Care Quality Commission

Runwood Homes Limited

Chelmunds Court

Inspection report

2 Pomeroy Way
Birmingham
West Midlands
B37 7WB

Tel: 07795658717
Website: www.runwoodhomes.co.uk

Date of inspection visit:
19 October 2020

Date of publication:
24 December 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Chelmunds Court is a care home registered to provide nursing care and accommodation for a maximum of 73 people. Bedrooms are located across two floors. People with nursing needs lived on the first floor. Most people on the ground floor were living with dementia. There were 67 people living at the home at the time of our visit.

People's experience of using this service and what we found
Some improvements to risk management had been made since the last inspection. Sufficient action had been taken in response to the issues identified in the warning notice we had served. However, further improvement was required to ensure people received safe, person centred, responsive care. Staff were recruited safely but staff told us there was not enough of them. This was despite the home being staffed in accordance with the provider's dependency tool used to calculate the staff numbers required to care for people.

An 'infection prevention control' audit was carried out by CQC during the inspection. We found the provider was not following government guidelines to keep people as safe as possible and minimise infection control risks associated with Covid-19. Staff did not consistently follow PPE guidance and requirements for isolating people were not followed as required. Covid-19 testing for people was not completed in accordance with required timescales. Effective arrangements were in place to ensure visitors to the home were made aware of infection control requirements to keep themselves and others safe.

Arrangements to protect people from potential harm and abuse needed improvement. Staff knew how to recognise abuse but the provider's arrangements to minimise and manage risks were not always clear or followed.

Governance systems to monitor the quality and safety of the service continued to be ineffective. When areas for improvement had been identified by audits and checks, timely action continued not to be taken to keep people safe and maintain their wellbeing. Staff spoke of the challenges they faced to follow procedures to ensure people received safe, person centred care.

People and their relatives spoke positively about the staff and the care they provided at Chelmunds Court. Relatives had maintained some contact with their family members during the national lockdown which included video and telephone calls.

Management changes had occurred since our last inspection. The new registered manager was supported by a management team. Regular staff meetings took place to inform staff of changes in practice and what was expected of them by the provider.

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 27 March 2020) and there were two

breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider remains in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections although there has been evidence of some improvement at each of those inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We needed to check whether the Warning Notice we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We had identified concerns in relation to medicine management and completion of risk assessments related to peoples care. Care plans were not up-to-date and food and fluid charts lacked information to show people had consumed enough to maintain their health. Significant events that had resulted in injuries sustained by people had not been reported as required.

The inspection was also prompted in part due to concerns received about people falling, infection control risks, and the management of people's care. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of Safe and Well Led only.

We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions not reviewed were used in calculating the overall rating at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two continued breaches and one new breach of the regulations. These breaches are in relation to safe care and treatment, staffing, and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well led.	**Requires Improvement**

Care Quality Commission

Chelmunds Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This was a focused inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We needed to check medicine management, that risk assessments were in place regarding risks associated with people's care and management oversight of these.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by five inspectors and two assistant inspectors. Two inspectors and an assistant inspector visited the home. One inspector gathered and reviewed information from the registered manager via email and two inspectors and the other assistant inspector spoke with staff and relatives over the telephone to gather feedback on the service they received.

Service and service type
Chelmunds Court 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 30 minutes notice of our inspection visit because the service was inspected during the coronavirus pandemic and we wanted to be sure we were informed of and followed the provider's coronavirus risk assessment for visiting healthcare professionals before we entered the building.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection and recurrent themes of concerns. We sought feedback from the local authority who worked with the service. This information helps support our inspections. We used this information to plan our inspection.

During the inspection
We spoke with four people who used the service and 10 relatives about their experience of the care provided. We spoke with 18 members of staff including nurses, care staff, the registered manager, deputy manager and training manager. We observed care in the lounges on both floors of the home to help us understand the experience of people who could not talk to us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We sought copies of records not viewed during the inspection visit, spoke with additional staff and sought clarification of regarding information received.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we had previously served and to follow up on concerns we had received about risk management since the last inspection.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● Information we received prior to our visit indicated risks associated with people's care were not effectively managed. Our findings confirmed this was correct.
● One person's risk assessments in regards to choking and pain had not been reviewed and updated as required by the provider to demonstrate these risks had been assessed and were being appropriately managed to keep the person safe.
● Not all staff were aware some people had health conditions that placed them at risk of having seizures. Care records were not completed consistently to inform staff of the symptoms associated with those conditions and how to mitigate risks to provide safe care.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the behaviour of others. For example, one person frequently called out which caused other people to become agitated. Staff knew it was unsafe for one person to sit next to the person who called out, but records demonstrated staff failed to prevent this from happening. This resulted in an item being thrown at the person who was calling out which placed them at risk of harm.
● We were not assured the provider had done all they were reasonably able to do, to manage risks to people. One person was known by staff to take food from others causing people to become anxious and show behaviours of retaliation. Records confirmed the person took food at 'nearly every mealtime.' Sufficient action had not been taken to manage this risk. On one occasion this had caused a person to drop their hot cup of tea into their lap. Whilst no serious injury was caused, this demonstrated this risk was not being managed.

