Runwood Homes Limited

Chelmunds Court

Inspection report

2 Pomeroy Way
Birmingham
West Midlands
B37 7WB

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

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 26 June 2018, and was unannounced. The inspection was brought forward earlier than planned due to concerns we had received from relatives, staff and external agencies. This was our first inspection of the care home since it registered with us in November 2017.

At this inspection we found the service was inadequate overall, and in all of the key questions. The inspection identified six breaches of regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 and 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.

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 58 people living at the home on the day of our visit, most of whom lived with dementia.

The provider had recruited their third manager into the home since it opened in November 2017. The home manager advised that they would be registering with the CQC so they could be 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 management of people's medicine was unsafe and put people at risk of significant harm. People had missed their medicines due to ineffective stock control. People had been placed at risk of harm and in some cases had sustained harm because of this. There were not enough staff with the knowledge of people's care needs to keep people safe. Staff felt people were neglected as there was insufficient staff to meet people's needs. People raised concerns about the safety of people who lived with a dementia related illness and relatives felt their family members were not always safe. Where potential risks to people had been identified the plans to reduce the risk where not consistently followed. Staff understood what abuse was and how to report it. Staff understood the importance of reducing the risk of infection to keep people safe.

People who had a dementia related illness were at risk of not eating and drinking enough to keep them healthy. Staff were unclear about how much people should be drinking and how they were sure people had sufficient to drink. People did not have suitable and timely access to external healthcare professionals. People's appointments with external healthcare professionals had not been missed. Where some people had been seen by visiting professionals staff had not consistently followed their guidance about how to support people. People who had been living at the home for some time had not had proper assessments or reviews of their care. The management team were re-assessing people's care needs with the involvement of external healthcare professionals. Where they had identified they could not support people adequately, they were working with the person and their families for alternative placements. The provider had taken steps to improve how people were supported to have maximum choice and control of their lives so staff could support them in the least restrictive way possible; the policies and systems in the service support this practice.

People shared their experiences were their dignity had been compromised and they had not been treated respectfully. Staff did not have time to adequately support people.

People did not always receive personalised care which met their needs in a timely way. People's individual preferences were not always known or acknowledged by staff. The provider had not invested in their staff so they could spend time with people so they could support them with their interests. People had access to information about how they could complain about the service, while these complaints were responded to, the provider had not ensured sufficient action had been taken and lessons learnt to improve the service delivery.

The provider had ineffective systems and processes in place to review the quality of the care delivered. This had resulted in people receiving poor care. People, relatives and staff told us they had not been involved in the way the service was run. Staff morale was low and they had felt let down and unsupported by the leadership of the service. The provider was not keeping us informed of events, such as allegations of abuse that they are required to inform us about. The new management team were implementing new processes and ways of improving the service, however these had only been in place for two weeks so the provider could not test these to understand if these were effective, working well and sustainable.

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.

People were not confident that some people who lived with dementia were safe. The management of risk was inconsistent.

People's medicines were not managed in a safe way and people did not always receive medicines as prescribed.

Low staffing levels meant people were at risk of harm and staff did not always have a good understanding of people's needs in order to provide safe care. Recruitment processes were not robust to ensure staff were safe to work.

Is the service effective?

Inadequate

The service was not effective.

People's care needs had not been assessed effectively.

Staff had received some training; however this was not specific to people's needs. The provider had not carried out checks to ensure staff were competent in their roles.

People were not supported to receive support and treatment with external healthcare professionals.

People were supported with care they had consented to. Where the provider had recognised they were restricting people of their liberty, applications had been submitted to enable them to do this with the correct authorisations.

Is the service caring?

Inadequate

The service was not caring.

People were not always supported in a dignified and respectful way.

Staff did not always have time to spend with people and were task focused in their approach.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was in-line with their individual needs. People were not always supported with activities they enjoyed.

Although individual complaints had been investigated, the provider had not managed the complaints they had received in a way which demonstrated they were listening and improving the service.

Is the service well-led?

