Akari Care Limited

Comfort House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Comfort House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 35 people with physical and mental health related conditions were using the service.

This unannounced comprehensive inspection took place on 3,4, and 5 July 2018. This meant that the provider, staff nor people who used the service knew we would be arriving.

At the last fully comprehensive inspection in September 2017, we identified two breaches of regulations which related to safe care and treatment and the governance of the service. Following the last inspection, we asked them to do an action as to how they were going to meet the regulations. We found whilst some improvements had been made, the service remained in breach of both regulations and during the inspection further issues were found.

There was no registered manager in place at the service. A deputy manager from another service had been in post a few weeks and managed the service daily as the previous manager had resigned very recently and the current deputy manager was not available. The temporary deputy manager had applied to become the manager of the service and it was confirmed during the inspection that they would be taking on this role and applying to register with the Care Quality Commission (CQC) in due course.

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 indicated in action plans that the management team at Comfort House carried out daily, weekly and monthly checks of the quality and safety of the service and were confident that issues had been or were being addressed. We did not find adequate evidence to corroborate these checks had consistently taken place or were completed robustly enough to identify the continued issues we highlighted during this inspection.

We found some irregularities with people's finances within the service. At the time of the inspection, an internal audit was underway and police were investigating. We will monitor this and follow up in due course.

Record keeping had deteriorated throughout the service since our last inspection. The lack of accurate and thorough details recorded within care records meant that neither we nor the provider could ascertain if issues had been correctly identified and followed up properly with the necessary action. We found accidents had not always been recorded fully and people's care records lacked the detail required to ensure they

received safe care and treatment that met their needs.

Care plans reviewed were either not in place, up to date or were incomplete. There were also gaps in risk assessments. Monitoring of food and fluid intake was not always robust, with records not fully accurate. This meant that important information may have been missed and this put people at risk of harm through not receiving the appropriate care and support. Care records did contain person centred information, but further work was required to ensure people's individuality was fully captured.

Medicines were not always managed safely. There were concerns relating to the ordering, administration, records and staff competencies.

Staff continued to be safely recruited. However, we found there was not enough staff, mainly relating to the upper levels of the service. We monitored call bells and found in some cases excessive amounts of time passed before they were responded to, for example over 15 minutes, more in some cases. We overheard one person being told not to use the bell. This was reported to the management of the service to deal with.

Induction was not at a suitable standard and staff training was overdue for some staff and refresher courses in key topics had not been routinely carried out. Although training was now taking place, this demonstrated that the provider had not assured themselves that people were supported by staff who had the skills and competence to provide safe care. In addition, supervisions were overdue and annual appraisals had not been conducted recently. This meant that staff had not been formally supported in their role or given a recognised opportunity to talk about their issues and any plans for development.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS). Applications had been made on behalf of some people to restrict their freedom for safety reasons in line with the Mental Capacity Act 2005. However, we found the service was unable to tell us who had been authorised and it was only with the help of the local authority that they were able to confirm which people had a DoLS in place. The monitoring system was not robust and had not been properly maintained. Consent was not always appropriately gathered from people or relatives (acting legally on their behalf) and it wasn't always recorded in line with the principals of the MCA.

Activities were very poor with no stimulating activities taking place at all. There was no activity coordinator at the service as the role had recently been vacated but the provider was currently looking to employ further staff and were aware they needed to quickly improve in this area.

Complaints were not managed in line with the provider's complaints policy. Although complaints appeared to have been dealt with, records were not always available which recorded action taken or to enable the provider to monitor complaints.

We saw some care workers did not always treat people with dignity and respect and we observed a number of occasions were staff did not show the kindness and compassion we would expect, including during moving and handling procedures and discussing people's personal care in an open environment. However, we did receive many complimentary words from people and relatives for the kindness and caring nature of other care staff which should be recognised.

Despite the issues we found, people told us they felt safe living at Comfort House. Most relatives confirmed this. Most staff were trained in the safeguarding of vulnerable adults and through discussion they could demonstrate their responsibilities with regards to protecting people from harm. The provider had

information to support staff in reporting safeguarding concerns, throughout the service.

The premises were generally clean and tidy but we found some areas in need of attention regarding refurbishment or maintenance, including the garden area.

A variety of foods were prepared at meal times, including hot and cold choices. A new chef was in place and aimed to review current menus with people. Recording and monitoring of people's nutritional and hydration needs was not effective, with tools to support this not being used correctly and information not being fully available to all staff (particularly kitchen staff) or accurately recorded. This meant there was potential for people to be placed at risk of harm due to inaccurate record keeping and monitoring.

We have identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Two of which have continued from the last inspection. You can see what action we told the provider to take at the back of the full version of the report.

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 timeframe. If not enough improvement is made within this timeframe so that 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.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. 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 it 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 the more serious 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.

Medicines were not managed safely.

There was not enough staff deployed at the service to support people safely, with frequent use of agency staff and call bells being unanswered for extended periods of time.

Accidents and incidents were not always reported correctly.

