Runwood Homes Limited

Chelmunds Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 15 August 2018 and was unannounced.

Chelmunds Court 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.

Chelmunds Court accommodates 73 people in one adapted building over two floors. There were 40 people living at the home on the day of our visit, most of whom lived with dementia

At our previous inspection on 26 June 2018 we rated the overall service as 'Inadequate' and it was placed into special measures.

At that inspection we identified six breaches in the legal requirements and regulation associated with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were breaches in Regulations 9, 10, 12, 14, 17 and 18. This was because there were not enough staff available with the knowledge needed to support people in the right way which meant people did not receive personalised care. Risks associated with people's care were inconsistently managed. Medicines were not managed safely and people were not assisted to external healthcare appointments when required. The provider failed to demonstrate people had received sufficient amounts of food and fluids to keep them healthy. Effective systems were not in place to ensure the service was delivering good quality care to people.

The significant concerns we identified during that inspection resulted in us imposing a condition on the provider's registration. This meant they had to complete regular checks of the quality and safety of the service and provide us with monthly reports of their findings to demonstrate the required improvements were being made.

The provider sent us an action plan which informed us of the improvements they planned to make to would be completed by 30 September 2018.

Since that inspection no further people had been admitted to the home. We received further information of concern in relation to the service. These concerns related to people not being given their medicines when they needed them, further management changes and the risks associated with people's care were not managed safely which had placed people at risk. As a result, on 15 August 2018 we undertook this unannounced focused inspection to check whether people were safe and whether the service was well-led. This report only covers our findings in relation to these two key areas.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Chelmunds Court on our website at www.cqc.org.uk.

As a result of this inspection the overall rating for this service remains 'Inadequate' and the service therefore remains 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.

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.
Further management changes had taken place at the home since our last inspection and the provider had recruited their fourth manager since the home opened in November 2017. Therefore, a registered manager was not 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.

Relatives continued to lack confidence in the leadership of the service and shared concerns about the competencies of staff who worked at the home. The checks completed by the provider and managers to ensure staff had the skills and knowledge they needed to provide safe care were not always effective and did not always take place.

People's medicines were not always managed safely and some people had not received their medicines when they needed which placed them at potential risk of harm.

People were not always protected from abuse by other people living at the home. The provider had failed to mitigate risks to keep people as safe as possible. Accident and incident reporting remained ineffective because the provider and managers were not aware of all incidents that had occurred. Also, staff did not always correctly report incidents in line with the provider's procedure.

Management audits and checks were not effective to ensure people always received safe care.

The recruitment of staff to work at the service was ongoing. Enough staff were on duty during our visit but the service remained heavily reliant on agency staff to provide people's care.

Staff felt more supported by their managers than they had done previously. Managers told us they continued to work in partnership with the local authority and the Clinical Commissioning Group to improve the quality of care people received.

The home was clean and tidy during our visit. People remained satisfied with the cleanliness of the home and staff understood their responsibilities to protect people from the risks of infection.

We found three continued 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?

Inadequate

The service remains inadequate.

Is the service well-led?

Inadequate

The service remains inadequate.

Chelmunds Court

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 was an unannounced focussed responsive inspection which was partly prompted by an incident which had a serious impact on a person using the service. This raised potential concerns about the management of risk at the home. Whilst we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks.

The incident had been brought to the attention of the police, and the local authority safeguarding team. Their investigations are on-going and outcomes were not known at time of writing this report.

Inspection site activity started and was completed on 15 August 2018. We inspected the service to assess compliance against the keys questions: Safe and Well Led. The team consisted of two inspectors and a member of the CQC (Care Quality Commission) medicines management team.

Prior to the inspection we spoke with local authority and Clinical Commissioning Group (CCG) who funded the care some people received. Both confirmed they continued to closely monitor the quality and safety of the service provided.

We reviewed information we held about the service including, statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

Some people we spoke with were not able to tell us in detail about their care and support because of their complex needs. We used 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.

During our visit we spoke with four people who used the service and six relatives. We spoke with seven care

assistants, one agency care assistant, one agency nurse, two permanent nurses, the deputy manager, the home manager, the provider, the head of quality and governance, and the provider's operational manager.

We reviewed four people's care records, and the medication records for 18 people. We also looked at medicine audits, staff rotas, three recruitment files, accidents and incidents, call bell monitoring response times, safeguarding records, complaint records and the provider's improvement action plan.

Inadequate

Is the service safe?