Preventing and controlling infection

● People were not protected from the risk of infection. Personal Protective Equipment (PPE) was not used safely by staff in line with government guidance. Staff were required to wear a fluid repellent surgical mask, gloves and an apron when they assisted people with their personal care. We observed this did not always happen.
● Government guidance on self-isolation within care homes was not being followed. We saw one person who was self-isolating was brought into a communal area by a staff member which placed others including members of the inspection team at risk. Furthermore, some staff did not know which people were self-isolating to reduce the transmission of Covid-19.
● Cleaning schedules did not show enhanced cleaning of the environment was taking place in line with government guidance. Systems for cleaning equipment shared between people was not in place.
● People were being assessed once daily to check for the development of symptoms associated with Covid-19. The provider was not aware of the requirement for people to be temperature tested twice daily and records did not always confirm daily testing had taken place.

This was a continued breach of regulation 12 (1) (2) (a)(b) (c) (h) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings, people felt safe living at Chelmunds Court and their family members felt the home was safe for their relative. Comments included, "Yes very safe, [Name] had a couple of falls, but not recently. Staff phoned straight away to tell me."
● Staff knew about the different types of abuse people might experience and told us they would report anything of concern to their manager.
● The provider prevented visitors from catching and spreading infections. Arrangements were in place to ensure visitors wore personal protective equipment (PPE) and understood what was expected of them to keep people safe during their visit. Visits were pre booked and staggered to minimise visitor numbers.
● Staff were reminded about good infection control practice during staff meetings.

Staffing and recruitment
● Staff told us there were not enough of them to provide safe care. We saw staffing arrangements were not effective. Staff were task focused and some people received delayed care. One staff member told us, "You can't do your job properly and care for people because there aren't enough of us…. we are like machines, on to the next one and the next." Another staff member told us how they had been left on their own to support 16 people in the lounge. While they were assisting one person, another person had fallen, and they had been unable to get to them in time.
● Staff told us they did not have enough time to assist people to consume their meals and drinks. One staff member said, "Somebody might want a drink and may be slow to drink physically. We don't have time to stay and assist them." Another told us, "The supper round can take three hours; there are 20 people who need support on the nursing floor." The registered manager confirmed 18 people did need assistance from staff at meal times and they told us all staff had been asked to assist at mealtimes. However, we saw people were still eating lunch two hours after lunch had started to be served.
● During a meeting in July 2020 the management team had discussed changing the night shift times. The registered manager told us this would help staff to meet people's needs during the busy morning period. However, this change had not been implemented during our visit - three months later. We saw people still being assisted with their personal care at 11.50am. A staff member told us people were offered a snack of some biscuits if they were up late, instead of breakfast, and then had their lunch.
● Staff said they had not completed specific training on managing people's behaviours to help them address people's mental health needs and keep them, and others, safe.

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

● Relatives had mixed views about staffing levels but overall, felt people's basic needs were met. One relative told us, "I think they (staff) would benefit from having a couple more. Checks are done on people, but they could spend more time with people. It's often difficult to get hold of staff on the phone, because the staff are very busy."
● Staff told us a new handover process that took place at the start of their shift had helped them to learn more about people's changing needs.
● Staff confirmed recruitment checks were completed before they were able to start work at the service. This included Disclosure and Barring (DBS) checks to make sure they had no criminal convictions that could impact on people's safety.

Using medicines safely
● At the last inspection, medicines management was not safe. For example, some medicines were not administered by staff in line with prescribing instructions. At this inspection, some improvements had been made. For example, action had been taken to ensure eye drops were administered correctly. However, further improvement was required.
● Handwritten entries on medicine records were not always signed and dated as required. One person had cream prescribed to protect their skin and records showed this had been administered. However, this cream could not be located by staff during our visit to demonstrate it was available to use.
● Some people's medicines could be administered covertly (in a disguised format such as, in food or drink) by staff as a last resort after being offered to the person first. Records did not always confirm the less restrictive options were tried before covert medicines were provided.
● The provider had implemented regular medicine audits to identify any medicine errors and were acting upon any errors found.