Risks people faced in their daily lives were not always assessed and reduced. Moving and handling procedures were not always safely completed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always completed a robust induction programme and training was not kept up to date, including checks on staff competencies. Staff supervisions and appraisals were not carried in line with the providers policies and procedures.

Consent was not always obtained in line with the Mental Capacity Act 2005 (MCA) and staff did not always follow the principles of the MCA.

People with specific nutritional needs did not always experience a positive outcome. A new chef had made some improvements in their short time at the service.

Improvements were required to the premises and garden areas.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider did not always enable staff to provide a wholly caring service due to the shortfalls throughout the management of the service.

People told us staff were nice to them and treated them with respect, although we did not always see this through observations

People and their relatives told us they had been involved in the planning of care, but records were not always in place.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints were dealt with but not always recorded in line with the provider's policies and procedures.

Information about people's current needs may have been missed because care plans were inconsistently reviewed and not kept up to date or were not in place.

Person centred information was available in care records but missing information from records impacted on this.

People at the end of their lives were looked after well.

There were no meaningful activities taking place. However, the provider was in the process of recruiting an activity coordinator to take up this role.

Is the service well-led?

Inadequate

The service was not well-led.

Audit and governance systems were ineffective. The service had continued to breach regulations from our last inspection and other areas of the service had failed to appropriately meet people's needs in a safe, effective, caring and responsive manner.

Record keeping had deteriorated. Issues raised during internal and external audits had failed to be fully addressed. The provider had poor oversight of the service.

There was no registered manager, however the interim deputy manager had accepted the post of manager and was in the process of applying to register with the Commission.

People, relatives and staff felt the home's atmosphere and staff morale had improved recently since the interim deputy manager started.

Comfort 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.

This inspection took place on 3,4 and 5 July 2018 and was unannounced on the first day. The inspection was carried out by one adult social care inspector, two assistant inspectors and one specialist advisor. A specialist advisor is a member of the inspection team with specialist skills and usually focusses on their speciality. This specialist advisor was a nutrition nurse consultant.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including statutory notifications we had received from the provider about deaths, safeguarding concerns or serious injuries. Notifications are incidents which the provider is legally obliged to send the Commission. We contacted the local authority commissioners and safeguarding teams and the local Healthwatch team. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We also contacted the fire authority and infection control leads for care homes. We used any information received to support our planning and judgements.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with every person at the service who could communicate and observed those who could not. We also spoke with five family members. We spoke with the covering deputy manager, the regional manager, a further supporting registered manager from another service, four senior care staff, eight care staff (including night and day staff), one domestic and the chef on duty along with one kitchen assistant. We observed how

staff interacted with people and looked at a range of records which included the care records for seven people and medicines records for 15 people. We looked at five staff personnel files, health and safety information and other documents related to the management of the service. We spoke with two GP's, two district nurses and one community health care assistant during the inspection and used their comments to support our inspection process.

We placed a poster in reception to inform visitors we were inspecting and asking them to share their views with us in person or via telephone with the lead inspector.

Inadequate

Is the service safe?

Our findings

At our last inspection, we identified a breach of Regulation 12 which related to safe care and treatment at the service for the people who lived there. Despite the provider addressing some of the specific issues we raised, we found that not enough improvement had been made and other aspects of the service had failed.

The management of medicines was not always safe. The service continued to use an electronic medicines management system and we found issues with its use. We found a number of medicines had been out of stock for some people. For example, one person had no codeine in stock for pain relief, while another had no Rivastigmine patch medication for four days until the deputy manager completed a medicine audit and found the out of stock item concern. Rivastigmine patches are used to treat people living with mild to moderate dementia. This particular concern was reported to the local authority safeguarding team and it was reported from the provider that lessons had been learnt. A GP told us that medicines had been reordered for people when they had been stopped by them and gave us an example which we checked and confirmed. They said, "I was told it was a problem on their system, but such a waste."

People did not always receive their medicines on time. For example, there were a number of people who had medicines prescribed to be administered before breakfast. We saw people receiving these medicines during or after breakfast. On day three of the inspection, senior care staff from another service had been asked to administer medicines to people living at the service. The medicines on this particular day took an excessive amount of time with some people not receiving their morning medicines until near lunch time. We noted two people had medicines given later than was prescribed on their MAR. We asked staff about these. Staff told us, "Oh, they don't get that till lunch time. That's what they like." When we asked why the MAR's had not been updated to reflect this, the staff member did not know why. We checked care records and found no rationale or explanation why the medicines were being given at a different time than prescribed. We brought this to the attention of the interim deputy manager and regional manager and they said they would look into the issue.

At the last inspection we found that 'as required' protocols were not taken with staff while they administered medicines. 'As required' medicines that are administered when the need arises, for example, those used for pain relief. The protocols regarding these medicines support staff with the details of how. when and why they may be required. This is particularly important for people who were living with dementia or others who may not have been able to communicate their needs. We found that protocols continued not to be carried by staff while the administration of medicines took place and only when we discussed this with management did this take place. We also found that not all protocols were in place and those that were, were in the process of being updated as information was missing.

