K & S Carehomes Limited

Plymouth House

Inspection report

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Date of inspection visit:
25 April 2018

Date of publication:
26 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

We undertook an announced inspection on 25 April 2018.

This is the first inspection of Plymouth House following the new provider's registration with us.

Plymouth House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Plymouth House accommodates 25 people in one adapted building. At the time of our inspection there were 16 people living at the home.

The provider did not have a registered manager in post at the time of our inspection as the former registered manager had left the provider's employment in April 2018. There was an acting manager in place whilst the provider was making arrangements to fulfil their legal responsibility of having 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 inconsistencies in the management oversight did not ensure safe and best practice was followed in all areas. The provider could not demonstrate they had strong quality checking mechanisms, to consistently identify the shortfalls in the aspects of care provision. The opportunities for people to voice their opinions about the quality of the service were in place however their feedback had not always been acted upon on.

We found the provider needed to make improvements to ensure people's needs were effectively met and they were safe. We saw staffing arrangements did not ensure people's individual needs were met in a timely way which compromised people's wellbeing and safety.

Staff were knowledgeable about how to reduce cross infections within their caring roles. There were some areas of staff practices together with the home environment which did not consistently reduce the risk of cross infections.

People's medicines were stored securely and made available to people as prescribed. The systems in place to ensure the safe disposal of medicines were ineffective.

The provider had recruitment procedures in place however they were not always followed to ensure people's safety was not compromised.

Staff showed a good understanding of how to recognise abuse and how to report if concerns were raised. Staff were aware of how to minimise risks to people's safety. We saw they used specialist equipment to ensure people's needs were met and the risks of injuries were reduced.

Improvements were being made to ensure all staff had the opportunity of receiving regular training to support them in their roles. We saw staff did not always apply their knowledge into their daily practices. People's personal information was not consistently stored to ensure their privacy and confidentiality was maintained.

People's wellbeing was not consistently enhanced with their individual needs considered due to the lack of improvements planned and taking place on the home environment.

Health and social care professionals were involved in people's care to ensure they received the care and treatment which was right for them. More consideration was needed to make sure
people had the support they required to eat their meals without any unreasonable delays and it was a sociable occasion for people.

People were supported to have maximum choice and control of their lives and staff assisted them in the least restrictive way possible; the provider's policies and systems supported this practice. Staff respected people's right to consent to and make their own decisions about their care and treatment. Where people did not have capacity to make their own decisions, systems were in place to support the ethos of people's decisions being made in their best interests.

People felt staff were caring and valued the relationships they had built with longer standing staff. However, staffing arrangements and the lack of leadership had impacted upon the time staff invested into providing care which was not always led by tasks staff needed to do. There was also little consideration made in how people were supported to maintain their dignity which reflected people were not always placed at the heart of staff practices.

People knew how to make a complaint if they wished to do so and felt comfortable in doing so. There were limited opportunities for people to follow their own interests and socialise. Staff missed opportunities to introduce into their caring roles time to spend socialising and supporting people with fun and interesting things to do.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff were not consistently available to respond to people who needed reassurance to improve their wellbeing and to feel safe. Risks to people's safety were not always mitigated as improvement work on the home environment was required. Staff used protective clothing when providing care to reduce cross infections. When staff were recruited the provider's procedures were not always followed. Staff understood their responsibility to report any concerns about people's safety or wellbeing.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs and wellbeing was not consistently enhanced due to the lack of actions taken or planned to improve the home environment. Staff did not always effectively put their knowledge into their everyday practices. People were offered meal's to meet their particular needs. However, meal experiences were impacted upon because of the unavailability of staff to meet people's needs and make it an enjoyable experience. Staff supported people to make choices and processes were in place where people lacked capacity to do so. Referrals had been made to health care professionals so people had the advice and treatment they required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

For some people their dignity was not always respected. Staff were caring and reassuring but often only had the opportunity to show care when they were focused on daily tasks. People's right privacy and confidentiality was not always protected. People were encouraged to maintain relationships which were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staffing arrangements impacted on people consistently receiving care which was individualised to their needs and supported people with their hobbies and interests. The information in people's care records reflected changes in their needs and was personalised. People knew how to complain and share any concerns they had about the care provided. Staff had received compliments from relatives about the care provided at the end of people's lives.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's quality checks were not consistently being undertaken which had impacted upon the lack of improvement actions being achieved to ensure people received high quality care. People knew who the acting manager was and felt the atmosphere was a positive one. People had opportunities to make suggestions about the running of their home. However people's suggestions for improvements were not consistently turned into reality. Staff felt they worked as a team and were supported to provide good care.