Learning lessons when things go wrong
● Actions taken following the last inspection had resulted in some improvements which showed some lessons had been learnt.
● The registered manager had recognised how the national lockdown in the home due to Covid-19 had impacted on people's mental health. Lessons had been learnt and actions taken to ensure people had increased contact with family members wherever possible.
● Staff told us they had raised concerns with management around staffing levels at the home. The registered manager recognised staff pressures during the evening and had implemented a twilight shift with an additional staff member working from 5 to 10pm. This change was due to be implemented on the day of our inspection with the aim of supporting staff to assist people with personal care in a more timely way and ensure people's needs were met.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served and concerns we had about systems and processes to monitor the quality and safety of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care

At our last inspection the provider had failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Quality assurance systems remained ineffective. Since registering with us in November 2017, the provider has failed to achieve a rating of Good in this domain. Systems to monitor the quality and safety of the service were in place and we found sufficient action had been taken to improve areas that had required attention within the warning notice. However, we identified further concerns during our visit which impacted on the safety and quality of the service people received.
- Areas of improvement identified by the provider, were not always acted upon in a timely manner to mitigate risks to people. For example, a care plan audit completed in September 2020 had identified shortfalls. One person's choking risk assessment had not been updated, and a pain assessment had not been completed in line with the provider's expectation. These actions remained outstanding at the time of our inspection.
- A system was in place to monitor the numerous people falling. Six people had fallen on multiple occasions since the last inspection. There had been a delay in the provider implementing their plan to implement 'falls champions' (these being staff who would work with people at risk of falls) to help minimise this risk. We were told additional staff training was needed to support staff in this role and this was planned.
- The provider used a dependency tool to determine the number of staff needed to support people's needs. This had not been effective in determining the number of staff required to ensure people received safe care that was responsive to their needs.
- The provider's arrangements to ensure staff worked in line with their infection control policy and

government guidance were ineffective. This placed people at increased risk of infection. Staff did not always wash their hands between supporting people and completing tasks. Safety measures to reduce the transmission of Covid-19 such as, self-isolation and mixing of exposed and unexposed people, were not risk assessed.

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

● Since the last inspection the provider had notified us of accidents and incidents in line with regulatory requirements. This demonstrated an improvement in the service.
● The service was under regular review by the provider in an attempt to drive forward improvement to benefit people. New monitoring tools had been implemented to help the registered manager and provider increase their managerial oversight of the service. Some improvement plans were in progress at the time of our inspection visit.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● People did not always receive person centred care due to staff deployment in the home not being effective. Staff practice demonstrated this. A staff member told us, "We can't put people to bed until 11pm when the CTL (care team leader) has finished the drugs so they can cover the lounge." During a staff meeting in September 2020 staff on duty during the day time had been asked to assist people to bed during the early evening (if people agreed) to take the pressure off the night staff. This approach demonstrated people's preferred bedtimes had not been considered.
● Some staff lacked knowledge of people's needs and they told us this was due to not having time to read care plans. This prevented them from delivering person centred care. For example, a person who required a straw to help them drink independently had not been provided with one. A staff member told us, "We don't get time to read care plans, so we don't really know what's in them." Another said, "I used to read two (care plans) on my shifts so I could get to know people. I'd try to learn a bit about their hobbies so I could talk to them and make a connection, we don't have time for that now."
● A relative told us people's basic needs were met but they felt staff should spend more time with people to support their wellbeing.
● The registered manager was aware of challenges related to meeting people's needs. They told us, "The biggest challenges at the moment are emotional support, eating and drinking and falls." They had worked with the GP to address people's mental health needs where this was impacting on their wellbeing. Care plans we saw that lacked information about specific needs such as dementia were updated following our visit. A new handover system where people's needs were discussed supported staff to be kept updated on people's changing needs.
● Staff wanted to provide personalised care. A staff member told us, "We always talk to them (people), those who are disorientated we try and find out if there is a problem. Sometimes, due to their level of dementia, we try to offer them a drink or something to eat and stay with them, so they get calmer."
● On the day of our inspection visit, people were not seen to be engaged in any activities other than reading whilst the television was on. The registered manager said the person who usually provided activities was not on duty but assured us people had access to social activities. Records confirmed some activities were provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Arrangements were in place to ensure people could maintain contact with family members such as via

telephone or video calls. We received positive comments from people and their relatives about the home.
● Relatives told us staff kept in touch with them about their family member. Comments included, "Chelmunds have been very supportive and helpful; when I phone, they always update me and ask questions or advice", and "They have phoned to ask for more information about hobbies so they can support [Person] with activities better."
● One relative said they had not been involved in any care plan review, satisfaction survey or meetings and stated they, "Would find it helpful to chat about things." Another said, "We used to have meetings, they were good because you could air your views, not had one for 18 months now." The registered manager told us of plans to address this.
● Records showed staff meetings had taken place as well as some staff supervisions to help keep staff updated on issues related to the home. Staff were able to raise their views and discuss any concerns during these meetings to help drive improvement of the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● The management team understood their responsibility to be open and honest when things had gone wrong. Following inspection feedback, some actions were taken in response to the immediate shortfalls we found.
● The provider worked with other organisations, including the local authority to support people's needs and ensure service development.

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 Risks associated with people's care and infection control were not always managed effectively to keep people safe. Regulation 12 (1) (2) (b) (h)

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 and processes to maintain the quality and safety of the service provided were not always implemented in a timely and effective way to keep people safe. 17 (1) (2) (b)

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 Sufficient numbers of suitable staff were not deployed effectively to meet people's care needs. Regulation 18(1)