a range of low sugar pudding options would be made available. However, there was no guidance available for managing individual's specialist and medical dietary needs.

We recommend that the service seek advice from a diabetes specialist service about developing best practice guidelines for supporting people living with diabetes.

Daily handovers provided staff with clear information about people's needs and kept staff informed as people's needs changed. Staff wrote daily records detailing the care and support provided each day and how people had spent their time. Staff told us handovers were informative and they felt they had all the information they needed to provide the right care for people.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. When concerns had been raised these had been dealt with in a timely manner and plans had been put in place to make any necessary improvements.

Requires Improvement

Our findings

Following the last inspection in December 2016 we found the service was not well led and rated this domain as Inadequate. While the culture of the service was essentially caring, it did not have a clear vision, set of values, or ability, to ensure people were well cared for or had choice and control over their lives.

We had 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 provision of person centred care as regards people's involvement in decisions about their care and how the service sought to meet their wider social needs. We were critical of the lack of systems in place to support staff, such as induction, training, supervision and appraisal.

During the period between January 2017 and May 2017 the service had worked to implement change to improve management accountability at the service. The provider had taken overall management responsibility for the day to day running of the service. An action plan was put in place to address the issues identified at the last inspection. The provider acknowledged that there had been a lack of management accountability and had worked with Cornwall Council to address the identified issues. However, there remained concerns about the management and oversight of the service.

There was no business continuity plan in place. This meant there was no documented strategy or plan to recognise potential threats and risks facing the service and to ensure it could function in the face of significant threats such as a fire or flood. This had been identified as a requirement in work the service had conducted with Cornwall Council quality assurance team but was not available at the time of inspection.

There remained limited quality assurance systems in place to assess and monitor the quality of the service that people received. There were no formal recording of audits for any aspect of the running of the service. A monthly medication audit in use at the last inspection to check stock levels and the quality of recording practices was no longer being used. This meant the service was not monitoring the quality and consistency of processes and recordings in this area.

Staff files containing recruitment procedures were not comprehensively completed. Two staff files did not have all relevant references and recruitment checks on file. We were told references and recruitment checks were in place and this was an administrative error. Further evidence of this was sent to inspectors following the inspection.

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.

The service had improved on some aspects of record keeping and data management systems including re-writing of risk assessments and care plans. However, clearer documentation and records for conditions such as diabetes were needed.

People and their families where appropriate, were not routinely involved in the development or review of care plans. Some people told us they had participated in putting their life history information together for their care plan.

The provider had not held any meetings for people who lived at the service or their families. Surveys for people to share their opinions about how the service operated had last been carried out in November 2016.

Management had introduced a staff supervision system although we saw some staff had no official recordings of this. Of the six staff records we checked only three had records to evidence that supervision had happened. The provider and staff confirmed that discussions had taken place but said these were not recorded or minutes kept. There was no staff appraisal system.

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

Staff meetings had begun and these were aimed to provide the staff group with an opportunity to discuss working practices at the service.
People spoke positively about how the service was run, comments included, "It's just a lovely, quiet, warm atmosphere around the home." We spoke with representatives of the Quality Assurance team from Cornwall Council who confirmed the provider had been co-operative in working towards meeting the actions of the action plan.

The provider now lived on-site and was available for management support for the head of care and other members of staff employed at Mount Pleasant. When the provider was not available a duty book was used to identify who held management responsibility for the service.

Staff commented that progress had been made to re-establish a management structure at the service. Staff comments included, "I feel more supported. Having [the provider] back has freed me up to provide more care on the floor and that is best", "There is definitely more accountability now. We are working to an action plan to get everything done that needs to be done. We are getting there" and "The environment has been updated a lot recently with new carpets and decorated throughout. We had a new upgraded fire system. It's all made a real difference to the place".

Cleaning and infection control schedules were completed. The service had been inspected by the Food Standards Agency in March 2017 and received a rating of generally satisfactory. An action plan with requirements had been met which included fitting fly screens to windows as well as re-grouting of kitchen floor tiles.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users, particularly people living with dementia, was not appropriate to meet their social needs and did not reflect their preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not operate a process to record and document evidence that the service were working in line with the Mental Capacity Act (2005)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured adequate quality assurance processes were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured appropriate

support, training, supervision and appraisal systems were in operation.