Plymouth House

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.

The inspection visit took place on 25 April 2018 and was unannounced. The inspection was undertaken by two inspectors, a special advisor and an expert-by-experience. The specialist advisor was a registered nurse. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service.

We looked at the information we received from the provider and management team. This included events which we had been notified about, such as any serious injuries to people. We asked various organisations who funded and monitored the care people received, such as the local authority and the clinical commissioning group. We also sought information from Healthwatch who are an independent consumer champion, which promotes the views and experiences of people who use health and social care.

We spoke with eight people who lived at the home, two relatives and two visitors to gain their views about what it was like to live at the home. During different parts of the day we spent time with people and saw the care they were offered and support. We looked at five people's care plans and sampled seven daily records to see how their care was planned and delivered. In addition we sampled people's medicine records and saw how medicines were administered to gain an insight into how people were supported with their medicines.

We spoke with three care staff, a nurse and administrator. We talked with the acting manager about the management arrangements and met one of the directors.

Records which showed how staff were trained to provide care and support appropriate to each person's needs. We looked at accidents and incidents, compliments and complaints and the staffing rota. In addition, we saw some quality monitoring systems however these were not up to date records.

Following the inspection we were sent documentation to reflect the assessments of people's dependency.

Requires Improvement

Is the service safe?

Our findings

People consistently told us how staffing arrangements did not always meet their needs and impacted on how safe they felt. People we spoke with said staff took too long to respond when they required assistance. One person commented, "Have to wait for staff when you want the toilet, use buzzer in room in an evening, they come but can be three hours. I want to go when I want to go and if I get an infection I want to go sooner, and I do get infections." Relatives and visitors also felt staffing arrangements required improving so people received the assistance they required so they remained safe. One person's visitor reflecting on this told us they, "Visit at all different times, sometimes no one [staff] around especially about two o'clock."

Staff we spoke said they thought there were enough of them to meet people's needs safely. One staff member commented, "I think there are enough of us so people have the care they need." Despite what staff told us we found staffing arrangements were not always sufficient to meet people's needs. There were periods of the day when staff were not around in the lounge areas to closely monitor and assist some people who relied on staff to ensure their safety. For example, one person was unable to eat part of their lunch as staff were not available in the main lounge area to assist the person when they were struggling. The inspector intervened to make sure the person had the assistance they required to eat their meal. In this person's care records it stated they required help with their meals however this was not forthcoming during our inspection. On another occasion a person in the smaller lounge area dropped an item from their side table and tried to pick this up but was unable to successfully do this. This person had a small hand bell on their table and used this however staff did not respond. Once again the inspector assisted the person as they were becoming frustrated as they were unable to pick the item up safely from their sitting position.

There were no staff in either lounge area when people required assistance as they were in other parts of the home. One staff member told us they were not always in a position to meet people's needs, "Straight away" as they were busy supporting other people. Reflecting on the unavailability of staff, one person commented, "I said we all needed a bell not just one person in the room, staff don't always hear it, think they turn a deaf ear sometimes. Care up and down, some days we get frustrated waiting for help, cut down staff to three, if two upstairs only one downstairs, dinner times worst for waiting."

We spoke with the acting manager about people experiencing delays because staff were not always immediately available to provide the care people required. The acting manager told us they believed staffing levels were assessed against each person's individual needs and when there were staff shortages regular agency staff were used so people received consistent care. However, the documents that related to these calculations were not available for us to see and so we could not establish how strong the registered provider's assessment had been. During our inspection one of the provider's told us they would ensure the information about staffing levels were calculated would be sent to us by one of the other provider's.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we received an assessment used by the provider to determine people's individual

needs. However, we could not see from this information how the deployment of staff had been considered by the provider to take into account the layout of the home and staff's skills, so the provider was able to assure themselves people's individual needs were consistently met by their staffing arrangements.