Inadequate

The service was not well-led.

People, relatives and staff had not been involved in the running of the service.

The provider had not identified through their own systems and checks that people had been receiving poor quality care.

The lack of effective checks put people at risk of unsafe care and treatment and potential risk of harm.

The provider was not keeping us informed of incidents that they are required to inform us about.

The provider had now recognised improvements were needed and had begun to implement steps to address this; however it was too early to test how effective this was.

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.

We undertook an unannounced comprehensive inspection on 26 June 2018. The inspection team consisted of three inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we had received information of concern from relatives and staff. The Local Authority and the Clinical Commissioning Group (CCG) had also contacted us to raise concerns about the safety to people. Due to the concerns we brought forward the inspection of this service to understand if people were receiving good quality care.

As part of the inspection 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.

We spoke with seven people who used the service and seven relatives. We spoke with four care staff, two agency care staff, one permanent nurse, two agency nurses, the chef, the deputy manager, a deputy manager from the provider's other service, a registered manager from the provider's other service, a HR manager, a staff member from the provider's dementia team, the home manager, the operations director and the head of quality and governance. We also spoke with an external healthcare professional who visits the service.

We reviewed aspects of four people's care records and daily records, 12 medication records and the staff

handover information sheet for people living in the home. We also looked at the staff rota, three recruitment files, the recruitment tracker, the DoLS tracker, complaints alongside the complaints policy and procedure and aspects of nursing staff's training records, incidents and accidents analysis, the provider's action plan for improvement and the medicines audit.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received concerns from people's relatives and whistle blowers. A whistle blower is a member of staff who may work or have worked at the service who has raised concerns about aspects of people's care to an external agency. These concerns were around low staffing levels, high level of agency staff, staff not understanding people's needs and missed medication.

The Clinical Commissioning Group (CCG) who commission people who require nursing care and the Local Authority who fund personal care undertook visits to Chelmunds Court and found serious concerns in how people's care was being provided. At the time of our inspection visit we were aware that commissioners were working with the provider to bring about improvements to the quality and safety of care people received. However, at the time of our inspection visit people continued to receive care that was not always safe.

We found significant concerns in relation to how people's medicines were managed, including stock control. People had been placed at significant risk of harm as the provider had not ensured people received their medicines as prescribed. On the day of our inspection visit an agency nurse told us they had been unable to give five people all of their medicines that morning as they were not in stock. We looked at the medicine charts for those people and could see that there had been other times that week where they had also not received all of their prescribed medicines. When we raised this with the management team, they were unaware that people had missed their medicines that morning. However, they were aware of other people who had missed their medicines on previous days. We found that people had not received and continued to not receive important medicine for their blood pressure, pain relief and for other health conditions such as Parkinson's disease and dementia.

Prior to our inspection we received safeguarding notifications from the provider which were around medicine errors, where, for example, one person had not received their blood pressure tablets for one week, which had resulted in them falling and sustaining an injury. We spoke with commissioners following our inspection visit to ensure they were aware that people were continuing to miss their prescribed medicines. They confirmed that they were being informed.

Poor recording practice of administration of medicines put people at risk of potential overdosing. For example, the medicine records gave staff administration times of breakfast, lunch, dinner and night for when the medicines should be taken, these were not time specific. An agency nurse told us that one person had been given their 'breakfast' medicine at 11:45, however when we checked to see if an accurate time was recorded, it had been signed under 'breakfast.' Staff could not clearly demonstrate when the medicine was given so the time intervals between doses could not be determined.

The often illegible handwritten medicine records put people at potential risk for receiving either the wrong medicine or the wrong dose or both. The provider's head of quality and governance told us they could not find any of the original prescriptions so the medicines could not be cross referenced with the hand-written records to ensure administration details were correct. We checked a sample of the hand written controlled

drug records against the prescription details written on the medicine boxes and found these to be correct. However, it was agreed that handwritten medicine charts and not having a copy of the original script put people at a significant risk of harm.