We noticed on one person's topical MAR a particular cream was classed as 'as required'. However, had been prescribed twice per day and not 'as required'. We could find no explanation why this was not part of their permanent medicines and staff could not tell us. There were inconsistencies in the recording of topical medicines and topical MAR's did not always match the prescription. Topical medication refers to, for example, applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. This

meant it was unclear when people should have creams applied and where they had been omitted no risk assessment was in place to support why.

We observed two people had their medicines left with them during breakfast time while staff administered to other people. As the two people were not fully observed, staff could not have been assured they had taken them. We checked the care records of both people regarding medicines and found no reference to staff leaving them unattended. One person's record stated, "Snr staff member administrating (their) medication will observe (person) whilst taking (their) medicine to ensure (they) do not drop any of (their) tablets. We saw that staff administering eye drops did not always follow best practice and did not wash their hands before applying people's drops. One person who administered their own medicines had no risk assessment in place to support this or checks by the provider to ensure they continued to be safe doing so. The ordering of the person's medicines had been taken over by the provider and not at the request of the person. They told us, "I have always collected my own medicine from the chemist. I still want to do that." The management team were in the process of finding out how this had occurred.

Risks were assessed to ensure people were safe and where possible, actions were identified for staff to take to mitigate these. For example, from the records we viewed we saw risks relating to moving and handling, mobility, falls, nutrition and hydration were identified. However, these risks had not been consistently reviewed monthly and in some cases a risk assessment was not in place at all or not fully completed. For example, one person who used oxygen had no risk assessment in place and another person had a moving and handling assessment in place but this had not been fully completed regarding risks to staff members. This meant both people and staff could be at risk during these interventions.

Recognised tools such as the Malnutrition Universal Screening Tool (MUST) were used, which would be used to help staff identify the level of risk regarding nutrition. The MUST tool is used to monitor weight and manage weight loss or obesity. However, out of the seven records we checked six were not completed correctly which meant that people had been placed at possible risk of harm due to incorrect information being recorded.

One person had not had their risk of malnutrition monitored properly for several months and had lost weight in the interim. Records showed discrepancies in the consistency of fluids to be given when thickeners had been added. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties.

GP's were involved with the person and confirmed with us they had no concerns about the weight loss as the person had also been unwell. However, as we were not able to see all the person's records because they had been archived and the provider was unable to locate them we were not able to fully clarify what their correct dietary and hydration needs were. We discussed this person with the deputy manager and they agreed that further discussion with specialist dietitian teams would take place to check all relevant dietary information was in order.

One person we reviewed was at risk of pressure damage. We found that the pressure relieving mattress setting was not recorded on care records, or any other documentation to confirm it was on the correct setting. This meant the mattress was not checked regularly putting the person at potential risk of unnecessary skin damage. We asked staff to check the mattress settings and it was identified that the setting was incorrect for this person. This placed the person at risk of harm from unnecessary skin damage.

We saw examples of staff using poor moving and handling techniques. This posed a risk to people of receiving skin damage or injuries. We also saw incorrect slings being used on hoists, such as a toilet sling

used instead of full body sling, and the incorrect size for the person. This meant the provider did not have sufficient slings of the correct type and size meaning people were at risk of falling.

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

The provider used agency staff to cover some shifts whilst they recruited permanent care staff. People's dependency on support from staff was monitored to ensure staffing levels were adequate. During our inspection, we found the staffing levels were not appropriate, particularly in relation to people living on the upper floors of the home. People and relatives told us there was not enough staff. Comments Included, "Never enough staff" and "You can never find anyone when you want them, but I know they are busy…there is just not enough."

We spent time observing interactions between people and care staff in the service and their response times, particularly regarding requests for help and answering call bells. One person told us, "I have to wait a long time when I ask for something." On two occasions call bells rang for excessive amounts of time and this was particularly in relation to those people who lived on the upper floors of the service. In one instance a call bell had been activated on the upper level when no staff were present. We attended and checked the person was not in distress and then waited for a staff member to arrive which took over 15 minutes. We asked for a report of the call bell activations for the last month. This showed numerous occasions where people had waited for well over 15 minutes and in some cases, 43, 21, 69 minutes from call to the call bell being reset were recorded. We raised this with the management team who said it was not acceptable.

Several staff were off work, for example, due to sickness or holidays. This meant regular care staff were not always available due to agency cover. This, combined with a lack of people's complete care needs recorded and poor management oversight in place until very recently, had led to procedures not being as safe and effective as they should have been. We were made aware of an incident in which a person had not been supported as well as they should have. Although no harm was caused due to staff negligence, staff had not acted as quickly as they should have and had been unaware of their complete medical history and wishes in an emergency.

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

We found some irregularities with people's money which the provider looked after. We have explained this in more detail in the well led domain.

Accidents and incidents were not always recorded in line with the providers policies and procedures. We found several examples where an incident or accident had occurred via referring to daily notes, speaking with staff or visit records by GP's or other healthcare professionals. For example, one person had fallen overnight and the management team were not made aware of this incident. Another person had fallen in June and this was not properly recorded or reported. This made accident analysis difficult.