The provider's recruitment procedures demonstrated checks were completed on new staff prior to them starting work at the home which included checks with the Disclosure and Barring Service (DBS). One staff member confirmed they had not started work until references had been made with their previous employers and a police check was completed to make sure they were suitable to work with people living at the home. Nurse's registrations with the National Midwifery Council (NMC) had been checked to ensure they were fit to undertake clinical practices to meet people's nursing needs. However, in some staff recruitment files there was only one reference obtained which did not comply with the provider's own recruitment procedures of obtaining a minimum of two references. The acting manager told us they would quality check all staff recruitment files. This was to make sure the provider's recruitment procedures were followed before prospective staff started to work at the home.

Some areas of the home environment could cause a hazard to people. For example, there were areas of carpet which were ruffled and presented potential trip hazards. Another example was the main stair bannister was loose. Although staff told us people did not use the stairs this could be a particular hazard for staff and visitors who did use the stairs to access the first floor. In addition, there were some items of electrical equipment which had not been tested to ensure they were safe to use. For instance, there was a set of decorative lights which were in use in the main lounge area and hairdryers stored in a ground floor communal toilet. The acting manager was unaware of these issues until we showed them. We asked the acting manager whether the provider's quality checks had identified these concerns and what plans were in place to mitigate the risks to people. The acting manager was unable to produce quality checks and or when actions would be taken so people's safety was not compromised.

People told us the home environment was clean with one person stating, "My room is clean." One visitor also told us, "Always clean, doesn't smell." Staff we spoke with confirmed they had received training in infection control and could tell us how they worked to reduce the risk of infection. For example, care staff told us when providing personal care to people they used personal protective equipment such as aprons and gloves alongside washing hands. We saw this happened during our inspection.

Staff understood their responsibility to report incidents and accidents. Records showed action had been taken to support people when an incident had occurred to ensure any treatment they required was provided. However, the acting manager was unable to show us the arrangements in place to ensure there was a management oversight of accidents and incidents. This was to show these events were analysed to make sure the correct action had been taken to promote each person's safety and welfare.

People told us they were happy with the support they were provided to take their medicines. One person told us, staff, "Put tablets on tongue and give a cup of water, they ask if I want painkillers." Another person said, staff, "Give meds on time and get pain killers if I ask." A visitor commented, "Meds always on time." We saw people were supported to receive their medicines. For example, the nurse knew how people liked to take their medicines and made sure people had drinks so that they were able to swallow their medicines with comfort.

Medicines were available for people and stored safely in a locked medicine trolley which was attached to the wall when not in use. The provider had an electronic medicine system which contained records of each person's medicine with a photograph of each person to reduce the risk of medicine being given to the wrong person.

Staff were trained in safeguarding procedures. Staff understood their responsibilities to keep people safe and were confident to raise concerns with the acting manager or the nurse and the role of external agencies. A staff member told us if they saw any type of abuse they would, "Go to the person or nurse in charge. Nurse would report to the Local Authority and CQC."

Staff were aware of risks associated with people's care and knew the support they needed to help keep them safe. We saw that staff had assessed monitored and reviewed people's level of risk in relation to all aspects of their care, such as their walking abilities, their skin and their level of dependence when meeting their daily care. Staff supported people to meet their needs by using specialised aids to make sure risks to people's health and safety were reduced, such as, pressure relieving mattresses and regularly helped people to reposition themselves. One person described to us how staff had supported them to wash and dress so they did not fall. Staff told us how they used people's monitoring records to reflect the regular care they provided to people to reduce risks to people's skin, and to ensure they drank enough.

Requires Improvement

Is the service effective?

Our findings

We found some people's needs were not fully met by the design and adaptation of the home's environment. This was because suitable steps had not been taken to support people who lived with dementia. For example different areas of the home to aid people to recognise their home and move around independently, had not been signposted. In addition, two wooden ramps were placed on three steps so staff could assist people in their wheelchairs. One person explained to us their anxieties in being supported when the ramps were in place. They said, "Frightened of ramps, girls [staff] struggle, needs two of them, dangerous." The provider's risk assessment of the ramps could not be found on the day of our inspection to show they had considered the safety aspects of the ramps together with people's experiences.

There were areas of the home environment where a toilet, bathroom and shower room required improvement work to ensure the facilities met people's needs. For example the door to a communal toilet on the first floor did not have sufficient room so that the door would open wide enough for people to use the toilet and or close to maintain people's privacy. The acting manager told us all of these rooms were not used and required improvement work but acknowledged there were no signs to redirect people to this fact. The acting manager and staff confirmed to us there were enough facilities for people to use. The acting manager told us these rooms would be refurbished however, they were unable to tell us what was planned or give any timescales for when this would be completed.