The administering of injections and application of skin patches and creams was unsafe and put people at risk of harm. An agency nurse said, "There are no body maps, if someone has dementia and they can't tell us where their patch is, we have to go looking all over their body to find the old patch. It's not very good for [the person]." They continued to say that, "When we give [a person] regular injections, such as insulin, we are not sure if we are rotating the injection site correctly, as there is no body map to tell us where the last injection was given." This put people at risk of having sore skin, or their medicine not working effectively. We also saw examples where the medicine record charts had written, "Cream chart in room'. A chart in one person's bedroom stated, 'apply sparingly to cover areas at risk.' The body map did not tell staff which areas were at risk, which meant staff could not sure they had applied this correctly and safely.

The provider's head of quality and governance told us, "We have been trying really hard over the last couple of weeks to try and draw a line under the medication issues, build relationships with the surgery and resolve issues." A meeting between the provider, GP, Pharmacy and the CCG took place in an attempt to improve communication and to ensure people received their medicines when they needed them. This was because there had been on going issues identified since the home opened in November 2017 which meant people had not received their medicines to manage health conditions. This had placed them at significant unnecessary risk.
The provider's head of quality and governance explained that the medicines would be put right in two weeks. However, they could not give us adequate assurances that suitable measures were in place to ensure people had their prescribed medicine before the new system was set up. We wrote to the provider following our inspection visit to understand how people's immediate safety was going to be managed. The provider confirmed that they were working with the GP and pharmacy to resolve this immediately. They confirmed to us that people living in the home had sufficient medicines and any missed doses would be reported to us. They confirmed that all staff administering medicines had their competencies checked and clear instruction for reporting missed medicines were now in place. Since this time, we have not received any further reports of missed medicines.

People who lived with dementia were not kept safe. People told us they felt safe, but were concerned for other people with dementia living in the home. One person told us, "When you ring the bell, they come. They shout from the corridor 'are you alright?' and I see plenty of staff passing by." While another person told us, "I am safe, but I'm worried about some of the others." This person described to us times where people who had dementia had been in their room and had been tearful. They told us, "I have told the staff, so they are aware." We received a mixed response from relatives about whether their family member was safe. One relative told us, "I feel if I don't come, [the person] would just be left." We asked if relatives felt there had been any improvement over the last week. One relative told us, "Things have got worse, not better."

Staff told us people's care needs were neglected due to low staffing levels and working with some agency staff who did not know people's needs. Staff shared examples with us where people were found on the floor and it had not been witnessed to understand how long the person had been there or how they fell.
In April 2018 a monthly analysis of a falls audit undertaken showed 32 falls had occurred. All 32 had been un-witnessed and five of these had resulted in injuries. An action from the audit to reduce further falls was for all people's walking aids to be visually checked which included checking the rubber ferrules of walking frames were intact so they were safe for people to use. However, there was no evidence that these checks were taking place. We asked staff if they checked the rubber ferrules and one told us, "I don't think we have to." Another said, "I'm not sure about that."

People and relatives shared their experiences of poor care that had been delivered, which had resulted in some cases the person coming to harm. Some relatives told us they did not trust that their family member was being cared for and carried out checks themselves such as checking from bruises or sore skin. One relative told us they had found a bruise on their family member's back and was unsure how they got this or whether staff were aware to investigate how they sustained it.

Identified risks were inconsistently managed which put people at continued risk of harm. For example, we observed a pressure relieving cushion for one person was not in use. We checked and found the person was sitting in a dining room chair at the table eating their breakfast. When we asked staff why the person was not sitting on their pressure relieving cushion one care staff member said, "I was on breakfasts," another care staff member said, "I don't know it's only my second day." When staff supported the person with the pressure cushion they had placed it the wrong way and an inspector had to ask the care staff to turn it over to the correct side.