People told us they felt safe living at the service and relatives told us their relatives were settled. However, due to some recent issues arising within the service two relatives told us they had considered other accommodation for their relative, however felt that this may be detrimental to their health and on balance had decided at this current time to stay at Comfort House as they had seen some improvement with the current deputy manager. Entrance codes were now available to staff only following the concerns we had about the security of the premises at the last inspection.

Premises and equipment checks had been carried out, including for example, those relating to mains electricity and fire safety. We noted that the fire service had found issues which needed to be addressed and during the inspection they confirmed that the provider had completed them. Staff confirmed that fire drills had taken place, one said, "Fire drills do happen, there was one about two weeks ago."

We noted that the lift in the service had a number of failures over the last few months. During the inspection, the lift broke down trapping a member of staff. The staff member was quickly released and lift repair staff were called and repaired the lift. People were concerned about using the lift. One person told us, "Don't go upstairs often, unless with my son, as I fear the lift will break." The provider had previously confirmed (people also) that major repair work had already been undertaken. The regional manager told us that their estates department was aware of the continued lift issues and were looking into this.

The premises were generally clean and tidy and the provider told us they were going to undertake a deep clean of the entire service in the near future. One relative told us, "The place is clean and the staff do their best." The chef told us they had already completed a deep clean of the kitchen area. Domestic staff were on duty and we saw they had designated responsibility for specific areas of the service. We observed staff followed best practice guidance in relation to the control of infection such as the use of colour coded equipment and degradable bags for soiled laundry. All staff were observed using personal protective equipment as necessary to prevent cross contamination. We spoke with a member of staff from night shift who we were not sure was a staff member as they were not wearing a staff uniform. They told us they had worked at the home for over five months and still had no uniform. We spoke with the management team about these issues and they said they would address them.

Staff continued to be safely recruited using the providers recruitment processes. Staff had completed an application form, attended an interview, supplied references and had been checked externally by the Disclosure and Barring Service (DBS) to ensure they were suitable to work with vulnerable people. We did note one staff member who had not had their DBS check renewed in line with best practice, however, the provider said they would have this addressed straight away to bring it up to date. Where staff had disclosures on their DBS checks, the provider had risk assessed these to establish if the staff member was suitable to work at the service.

The provider was striving to maintain a permanent staff team with ongoing recruitment. One staff member commented, "There's high staff turnover, some start and can't handle it." Another staff member told us, "If we had a permanent manager and some stability, staff might stay instead of starting and then leaving and staff might not have left anyway." A third staff member said, "There are issues with staffing, lots of staff on sick" Staff told us changes in management, including regional manager, manager and deputy manager, this had impacted on the staffing team overall.

Requires Improvement

Is the service effective?

Our findings

An induction programme was in place. However, when we asked staff about their induction process, comments were not always complimentary. Staff told us, "My training and induction was poor"; "I was just thrown in" and "I was not aware of how to report safeguarding concerns until recently" (although we found information to support this displayed within the service on notice boards).

We reviewed induction records to see whether staff had been enrolled on the 'Care Certificate'. The Care Certificate is a benchmark for induction of staff who are new to the care industry and was introduced in 2015. Whilst it is not mandatory, providers should be able to demonstrate that staff are competent in the standards. The guidelines suggest the 'Care Certificate' is completed within the first 12 weeks of employment. From the information we were provided and by talking with staff we found staff induction was not as robust as it should have been.

The training matrix showed gaps in care workers skills which the provider deemed mandatory. For example, regarding moving and handling, nutrition, equality and diversity, Mental Capacity Act (2005) and health and safety training. We confirmed this was correct by speaking with staff and referencing the information with individual staff records. Comments from staff about training included, "Training is well behind, some have been put on and then cancelled"; "We get put on courses sometimes when on shift which means we have to try and cover the floor and do training which means we miss parts"; "I still haven't had any training on DoLS – it's coming up I think" and "I asked the last manager for training all the time, but still waiting. I think they are sorting something out now though." We spoke with the management team, who confirmed that training had not all been delivered, although they sent us a training plan of future courses. This meant that some staff had not received suitable training to support them in their role.

Records showed and staff confirmed that staff supervisions and appraisals had not been consistently undertaken with staff. One staff member told us, "No supervisions or appraisals for a while." Another staff member told us, "I don't feel supported." A third member of staff said, "I get no supervisions as there have been too many changes with managers." Staff reported a divide between day and night shift. One staff member told us, "There is a divide with day and night staff, people don't get on, some night staff don't even speak to people (staff) on days." This meant that staff has not been appropriately supported in their role.

We reviewed medicine competency records which had been carried out with senior care staff. We were told all eligible staff should have received a completed review of their competency. However, we found not all senior staff who administer medicines had received these checks. The management team told us that in the following week a trainer would be at the service to complete these.

These issues meant people were not receiving care from fully trained, competent or supported staff.

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

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 so that they can 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 found that mental capacity assessments and decisions made in people's best interests were not always recorded for people deemed as lacking capacity. On some occasions we found best interests' decisions recorded that were inappropriate, for example one person had a best interests' decision in place for reducing risk of self harm, which should have been dealt with as a risk assessment. Relatives told us they were usually involved with any decisions that needed to be made and confirmed healthcare professionals had been involved too. However, records did not always reflect who had been involved in the decision making.