We saw there was a proposed training plan in place so gaps in staff knowledge and skills could be met. However, we saw examples where staff did not always use the knowledge they had gained from their training. For example we saw staff had not incorporated their infection prevention and control knowledge consistently into their everyday practices to ensure risks of cross infections were reduced. This included, leaving loose continence aids in ground floor communal toilets and personal toiletries. The acting manager would ensure staff were reminded about their practices in reducing cross infections. In addition, we saw flooring was peeling away from the wall creating a potential infection control risk which had not been identified by staff or management.

Staff told us they felt they had the skills they needed to care for people who lived at the home. One staff member said, "I have completed training, infection control and hoist, practical courses, they were really useful." Another staff member told us, "We have the training we need to support residents." A further staff member told us there had been a staff meeting with the former registered manager and they had found this, "Useful to discuss any problems and share information with the management."

People we spoke with had differing views about how effective staff practices were in meeting their needs. One person told us, "Staff are really good at helping me." Another person said they felt, "Secure when transferring [with staff support] but have to wait for their time." A further person commented, "Staff don't all have the training they need to help me." We saw staff meeting people's needs with different pieces of equipment and they knew how to use these effectively.

People had varied opinions about the meals offered. Some people felt there was plenty to eat and were

happy with both the choices and quality of meals offered. However, other people were not so happy about the meals offered with one person stating the meals "Were not perfect" and another person commenting the quality of the food was "Up and down."

People's dining experience was impacted upon by the ineffectiveness of the staffing arrangements together with the leadership of the staff team during lunchtime. When staff were available they asked people their preferred choices, such as would people like a clothes protector and or what flavour drink they wanted. However, for the majority of lunchtime when staff were unavailable we saw some people struggled to eat their meals, such as, one person who only had a fork was unable to cut up their meat. Another person informed a staff member they did not want their meal and the staff member said they would get someone from the kitchen. However, no staff came from the kitchen. The impact for the person was they only ate their potato with great difficult due to their sitting position. Another person struggled to eat their meat stating, "Isn't very nice." Staff did not notice the person had left half of their meal. The person in reference to their pudding said, "This was terrible." The person expressed their dissatisfaction with their meal through their behaviour which showed their wellbeing had not been enhanced by their dining experience.

Although staff were able to tell us how they supported people at mealtimes we found this fell short of what we saw happened. Staff were aware someone should be in the main lounge area to support people however they were busy responding to people's needs in other parts of the home for the majority of lunchtime. We did see staff come into the lounge area to bring in people's puddings. We could not find and the acting manager was unable to show, us how staff practices were checked to make sure the care and support people received remained effective. We were assured staff practices would be checked to identify areas of improvements together with what staff did well so this could be built upon.

Staff we spoke with could identify people at risk of weight loss. People's ability to maintain a healthy weight was monitored by checks staff completed. This was to make sure people received effective care and risks of weight loss were being effectively managed. Where people were at risk of being unable to eat enough to stay healthy we saw they were referred to their doctor for further support. Staff and the cook were aware of which people required a specific diet to meet their health 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 an assessment shows a person lacks 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 are called the Deprivation of Liberty Safeguards (DoLS).

People's records confirmed best interest meetings had taken place if people did not have capacity. Staff demonstrated their understanding of the MCA as supporting people to make choices. One staff member explained, "We help people to make choices and decisions." A person confirmed, "The carers [staff] show me my clothes, it helps me to choose what I want to put on."

We saw staff seeking consent and approval before supporting people, such as providing support with personal care. For example, one staff member asked a person what drink they would like. The staff member then waited for a response before obtaining the person's drink. This showed us they understood the principles of the MCA and knew they could only provide care and support to people who had given their consent.

The acting manager was unsure about how many people had a DoLS authorisation in place. However they were knowledgeable about DoLS, such as they understood DoLS applications had were made on a case by case basis following an appropriate assessment of each person's capacity and care arrangements. After our inspection visit the deputy manager confirmed they had made further applications for DoLS to the local authority.

New staff members received support when they first started working at the home. Staff confirmed they had completed an induction in line with the Care Certificate. The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected. One staff member told us their induction was, "Definitely useful" as they were introduced to people and shown the equipment used to support people's individual needs. Staff explained the induction had given them the confidence they needed to do their job. It ensured they understood their responsibilities in line with the provider's policies and procedures.