Our findings

At our previous inspection in June 2018 we rated the key question of 'safe' as 'inadequate'. This was because we identified significant concerns in relation to the management of medicines and the management of risks associated with people's care. Low staffing levels and the high use of agency staff resulted in people's care needs being neglected. This meant people were not kept as safe as possible.

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

Following that inspection, we immediately wrote to the provider and asked them to submit an urgent action plan to tell us how they were going to improve medicines management at the service. Their response detailed how serious immediate risks had been mitigated to keep people safe.
The provider's action plan told us how further planned improvements, to address all the issues we had identified, would be completed by 30 September 2018.

However, after our inspection in June 2018 and following receipt of the provider's action plan we were informed by the service, in the form of statutory notifications, people continued to be at risk because they had not received their medicines when needed.

During this inspection we found some improvements had been made which included the ordering and stock control of medicines. However, we found that other areas we had previously identified as requiring urgent improvement remained unsafe. Therefore, the provider remains in breach of this regulation and the rating remains 'inadequate.'

We reviewed medicine administration records (MARs) for 18 people which showed us some people had not received some medicines in the week before our visit which placed people at risk. Despite the introduction of daily audits, the registered provider's systems failed to ensure people received their medicines appropriately. This placed people at risk of harm.

Previously, we found MARs did not instruct staff to administer people's medicines at specific times. This was important because medicines to manage some health conditions, for example, Parkinson's disease must be given at set times if they are to be effective. The provider previously assured us they would take action to address this. When we checked to ensure action had been taken, we found sufficient progress had not been made.

We, again found the specific administration times for some medicines were not documented. Following our inspection visit the provider informed us this issue had been resolved. Furthermore, our discussions with staff did not assure us they understood the importance of administering medicines at specific times. We raised this with the onsite pharmacist who assured us action was being taken to address this.

Previously, we were unable to determine the time intervals between medicine administrations which was

unsafe. A gap between the administrations of some medicines is important because it takes time for medicine to be effective and/or to prevent overdosing of a medicine. During our visit we found action to mitigate this risk had not been taken. This was because some MARs did not include clear administration times and our observations of staff practice showed us the morning medication round took place later than planned. We brought this to the attention of the provider and the onsite pharmacist. They told us the times staff started their shifts were in the process of being changed to address this issue so morning medicine rounds would start earlier to ensure intervals between doses were sufficient. Guidance to ensure medicines were given at correct times was also being implemented.

We saw staff did not always follow the prescribing instructions for some medicines which meant medicines might not be effective or could cause negative effects on a person's health. For example, one person's medicine should have been stopped whilst they took a course of prescribed antibiotics. Records showed and staff confirmed the person had continued to take this medicine. Another person needed to take their medicine two hours after food. We saw the person was given their medicine immediately after they had eaten their breakfast.

The provider's medication policy did not advise staff what action they needed to take when a person refused, or was been unable to take, doses of a medicine. We saw one person had refused doses of two medicines in the week prior to our visit and from the information available to us it was not clear if action had been taken to address this. Also, staff we spoke with provided different accounts when we asked them what they would do if this happened.

At our previous inspection people did not receive safe care because risks were not managed. During this visit we saw people used the specialist equipment they needed such as, pressure relieving cushions which showed us some improvement had been made.

However, we identified further significant concerns in relation to the risk management at the home which meant lessons had not been learnt by the provider. This was because we found people were not consistently protected from abuse by other people living at the home.

Prior to this inspection we were informed that a recent incident had occurred between two people who lived at the home which had resulted in one person being seriously harmed by the other. During our visit we found the provider had failed to mitigate the risk. A risk management plan was not in place and the information provided to staff to help them to provide safe care did not inform them of this risk. Also, staff were not always aware of the safest way to support people because they gave differing accounts when we asked them how they supported people when they became anxious and displayed behaviours which could cause harm to others.

Records showed the person who had caused the harm had been involved in a similar incident three days after the initial incident. Whilst this did not result in harm we were extremely concerned that the management team were unaware of this. We were told this was because staff had not followed the provider's reporting procedures. One manager said, "I was on duty but no one told me. They (staff) should have escalated."

Another person at times felt anxious and displayed behaviours that had the potential to cause harm to others. These behaviours had been identified in April 2018 but guidance to support staff to manage the person's behaviours was not in place. In response to our findings the provider assured us a review of every person's behaviours would take place to drive forward risk management at the home.