The provider had no clear record of which people were subject to a DoLS authorisation. During the inspection the covering deputy manager showed us an email exchange with the local authority in which they had had been able to clarify all authorisations as they had not been able to prior due to poor record keeping. Staff we questioned, were not clear on who had a DoLS in place. This meant the provider had not taken steps to ensure people were not subject to any unlawful deprivation of their liberties.

At the last inspection we noted the provider did not always have copies of Lasting Power of Attorney (LPA) documentation and this was going to be addressed by the manager. This continued to be the case. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. This meant any consent given by relatives assumed to have LPA could not be confirmed as appropriate as proof was not always available. We brought this to the attention of the management team during feedback and they said this would be addressed.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Need for consent..

People told us the service was effective for them. Comments included, "I like it here, it's very nice and quiet"; "I like living here, I have a nice room, a nice view and I am happy" and "My room is nice, it's clean and I have everything on hand." Relatives told us, "It used to be a good service but things have slipped over the last year or two. It's looking a bit more positive now though and the new deputy seems to be going through what is wrong, which is good."

People's needs were assessed before they moved into the service to make sure the staff could provide the correct care and equipment to ensure their safety and comfort. We found these assessments did not always contain full details of people's care needs.

Handover meetings took place when the staff team changed. For example, when night shift finished and day shift started. We attended a handover meeting and later asked questions about people. We found that issues which had been identified in the previous shift had not always been passed on as well as it should have. Including, for example, one person who should have had a urine sample taken and this had not been completed in a timely manner. During the inspection the management team implemented 'flash meetings'

which was an addition to the usual handover and included head of departments (housekeeping/kitchen/care etc.) coming together to discuss any issues arising and how they would be addressed. We spoke to one senior carer after the first flash meeting and they said it had been "positive and useful."

As part of the new handover procedure, staff were allocated tasks to do throughout the day. This meant the staff knew who was responsible for various tasks which needed to be completed, including personal care, or drinks to people. Staff told us they thought communication was better since the interim deputy manager arrived. One said, "Communication is much better, there is a new work sheet, everyone knows who is doing what." We saw this in action and staff seemed to be undertaking what they had been requested to.

At the last inspection kitchen staff did not always have up to date details of people's dietary needs and we made a recommendation. This continued to be the case, although the new chef was aware of this and was about to start addressing it. Currently, kitchen staff relied on care staff telling them verbally the dietary needs of people living at the service, although a list of people who had diabetes was available in the kitchen area. Daily recording of food and fluid were kept for people at risk of malnutrition or dehydration. However, these were not always detailed and lacked totals in the case of fluids charts. This meant it was difficult to calculate if people had received enough drinks to maintain their hydration needs and to monitor if enough food had been consumed. We have dealt with recording issues under the well led domain and its governance procedures.

Improvements had been made to the dining experience with the introduction of a new chef, and people told us that the food had improved. However, people using the service continued to share mixed views about the food and drink available and people remained unsure what was going to be served. Menus on display did not reflect what was being delivered, however, the chef explained that they had been told to wait before making changes to the permanent menu displayed until the new manager came into post. Comments from people about food included, "The food has improved, I'm given two choices and can ask for an alternate"; "Feel there is enough food, it's sometimes good, sometimes its rotten"; "Food isn't too bad, its basic but no choices"; "Food isn't great and not very good"; "I get plenty to eat and there has been a change lately, bit better" and "It's hard to please everyone all the time, but they try and it's okay (the food)."

We saw people enjoying a full cooked breakfast on all three days of the inspection and a range of food choices were available in line with the governments recommendations of five fruit and vegetables per day. People were supported to eat their meals if this was required and given encouragement to eat enough. We made a number of observations during meal times over the inspection period, including at different times of the day. We found that on a small number of occasions people had to wait excessive amounts of time (some over 30 minutes) for food to be served.

Three people told us they were not offered hot chocolate or Horlicks in the evening. We asked the deputy manager about this and they said they would check this was being offered. We saw there had been an increase in the supplies of ice cream, lemonade and ice lollies due to the hot weather and this had followed a request from the provider. Staff had increased the amount of fluids offered to people. This included non-alcoholic cocktails which people enjoyed as a new experience. However, the increase in fluids had not always been recorded fully. When we discussed this further with staff they agreed that the information recorded on the daily charts did not always reflect the actual amount eaten or drank on each occasion and that further guidance for staff on how to record this information was needed. This is being dealt with in the well led domain relating to governance.

The home had suitable adaptions such as walk in shower facilities and bathing equipment. However, one

staff member raised an issue about the angle of a bath chair and said, "It's really tight to get in to get people dressed. You have to twist and that's not good for your back." We spoke with the management team about this, who said they would look into the issue raised. The home was reasonably decorated but there were areas which needed updating. This also included scuffed walls and paintwork. The garden area also needed attention, for example, there were empty hanging baskets, dated garden furniture and the area generally lacked maintenance. The bedrooms we were invited into contained family photographs and personal effects.