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

There were not enough staff on duty who knew people's care needs and how to keep the safe. People told us the staffing levels in the home were insufficient and they were usually supported by staff who did not know them. One person told us, "I pressed the buzzer at 20:55 last night and they came at 22:10." They told us that during this time they had been waiting for staff to assist them with personal care so their dignity could be maintained. A relative said, "I hear bells ringing and ringing, and people shouting 'Help! Help!' I come at lunch and don't leave till 8 o'clock. I see it all." We spoke with an external healthcare professional who visits the service. They told us that it had been "Chaotic," as they could not always find a staff member, or a staff member who knew the person but told us, "I've found lately there are more staff I recognise and who know people."

One care staff member told us, "Everything is unsettled. We are rushed off our feet." A further care staff member told us, "It's me and two agency staff this afternoon. It was the same yesterday. They [agency staff] don't know people, so I feel that I'm working on my own." On the day of our inspection visit the service was operating on one less staff member, as the provider could not find enough staff to cover the shift. We saw staff were busy, with little time to spend with people. During the late morning we saw people still asking for support with their morning routine, and requiring assistance with their personal care. We also observed a staff member working alone with people despite the manager confirming they were working in a 'shadow role' as it was the second day of their employment.

The manager said, "50% of shifts are covered by agency. We are block booking agency staff so people see the same faces. We want the same staff to come. We are working hard on recruitment but about 30 day shifts and 20 night shifts are agency workers each week." The head of quality and governance told us, "We need to re-assess everybody's care needs." They told us that they were starting from scratch, to ensure they had the staffing levels based on people's assessed needs. They told us that given the staffing situation they could not support people with very high needs and were working with people's social workers to help them source alternative placements.

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

The provider did not have robust systems and practices in place to ensure the staff they employed were suitable for employment. We reviewed the recruitment records for three staff. We read in one record that

the staff member had a three year gap in employment history and the provider could not evidence this gap had been followed up at interview. This meant the provider could not be assured of the full employment history of their staff member. We also found that a staff member who worked night shifts had begun working before their Discloser and Barring Service (DBS) had been returned.

The manager had been in post for two weeks. We spoke with them to understand if they felt people were now safe after the involvement of the external agencies and provider's senior management. They told us, "I do think people are safe, if you had asked me that two weeks ago I wouldn't have been able to give you a confident answer." The deputy manager said, "People are safe now, much safer than they have been over recent months." They explained this was because managers were working together to make things better for people and said, "Communication is really being worked on so staff have the information they need to provide people's care." Staff were able to tell us what different types of abuse were, and how they would escalate their concerns. They were aware of external agencies that they could also report this to.

People and relatives were satisfied with the cleanliness of the home. One relative said, "[The person's] room is clean and fresh and everything I ask for is put there." People and relatives told us staff used gloves, aprons and washed their hands when required. Staff told us they had received training in food hygiene and infection control, they confirmed they had access to equipment that protected them and people they supported. A registered manager from another of the provider home was working at Chelmunds Court during our visit and they had completed an infection control audit. They told us that infection control practices were good; however, they had observed some staff had failed to use correct hand washing techniques to reduce the risk of cross infection. They explained the outcome of the audit would be shared with the home manager for them to address the issue with staff.

Inadequate

Is the service effective?

Our findings

People were not supported to have sufficient food and fluids to keep them healthy. Relatives raised concerns with us about the support offered to people who had dementia. One relative told us they "I arrived at 11am and [the person] was on the edge of the bed they had a dirty shirt on and said to me, 'I've got to get dressed, I'm hungry and I'm thirsty." A further relative told us their family member was given food they could not chew and had begun to bring in softer food such as cottage pie for their family member to eat as an alternative. Another relative told us that staff relied on them to assist their family member to have their meals.

At lunch time we saw people were offered a choice of gammon and chips or tuna pasta bake, we found some people could not eat the gammon as they could not chew it. One person told staff, "I can't eat this." We saw staff offer people more chips instead of an alternative meal. Some people were given their meals in their room; however staff had not asked if the person wanted their meal or made them aware it was there to eat. For example, we saw one person's meal had been placed on their bedside table when they were asleep; when we checked again half an hour later the person was still asleep and the food remained untouched. A relative told us that meal times where chaotic, and said, "Last week, all people were waiting for tea but the food had not come. I went along to the lift and found the food trolley had been left in there for at least half an hour. The soup was cold."