This was a continued breach of regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

At our last inspection there were not enough staff on duty who knew about people's care needs to ensure care was provided safely. Staffing levels in the home were insufficient and people were supported by staff who did not know them. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Staffing.

Following that inspection, the provider's action plan detailed how they would recruit new staff, and ensure regular agency staff were used to ensure people's care was consistent.

During this visit we were made aware that some new care assistants had been recruited and were due to start working at the home shortly after our visit. However, the recruitment of permanent nurses remained a challenge. Following our inspection visit the provider told us one new nurse had been successfully recruited. We saw enough staff were on duty but the service remained heavily reliant on agency staff who some relatives felt did not always know people. We asked people if the consistency of agency staff had improved since our last inspection. Some people told us they had noticed improvement and one person commented, "I can assure you there are absolutely no problems here."

However, people's relatives told us this had not improved. Comments included, "I still worry as often there are new faces," and, "What we need is regular consistent staff who know the residents." One relative explained they continued to feel their relation was unsafe living at the home. They told us, "We are so worried some staff don't know (person) we leave notes. We put a poster on (person's) bedroom wall telling staff what they need to do."

Relatives also shared their concerns about the knowledge and skills of staff working at the home. Relatives felt this put people at risk. One said, "I saw there were two staff. They were very kind and caring but they didn't know how to use the hoist. The sling kept slipping. In the end they had to get help. It's not right to put two staff together who don't know what to do." Another told us, "I have had to tell staff about people who need thickener because I saw them giving people drinks without it. I know the residents well."

The deputy manager explained the competencies of all staff were checked before they administered people's medicines to ensure they could complete the task safely. However, we could not be sure these checks were not effective because an agency nurse had failed to give six people their medicines during one shift the week before our visit. Following the inspection visit the provider made us aware they had completed a root cause analysis in relation to the missed medicines which had concluded the medication errors could not have been prevented. (Root cause analysis (RCA) is a method of problem solving used for identifying the root causes of faults or problems.) However, during our visit we saw an agency nurse, working in the home for the first time, was instructed to administer medicines before their competency had been assessed. We shared our findings with the provider who assured us they would take action to address this.

This was a continued breach of regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

During our previous inspection people told us they had to wait a long time for their nurse call bells to be answered. This meant staff were not available when people needed them. The provider told us they would take action to address this.

During this visit records showed the provider had introduced call bell response times monitoring to review how long it took to attend to people. Records we reviewed between 14 and 17 July 2018 confirmed call bells

had been responded to promptly. We saw staff responded quickly to nurse call bells which further assured us improvement had been made in this area.

Staff told us some improvements had been made which made them feel people were cared for more safely than at our previous inspection. This was because some new permanent care assistants had started working at the home in July 2018 which meant people had begun to receive care from staff who were getting to know them.

At our last inspection we could not be sure staff had been recruited safely which placed people at risk. At this inspection we found improvements had been made. Recruitment records showed prior to staff working at the home, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff told us they had to wait for DBS checks and references to come through before they started working in the home.

The home was clean and tidy. People remained satisfied with the cleanliness of the home. We saw staff used gloves and aprons when required to ensure people were protected from the risk of infection.

Inadequate

Is the service well-led?

Our findings

At our last inspection in June 2018 we rated the key question of 'well led' as 'Inadequate'. This was because the provider's quality assurance systems had failed to ensure people received good quality, safe care. We found serious concerns about the service had not been responded to and complaints about the service had not been managed in line with the provider's policy and procedure. Relatives lacked confidence in the leadership at the service and people had not been involved in developing the service. There had been frequent changes of manager, staff did not feel supported of listened to and moral was low.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance. We imposed a condition on the provider's registration. This meant they had to complete regular checks of the quality and safety of the service and provide us with monthly reports of their findings to demonstrate the required improvements were being made.

Following our last inspection, the provider submitted an action plan which stated all required improvements would be completed by 30 September 2018.

During this visit we saw some improvements had been made. However, people remained at risk of harm and sufficient improvements needed to ensure people received good quality, safe care had not been made. The provider remains in breach of regulation 17. Good Governance and the rating remains 'inadequate.'

Prior to this inspection we received information about further management changes at the home. People, relatives and staff told us they found these further changes unsettling and did not give them confidence the home was being well managed.