People told us and we saw in care records that they had access to healthcare professionals such as GP's, community nursing staff and opticians. People told us they were happy with how staff reacted when they were unwell.

Requires Improvement

Is the service caring?

Our findings

We found that although most people and relatives made positive comments about staff regarding their caring nature and attitude, this was not always what we observed during the inspection. Also, due to the shortfalls we found regarding, training, governance and management, the ability of staff to provide a fully caring approach to people's care was restricted. This meant that people were not always at the centre of the care they received.

During one lunch time we observed one person who was anxious and thought they were choking. The person was coughing and staff came to assist. The person explained they did not want any more food and despite this staff said that she could not go without first eating some more. Staff did not take time to comfort, reassure or support the person who was unsettled and focussed on trying to maintain their food intake. Despite the person refusing food, staff brought some mashed potato and gravy which the person continued to refuse. Staff did not respect the person's wishes and showed little care in the way they dealt with the situation.

On one day of the inspection, during breakfast time, one person commented that "staff have been to charm school today", indicating that they were being extremely pleasant, more than normal. One person also told us, "They [care staff] are being extra nice today…must be because you are here!" We overheard one staff member shout across the lounge to another colleague relating to a person's current personal care requirements. One person who lived with dementia requested to visit the toilet and although they had recently visited, the response from staff was not appropriate as the person was told you only go "On the hour every hour." We raised this with the management team, who said they would look into this.

Two healthcare professionals told us that many staff "Go the extra mile" for people. One said, "Many of the staff are very good and very caring."

We heard words of encouragement offered and words of explanation whilst staff undertook moving and handling with people, when hoists were being used. In one instance a member of care staff spoke with one person throughout the procedure and correctly completed the task in the shortest period of time to reduce stress caused during the procedure. However, we also observed staff not speaking to people during moving and handling procedures and treating the process as a task which needed to be completed. We brought this to the attention of the management team.

Although we observed and were given examples of poor care, we were also given examples of kindness and compassion. People told us the staff team were kind and looked after them well. Comments included, "They spoil me rotten, they know my routine and ask if I need anything"; "The staff are hard-worked"; "Staff are all good"; "Staff are nice and caring"; "Carers are all very helpful and are lovely"; "The staff are always smiling" and "The staff are good, kind and pleasant."

Relatives told us, "The staff are spot on"; "The staff try their best, but sometimes there are agency staff who don't know the residents well. They seem kind, but of course I am not here all the time" and "I truly believe

that staff are kind and caring but just don't have enough time to show it sometimes."

Staff told us, "I love to hear people's life stories and entertain people but I can never get time to spend with people"; "I don't get time to spend quality time with residents and that's what I came here to do"; "I want to be able to have time to sit and have a chat, but no way at the moment and this is seen as something you just don't do…sad really" and "I love the residents. We have some proper characters. It's sad what the place has become, but it is improving now and I think that is the deputy. She seems really nice and caring."

It was very hot during the inspection and we saw the interim deputy manager send out staff to purchase fans for the home. We then observed they had been placed around the home to keep people cool.

We observed staff knocking on people's bedroom doors consistently before entering which showed they respected people's privacy. However, on two occasions when staff knocked on bedroom doors they did not wait for a response before entering, despite both people having capacity and vocal ability. One person told us, "The staff always knock before they come in." One person thought they were treated with respect and said, "I'm lonely but feel treated with respect."

Families of people who had passed away had sent thank you cards to the service for the care received at this sensitive time. One very recent card thanked staff for the care given to their loved one and also to the family as a whole. We found many thank you cards within the service, thanking staff for the care shown.

People and relatives told us they had been involved in some aspects of care planning. Care plans contained information about people's likes, dislikes, preferences, interests and hobbies. The regular staff we spoke with knew people well although records did not always reflect people's life histories, past employment, family lives and relationships, so newer staff or agency care staff would have struggled to be able to have meaningful conversations with people.

Information, advice and guidance was displayed around the service on notice boards to benefit people and their relatives. People were given a 'service user guide' which told them what they should expect from the service. A suggestion box was available for people, relatives, visitors or staff to share their views. The suggestion box was situated in the main lounge near the lift which meant anyone wishing to use may have been put off by the location being very central and within clear sight of staff and others. We were told by staff that the suggestion box is never used. We spoke with the deputy manager and regional manager about this, who said they would review the location.

People's care records were now stored securely in locked cabinets after the interim deputy manager relocated them when they started working at the service. The staff working station held daily notes and other daily records which we found was not always locked. The provider informed us that the staff working station was no longer in place and records had been relocated to a more secure environment.

Most people had family or friends who acted on their behalf as advocates. The management team were aware of how to access an independent advocate if they felt it was needed. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, to ensure that their rights are upheld.