Relatives raised concerns about accessibility to drinks and we saw that while jugs of juice were available in people's rooms, people did not have a glass to drink out of. A relative told us, "Some staff don't even know who needs a spouted beaker." We saw one person attempting to drink from an empty glass, staff explained the person needed their drinks thickened but they had run out of thickening powder to thicken the fluids so it was safe for them to drink. We noted it took one and half hours for staff to be able to obtain the thickener and give the person a drink with their meal. A staff member told us, "On a hot day like today, we can't give [the person] a drink. It's just ridiculous." We saw that ice creams and ice lollies were given to people as the weather was very hot. However when one person was asking a care staff member what to do with their ice lolly the person's requests were ignored on two occasions until the chef intervened and assisted.

The lack of support offered to people with dementia with their eating and drinking meant the provider had put people at risk of malnutrition and de-hydration. We spoke with a nurse about how they monitored people who were at risk of not eating or drinking enough. They told us that every person on the nursing unit was on a fluid chart this week to monitor their intake. They said, "[People] don't always drink their required amount, so we are going on what they usually drink." However, staff told us they were busy, we saw care provision was chaotic and the lack of clear leadership on each of the units meant that staff could not be sure people with dementia had enough to eat and drink.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Meeting nutritional and hydration needs.

People had not always received referrals to external healthcare professionals or kept appointments, which

had resulted in people not always receiving the care and support that was in line with best practice. One person told us, "The GP came last Friday about my medication, but the GP didn't see me in my room." The person continued to tell us how they felt upset and frustrated they had not been supported to see other healthcare professionals to support them with their health. They continued to tell us how they had missed an appointment with their consultant at the hospital and said, "I don't know why, and no one's said anything about another appointment. I feel I've just been left here to rot." We raised this person's concerns with the home manager so they could speak with the person to work towards resolving their concerns.

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

The provider's head of quality and governance told us people's care and support needs had not been appropriately assessed and this had had an impact on the person and other people living in the home. The manager had met with seven people and their relatives since their arrival to discuss their care needs. It was acknowledged that all people would need a review of their care, and additional support for the manager had been sourced from the providers other services.

An overview of information was available for staff related to people's medical conditions, how they could mobilise and what their preferences were. Staff told us this was helpful to refer to. An agency staff member told us the information they had about people was sufficient. Care staff told us they had received basic training that was appropriate for the people they cared for, such as safe moving and handling, first aid and safeguarding. However, staff had not been supported to develop and enhance their skills with further training that specialised in different areas related to people who lived at the home. We looked at training specific to the nursing staff team. Electronic training had been completed however the provider could not demonstrate that competency tests had been undertaken to assess whether nurses were competent in what they were taught. The provider's head of quality and governance told us they had arranged additional staff training and competency checks would be undertaken by the new manager.

Poor communication and lack of effective leadership on the units meant people received inconsistent care which placed them at risk of harm. A healthcare professional who visits the service told us when they arrived for their scheduled appointments staff would ask them to assist other people rather than request appointments for them. They told us that while they would see people to ensure they were safe and offer guidance and support, these impromptu requests meant that they did not have as much time with people. They also explained their offered advice, for example, of using pressure relieving cushions, was not consistently followed and felt this was down to communication within the staff group. Nurses also lacked clear direction and leadership. They were unable to clearly answer what their specific tasks were. With this inconsistent approach people were at risk of not receiving the right care at the right time.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met.

People told us staff would ask for their consent before undertaking any personal care. Where people lacked capacity to make decisions about aspects of their personal care, relatives and external healthcare professionals were involved so that the care provided reflected what was in the person's best interests.