Further changes to the management team had occurred since our last inspection. The previous manager who had worked at the home for two weeks had now left their employment. The provider had employed their fourth manager since the home opened in November 2017 who at the time of our visit had worked at the home for one week. Therefore, the home continued not to have a registered manager in post. However, following our inspection visit the new manager told us they had begun the process with CQC to become the registered manager. 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's head of quality and governance had been based at the home and told us they had worked hard since our last inspection to drive forward improvements. They said, "I have been here around the clock checking and checking again things are getting better." Another manager told us, "I think the enormity of the task was under estimated but I'm confident things are on the up now."

However, relatives told us they continued to lack confidence in the leadership of the service. One said, "We have seen a slight improvement since your last inspection. I think they (managers) are trying. It's not right

but they are trying." They went onto say, "Some days are good. Other days are chaotic. As a family we want to see someone in charge, delegating and checking."

A second relative described why they had no confidence in the provider's management team. They told us, "We have been told the new manager is going to get it sorted but that's been the same message for every manager. I won't hold my breath." A third commented, "I've met so many managers I don't know who is in charge now, it can't be well led as it's a different person in charge every week." We asked them what would need to happen for them to regain their confidence in the management team. They said, "Just a good manager who is committed to making things better. Surely, that's not too much to expect?"

Previously, we identified the provider's accident and incident reporting systems were ineffective. This meant we could not be assured action had been taken to mitigate known risks and reduce the possibility of a re-occurrence to keep people as safe as possible.

During this visit we found improvements had not been made because staff did not always follow the provider's reporting procedure. Also, the system for checking staff followed procedures was not effective. For example, staff had recorded but had not reported an incident where a person displaying behaviour which could cause harm to other people and staff. We spoke with a peripatetic manager who was on duty at the time of the incident. They confirmed staff had not shared this information and no actions had been taken to assess and reduce any on-going risk.

Previously, we found audits and checks of the quality and safety of care provided such as, accidents were inadequate because shortfalls and areas requiring improvement had not been identified.

At this visit records showed the management team completed a range of audits and checks. We saw audits had identified some shortfalls such as missed medicines, but not all. The audits were not always effective to drive forward improvement because people continued to not receive their medicines as prescribed. The provider told us ongoing action was being taken to address this.

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

Previously, the provider's systems to respond to serious concerns raised about the service had been ineffective. The provider told us they would take action to address this issue. At this visit we saw a new system had been implemented to ensure the provider was made aware of any complaints received. This meant they could respond to and address any concerns. A relative commented, "My complaints are going to the top managers because one phoned me to resolve an issue I was unhappy about."

At our last inspection the provider had not involved people in the running of the service. The provider acknowledged this shortfall and assured us this would be addressed. During this inspection we saw people and their relatives had the opportunity to share feedback on the service they received. During our visit we attended a meeting which was held for people and their relatives which assured us improvement was being made in this area.

At our last inspection the provider had failed to support their staff because staff told us they did not feel listened to which had resulted in low staff morale. During this visit some staff told us they felt some improvements had been made. One said, "The managers are more visible now, they come onto the floor to ask if we need anything and to ask if everything is okay." Another said, "Support is a bit better. They (managers) have listened because some new staff are starting which will help." A third told us. "I just hope

this time the manager sorts the problems out. We have been at rock bottom so we couldn't get any lower."

New processes had been introduced in the week before our last inspection. For example, 'daily walk arounds' were undertaken by members of the management team. We saw during our visit the deputy manager spent time walking around the home speaking with people and offering staff support.

The provider's head of governance told us they continued to work in partnership with the local authority and the CCG. This included weekly conference calls to review and evaluate the progress being made. The head of governance told us the meeting were important because it gave them the opportunity to demonstrate improvements were being made.

Whilst we saw some improvements had been made in a short space of time further sustained improvements are required to demonstrate people receive good quality care. The provider told us, "We are very clear about the recovery plan. There is clearly a number of positives but further work to do."
Following our inspection visit we met with the provider. They acknowledged our concerns and spoke of the action they had already taken and further actions they planned to take to address the issues we had identified. The provider and home manager told us they were confident that actions were on track to be completed by the end of September 2018

We also shared our findings with the local authority and the CCG. They informed us they continued to closely monitor the quality and safety of the service provided to people. However, they and the provider continued to restrict further admissions into the home until improvements were made.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed in a way which kept them safe. People were not consistently protected from abuse because the provider had not taken action to keep people as safe as possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective to ensure people received safe, good quality care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have the skills and the knowledge they needed to carry out their duties.