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at contained some person-centred information on people's support needs and reinforced the need to involve people in decisions about their care and to promote their independence. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to them. However, some care plans were not in place at all or were limited in content or were out of date. For example, one person who used oxygen had no care plan in place to help support staff meet the person's needs in connection with this. Another person had no nutrition care plan in place, yet they were weighed weekly and a GP had been called to seek advice as the person had lost a small amount of weight (less than 0.5kg). Another person had a care plan in place for mobility yet they had no needs and were fully mobile with no risk of falls at all. One person who had lived at the service since February 2018 still had 'respite' care records in place which did not include all their details or specific care plans they needed to support them. Staff confirmed care plans did not always have up to date information. One member of staff said, "Care plans are hard to follow as they are not always accurate."

Care plans were inconsistently reviewed despite the provider's procedure to update them once a month to ensure they reflected people's current support needs and preferences. This meant some vital information about changes to needs and support may have been missed.

The records we looked at did not routinely demonstrate that people, their relatives and staff attended review meetings. Care plans were not always signed by the person where they were able, and where people were unable to sign themselves their legally authorised representative had not signed on their behalf. This meant that people may not have been consulted about their care, and therefore the quality and continuity of care may not have been maintained.

The provider had not maintained accurate and complete records for people, including a record of the care and treatment provided.

People and relatives informed us that they knew how to raise a concern or complaint. One person old us, "Staff are nice and I have no complaints." Another person told us, "I would not be frightened to complain and my family would too." One relative told us, "I have complained a number of times and there is some action and then none and its back to square one. It does seem a bit better now though, better communication for a start." We found that although complaints seem to have been dealt with from the people and relatives we spoke with, records were not always available to show the complaint having been made. For example, one relative told us of a complaint regarding their relative's personal care, which we found no record of, although they said it had been addressed. This meant that records had not always been maintained appropriately and could have meant complaints were not addressed fully in line with the providers policies and procedures.

These are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled, Good governance.

Although records were not appropriate, people and their relatives thought that in the main staff at the service were responsive to their needs. One person told us, "If you have to be in a home, this is a pretty good one to be in." Healthcare professionals also commented regarding the responsive care and treatment received. We saw notes in health care professional visit records which stated, "Seen by Psychiatrist – very happy with (person's) progress" and a month later "Seen by psychiatrist who is very happy with (them) and has discharged (them) from the service."

End of life care was sometimes provided in the home and when it was, a GP told us staff acted quickly to ensure the person had the correct support and pain relief in place, including additional support from district nursing teams.

People, relatives and staff told us there were no activities for them to participate in, although they told us they enjoyed each other's company. Comments from people included, "I don't get out much only sometimes go in the garden"; "We don't get any entertainment here"; "We just sit around and I am bored"; "Activities could be better as I just sit here all day"; "I don't get to go out but I would like too, other than that I have no grumbles"; "There's nothing for me to do here"; "There's no activities and no transport available" and "Used to go out, now I don't shop, don't go out." There were no activity staff employed at the service as the previous staff member had changed roles. Care staff had no time to complete any forms of activity and during the inspection the only change of scenery some people had was when staff took them into the garden, which we were told was a rare event.

There was an activity room on the second floor with a variety of games, paints and other activity tools, but during the inspection this was never used at all. We noted on two days of the inspection that music was played from the era many of the people had lived through. Several people started to sing and seemed to enjoy the interaction. However, we were told that this was not a normal occurrence. One relative told us, "They put the TV on in the corner and that's it. They have not got time to do anything else." One healthcare professional told us, "They have chickens and rabbits in the garden, but I have never seen any interaction with people, such a shame."

A hairdressing room was available for people to use. We asked people and residents about this. One person said, "The hairdresser has been coming here for a long time. They are very good." A relative told us, "That hairdresser has been coming here for about 10 years. She is great with the residents." We were not given a full answer as to why the hairdresser had not been to visit in the week of the inspection, but we were told by staff that they would be back next week.

The provider was in the process of recruiting to the post of activity coordinator and in the meantime told us they were going to organise a number of events for people to take part in, including a summer fete with people being fully involved in its organisation. The management team were aware that people needed to be fulfilled with meaningful and stimulating activities at times and were planning to address this.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we identified a breach of Regulation 17 which related to the governance of the service. Despite the provider drafting an action plan and addressing some of the specific issues we raised, we found that not enough improvement was made and shortfalls continued throughout the service. These included continued lack of record keeping in care planning, needs assessments, risk assessments, mental capacity assessments, best interests' decisions, people's dietary needs, personal care, medication, skin damage, accidents and analysis, complaints and other monitoring processes. Copies of relevant information were not always kept, including copies of lasting power of attorney.

The deputy manager was in the process of ensuring they knew the needs of all the people who lived at the service well. They acknowledged they needed to continually monitor for changes, particularly regarding weight loss, pressure damage or any other changing needs.

A range of audits and checks had been completed by the previous manager, including for example, medicines, infection control and health and safety. Audits which had been completed had failed to recognise the issues we identified during this inspection or had recognised them but failed to address them. We noticed that page 11 of the medicines audit was missing on all audits undertaken, but no one could tell us why that was. We noted that audits completed in March and April for medicines had remained at 100% correct as completed by the previous deputy manager. This now ranged in the region of 79%. This demonstrated a previous lack of oversight by the last manager and the provider's previous representative. Although we noted that corrective action was now underway.