We found arrangements were in place that were designed to assess people's needs and choices so care was provided in a way which met their expectations. Care records were personalised and included information about what practical support people required before people moved into the home. For example where people required specific equipment to meet their needs this had been provided. In addition, care records showed consideration had been made towards people's cultural expectations, such as how people would like their intimate personal care needs met.

People's records showed us how staff worked in partnership and maintained links with health professionals. For example, doctor, Parkinson's disease nurse specialist, and foot care practitioner. Where changes in people's health were identified, they were referred to the relevant healthcare professionals to meet their health care needs. A person said, "A fortnight ago I was a bit rough and they called the doctor." A relative said, "Doctor called if needed, had them due to hip pain, had 'x ray' and doctor explained everything, chiropodist visits and went to hospital regarding eyesight." Any healthcare professional involvement was discussed during the handing over of information to support staff in providing effective care.

Requires Improvement

Is the service caring?

Our findings

People consistently told us there had been changes in the staff team which had impacted on their experiences of getting to know staff and building up relationships. However, people expressed their varied views about how staff were caring, especially staff who they had become to know well. One person told us, "Care quite good on the whole." Another person said, "Staff all very pleasant and helpful, I'm happy here, get on with everybody." A further person told us, "Some [staff] treat you like dirt, have to do things their way, some okay." Another person said, "Staff alright, a bit here and there." The acting manager was aware some people's care experiences were impacted upon by the use of agency staff. In view of this improvements had commenced to ensure the same agency staff were employed to fill any staffing gaps whilst recruitment of new staff took place where required.

Relatives and visitors were positive about how caring staff were but also commented on the changes in the staff team. One relative told us, "Staff seem to care here, [family member] a lot happier here, content." Another relative said, "Staff very caring and very professional, very on the ball, notice the slightest change and act on it." One visitor told us, "I visit every day, care very good what I've seen, been a lot of staff changes." Another visitor told us, "Care good but turn over of staff seems quite high."

We saw some individual care provided by staff which brought people happiness and a sense of comfort. One example of this was when a staff member spoke with a person about an item they cherished in a way that showed they understood what was important to the person.

However, there were elements of the routines staff followed which did not always show a caring approach to people's needs. For example, one person's item of clothing had ridden up exposing part of their body for long periods of the day without staff noticing and offering to support the person to ensure their dignity was maintained. A staff member when asked about this said, "I had not noticed, it has been busy." Another example was shared with us by a person who lived at the home. They described to us how people had their hair washed using a bowel at a table in the small lounge area which did not afford them any privacy. Another person told us they wished there were alternative facilities for the hairdresser to use as they felt, "It is not dignified, it is embarrassing sitting at a dining table having your hair washed. You feel you are on show." In addition, the feedback in questionnaires noted the hairdressing practices required improving with one comment stating the practices were 'Crude.' We asked a staff member about this practice. The staff member confirmed this is how people had their hair washed as there were no hairdressing facilities. The staff member also told us other people could continue to use the lounge whilst people were having their hair done. The acting manager was made aware of this practice so they could ensure people were supported with their hair in a dignified way.

Personal information about people's care needs was not consistently stored securely to protect people's confidentiality. In a communal toilet there was information about people's continence needs. Staff told us and we saw this toilet was used by people who lived at the home and visitors. This meant people's personal information was accessible to people who were unauthorised to read this. We showed the acting manager this information and they would remove this. People's other care records were stored securely to protect

people's personal information and they were accessible to staff.

People told us staff gave them choices and felt they listened to them. One person said, "I choose to go to bed late, they don't mind, can go when you like, I like to be first up in a morning and I was yesterday and today." Another person told us, "I can make my own choices, I chose what I am wearing today." We saw people were offered choices; such as what they wanted to eat or drink or where they would like to sit.

We saw there were some arrangements in place for people to be involved in making decisions. There was no one using an advocate at the time of our inspection. However, staff could access an advocate to support people in their lives and speak up on their behalf when this was required.

People told us their relatives and friends were able to visit at any time and staff made them feel welcome. We saw relatives and visitors were welcomed by staff and staff made time to talk with relatives and visitors. One relative told us they were, "Made welcome, no restrictions on visiting, sometimes offered a drink and cake." One visitor said they were, "Offered a drink, made welcome, no complaints."

We heard some positive examples from people about their experiences of staff respecting their dignity and privacy. One person told us how they liked to remain as independent as possible. They said staff respected this by supporting them to do some aspects of their personal care themselves which gave them dignity. Another person said, "Staff close the door when taking me to the toilet or assisting with personal care." Relatives we spoke with were also positive about how staff respected their family member's dignity and privacy. One relative told us staff, "Treat [family member] with dignity and respect, we leave the room when they assist with personal care." Staff were seen to knock on people's personal doors before entering and closed the door before supporting the person with their personal care.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with had differing experiences of receiving care which was individual to them and responded to their needs in a timely way. One person told us, "Staff try their best but I do have to wait at times. When they do come they do know how I like my care provided." Another person said, "Allowed one shower per week and would like one more often if time and staff." A further person told us, "My bath is on a Monday would like one more often."

We asked staff about how they supported people with their personal care choices. Staff told us there was a bathing and showering rota system in place to meet people's needs. However, people could also choose to have a bath or shower on other days if they preferred.

We saw people's needs were responded to by staff that had grown to know each person's individual ways. For example, one staff member told us how people were supported to remain living at the home and did not have to move when their health deteriorated which meant people continued to receive care from staff who knew them well. One staff member said they made sure a person had an item they cherished with them as it supported the person to feel reassured. We saw this happened on the day of our inspection. In addition, a relative described how impressed they were with how their family member's skin had healed when they came to live at the home.

However, some people told us that they were not offered enough opportunities to pursue their hobbies and interests. People consistently told us social events had reduced in the last few months with one person stating, "Bored in here, only watch TV, used to play golf, sit here all day" and another person confirming they did some colouring but would like to go out. Visitors had also noticed the decline in social events with one commenting, "Seems less activities, about two months ago some keep fit and I think at Easter a church service."

The acting manager was already aware support for people to have opportunities for interest and fun required improving. We were told an activities coordinator had been appointed but they did not turn up to commence their role. In the interim period whilst recruiting to the post of activities coordinator care staff tried to find time within their roles to hold social events and support people with their interests. Care staff told us that in practice they tried to support people with social events but at times they were too busy to do this and during our inspection visit we did not see any social events taking place or hear about any planned events. Some people were doing solitary activities, such as one person was doing some artwork and another person was watching television. However, at other times we saw people sat for significant periods of time with no stimulation or distractions and no staff encouragement to engage in an activity. One person stated, "Time can hang heavy when there's not much to do." In addition, some people who required support to undertake leisure or social activities were left in their rooms for long periods of time with little or no stimulation.

People's daily records showed that on most days people had not engaged in any social events. We raised our concerns with the acting manager who assured us action would be taken to provide people with a

suitable range of opportunities to pursue their hobbies and interests.

Staff we spoke with described how people received care personalised to them. One staff member said, "I always ask people what they want." Another staff member said, "We have information about how people have been through handovers." Staff had handovers that took place at the end of each shift and staff told us they were able to refer to people's care records during the shift. This showed us there were processes in place to share information to support staff so that people received care personalised to them. This was important as the provider was relying on agency staff whilst recruitment for staff was on-going to ensure staff continued to be responsive to people's individual needs.

Care staff understood the importance of promoting equality and diversity. People's lifestyle preferences were written down in care plans for staff to follow. On the subject of whether people preferred a female or male staff member to assist them with their personal care, one person told us they, "Prefer male carer [staff], he's real gentlemen and ask for him." Another person said, I'm not religious but if I was I could join in the church services."

We saw people who lived at the home and their relatives were involved in attending review meetings and had been kept fully informed of any changes. A relative told us, "They [staff] definitely notify us of any changes."

At the time of our inspection there was no one receiving end of life care. A staff member told us they had provided end of life care to people if the home was their preferred place of death and their needs could be met. Records showed people and their relatives where appropriate had been consulted about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive. We asked staff what they thought was important in terms of care and support for people near the end of their lives. A staff member described to us how they made sure people were as comfortable as possible and were provided with reassurance when needed. In addition, we read comments from relatives who had valued the care their family members had received at the end of their lives. One relative had written, 'Would like to thank everyone at Plymouth House for their kindness and care during [family member's] final few weeks.'