Some of the issues raised and recommendations made by an external pharmacist in April 2018 were not entirely rectified. For example, in relation to medicines out of stock and labelling medicines with a limited life (we saw one eye drop not dated). These issues were highlighted again at this inspection.

There was no registered manager in place and had not been since December 2017. The previous manager who had been in the process of registering with the commission had recently resigned. The deputy manager in charge was covering from another service but had accepted the position of manager at Comfort House and told us they would apply to become registered in due course.

At the inspection a financial audit was already underway which had been implemented by the provider. During a change of staff, the provider had found money may have been missing from their own funds and from people's own monies. The provider had contacted the police and made appropriate safeguarding alerts. As these issues are still open investigations with the police, we cannot include the content of them within the report. However, our inspection identified no oversight by the provider to protect people's finances from potential abuse. We were also made aware from discussions with relatives and staff that the receiving of gifts by staff was still taking place which was against company policy and procedures. A meeting was due to take place with people and relatives to discuss finances further.

'Resident of the day' had been introduced. This meant that one person on most days was chosen to have

their records checked, to ensure their room was tidy and all other actions had been taken including contacting the person's family to ensure they were satisfied. From May we found that although this had taken place, the recorded actions did not match what we found in records. For example, one person was marked as having daily record and fluid and food charts completed. Although they did have these records completed, they were not completed accurately or fully. We also noted that people were marked as not having a Deprivation of Liberty Safeguard (DOLS) in place when they did.

These issues meant the provider had processes and procedures in place to monitor the quality of the service by management which were not being followed fully or had not being completed robustly. It also meant the provider had no robust oversight of the service as they would have uncovered, sooner, the issues we had during the inspection.

First aid boxes were not always complete or checked. This meant that if an accident should have occurred, staff may not have been able to supply first aid treatment appropriately.

These are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance. We have taken action against the provider and will report on this in due course.

Staff, people and relatives said that the interim deputy manager was being very proactive, honest and ready to address areas of concern. Comments from staff included, "[Interim deputy manager name] is helping greatly and we like her"; "She seems to be doing a good job" and "It's good to have someone who seems to listen and act." Relatives told us, "She is the first person who had been honest. I have trust and confidence in her, she is not a liar"; "She seems open and honest, we are not used to that. Seems like a breath of fresh air" and "Very impressed so far, let's hope she stays and continues in the same way."

People, relatives and staff told us that within the last few months, the atmosphere and morale in the home was not good, although they indicated it had improved in the last few weeks since the interim deputy manager came into post. One staff member said, "There's tittle-tattle, some people are CQC happy and will threaten to go [to them] about anything." Another staff member told us, "When no one listen's staff feel at a loss what to do. Think this is why some have resorted to ringing you (CQC)." A relative told us, "Staff need someone at the helm, to show leadership and that just has not happened properly of late."

Staff meeting had taken place, but not regularly. One staff member told us, "Handovers happen daily but we hardly ever have staff meetings." We confirmed via records that meetings had occurred approximately every three months.

One staff member felt the new deputy manager valued the staff, listened and heard what was being discussed or requested. Healthcare professionals told us that they had no relationship with management at the service, dealing with senior care staff in the main. A GP and two district nurses told us they had never met or spoken with the previous manager and were not sure who was currently in charge. One GP said, "Never been introduced to a manager since a male manager worked here." This meant that relationships between outside healthcare professionals were not well developed.

'Resident and Relatives' meetings had been held, but not as often as they should have been. This had been improved by the interim deputy manager and a meeting was planned to take place soon.

The regional manager told us surveys had been sent to the previous manager for distribution. However, we found that no one had received a survey to complete when we asked them and there was no evidence of

any being returned which suggested they had not been sent out by the manager on receipt. One person told us, "Never had a survey to complete." A relative said, "I have had them in the past, but not for a while now."

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of people had not always been provided with the consent of the relevant person. Regulation11 (1)(2)(3)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was delivered in a safe manner. The risks people faced were not always appropriately assessed. The provider failed to do all that is reasonably practicable to reduce the risks people faced in their lives. The provider failed to ensure that people received safe care from staff who had the skills and competence to do so. Medicines were not always managed in a safe and proper manner. Regulation 12(1)(2)(a)(b)(c)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were

sufficient numbers of staff and that they were suitably, qualified, skilled and competent to meet people's needs. An induction programme was not robustly monitored and training relevant to staff roles was not always available or monitored for completion.

Staff had not always received appropriate supervision and formal support to identify their learning and developmental needs. Competency was not always carried out robustly.

Regulation 18(1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process were not operated effectively enough to ensure compliance with the regulations. The provider did not ensure they effectively assessed, monitored and improved the quality and safety of care provided to people. They also did not assess, monitor and mitigate all risks relating to the health, safety and well-being of people who used the service. Record keeping was not satisfactory. Accurate, complete and thorough records were not maintained in respect of all people who used the service, staff records and the management records. The provider's audit and governance system was not effective. Regulation17 (1)(2)(a)(b)(c)(d)(ii)(e)(f)

The enforcement action we took:

We issued a warning notice in relation to regulation 17, good governance.