People who lived at the home and relatives we spoke with told us, they felt comfortable raising concerns if they were unhappy about any aspect of their care. One person told us, "If any complaints son deals with it." One relative said, "Not needed to raise any concerns." One person's visitor told us, "No complaints, satisfied." No complaints had been raised since the new provider registered with us. However, there was a complaints procedure available to people who lived at the home and relatives which could be produced in different formats to suit people's individual needs.

Requires Improvement

Is the service well-led?

Our findings

This is the provider's first inspection since they purchased the home and registered with us in June 2016. There had been changes in the post of home manager since the provider registered with us and the former registered manager had left their post in April 2018. An acting manager had been appointed in April 2018 in the interim period, of the provider recruiting to the position of home manager. This was so the provider met their legal requirements in having a manager who was registered with us.

People we spoke with knew who the acting manager was and considered the atmosphere to be a positive one. One person told us, "I know the new manager and last one." A person's visitor commented, "Manager is only temporary and didn't know the last one, atmosphere very pleasant."

However, we found people who lived at the home and relatives had not been fully involved in making improvements. People told us and we saw from completed questionnaires, people were invited to provide their feedback on their experience of living at the home. Comments from people in their feedback had shown areas of suggested improvements, such as updating the decoration of the home environment and improvements needed to the hairdressing arrangements. We found there was no organised system to analyse the comments made and act upon them.

We found quality checks to assist the provider in ensuring people received safe, effective and responsive care had not always been completed. The acting manager was unable to tell us and or show us what checks were in place to ensure people received good standards of care. One of the directors told us this information would be sent to us however we did not receive this. We found there was no planned approach to assist in improvements being undertaken to make sure these were completed in a timely way. For instance we heard similar concerns from people which had already been included in the questionnaires, such as how the hairdressing arrangements were unsuitable. A person's comments read the, 'Hairdressing arrangements, crude and unsafe.' The hairdressing practices had not been reviewed and continued.

The deployment and management of staff did not always support the provision of high quality care. For example, we saw people struggled to eat their meals due to the lack of staff support. People also raised similar comments about the impact of the staffing arrangements on their care experiences with one person stating, "I don't feel safe, as I'm not sure staff will always help me." We could not find in the quality checks provided, where people's dining experience had been checked to make sure staffing arrangements and practices were effective. The provider did assess people's dependency levels however; there was no calculation to show how other areas of staffing could impact on people's care experiences, such as the layout of the home environment.

There were aspects of the home environment which did not promote people's wellbeing and safety. We saw many areas of the home environment where redecoration was required due to issues such as chipped paintwork, facilities which people could not use and worn carpets. In addition, in two people's personal rooms there was a cracked window pane. There was no information to confirm when people's windows would be repaired. This did not reflect a caring approach was being taken to make sure people had rooms

where the décor and facilities were undertaken in a timely way to enhance people's wellbeing. The provider's own quality checks and management oversight of the home should have identified these areas but once again the acting manager and one of the directors were unable to show us the improvement plans.

Failure to suitably assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity (including the experiences of people receiving those services) was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with believed they worked well together and when they had any concerns about people's welfare they would discuss these with the nurse in charge of the shift or the acting manager. One staff member told us, "Very nice staff to work with, all supportive of each other." Another staff member said, "I'm happy here, helping residents."

The acting manager was open and acknowledged the concerns we identified where improvements were required. The acting manager had come into post originally as deputy manager however when the former manager left the provider's employment in April 2018 they 'stepped up' into the position of acting manager. The acting manager told us they did not feel experienced enough to undertake the role of manager as they lacked knowledge in some aspects of the manager's role such as, legislation requirements and inspections. The acting manager commented, "I came here with no management experience. I came here believing I was going to learn to be a deputy manager." The acting manager said to us, "There is a lot of work to do."

The acting manager was supported by the administrator, who had worked at the home for many years. The acting manager told us since the local authority had visited and the improvement work required for the fire doors had now been completed. However; the acting manager recognised improvement work needed to continue to benefit people who lived at the home. We saw the acting manager was well known to people who lived at the home and was visible around the home during our inspection to answer any queries raised by staff in order to support them.

The provider has now made the decision to close the home and people are currently being supported to find suitable alternative care settings to meet their needs.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have strong processes in place to ensure the safety and quality of the service was adequately monitored and improved, and to ensure known risks were acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staffing levels and deployment of staff were sufficient to meet people's needs.