Staff said they assumed people had the capacity to make their own decisions and would always seek consent from the person first. They told us that should the person decline, they would respect their choice. The manager had recognised where they may be restricting some people's liberty and had made applications for approval to restrict the freedom of people who used the service, and we saw these had been granted.

Chelmunds Court is a large purpose built nursing home which is over two floors. The ground floor was residential care while supporting people with a dementia related illness. The top floor was a nursing floor which also supported people with a dementia related illness. People had their own private bedrooms and had en-suite facilities.

The provider had equipped the home with specialist baths and showers which were appropriate to support people's individual care needs. People were cared for on specialist profiling beds and staff had access to enough hoists, slings and wheel chairs to enable them to support people in the right way. People had access to communal areas and could move around freely and independently. People who lived on the ground floor had access to a garden area which promoted wheelchair access, where people lived upstairs we saw staff offer and support people to sit outside in the garden. The checks of the building and the equipment had been made to ensure they met the right standards and identify any areas that may require further adaptation.

Inadequate

Is the service caring?

Our findings

Peoples were not always treated with respect and there had been times when people had their dignity compromised. One person told us that only a few days ago they had been left without any assistance with their continence care needs during the night. They told us that when the day nurse came on shift the nurse, "Cried because of the mess that I was left in." They confirmed that the nurse had been supportive and helped them with their care needs and, "Reported it to management." We spoke with management staff who told us they had put in place a visual check of every person before the nurse or the senior care staff member finished their shift. They told us that should they find a person whose care needs were not met, this was dealt with immediately. They told us that they had implemented a zero- tolerance policy for any staff member who had not supported people to be clean and comfortable.

Some staff were not always caring. One person told us, "Nights are terrible for staffing. The night staff are the worst. It sounds like they're quarrelling with each other and they slam doors. They tend to shout across the corridor when people are asleep." We reported this to the manager to ensure they were aware of people's concerns so this could be addressed.

Relatives shared examples were people were not supported to maintain their dignity. A relative told us, "I came and [the person's] nightie was up, they were not decent, and I felt uncomfortable. I was a bit upset but I didn't ask the staff [for help]." Other relatives told us about how they had seen their relative unkempt and asking for help. A healthcare professional told us that upon their arrival one morning they found a person in the corridor where their dignity was compromised. They said, "There were no staff around, I took the person back into their room and went to find a staff member to help."

During the inspection, we saw one person walking along the corridors on the ground floor and were trying to get in through the bedroom doors. The person told us their trousers were wet and it was clear that the person needed support. At that moment a senior staff member walked past the person and asked if they were okay, however they did not wait for a response from the person or offer assistance. The inspector went and informed the deputy manager who then assisted the person. During the morning we saw other people walking around with food on their clothes, bare feet, unkempt hair and men unshaven, there were no staff visible to support people to ensure they were okay.

When we reviewed the medicines, we saw staff had taken some pictures of people to help those administering the medicines identify them. The pictures taken were not dignified, we saw pictures of people sleeping, their hair and beards unkempt, and where one person had a large bruise on their face. We saw the person during inspection, and they did not have this bruise anymore, however the picture remained in their file. A nurse who assisted us with our medicine checks confirmed that these photographs were not dignified or taken in a respectful way.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Dignity and Respect.

We saw staff were taken away from their caring role to do other tasks such as prepare breakfasts, load dishwashers or plate food for people's lunch. Staff mostly only engaged with people about different tasks, such as offering of a drink, or asking them where they would like to sit. Staff shared with us that they could not support people the way they wanted. A staff member told us they were, "Frustrated". Another staff member told us that staff morale was low; which also affected people and said, "[People] can pick up on it."

It was clear from speaking with staff they were upset that they could not provide a good standard of care to people. Staff had not been supported by managers to develop their knowledge about people and build a good rapport with them. A staff member told us, "Quite a few staff have left. There are staff crying on shift because we can't cope." A staff member told us, "Relatives have lost their trust in us." A relative confirmed, "There are far too few staff, we had some lovely carers. Nine have left; they just couldn't cope with it."

Some people told us they received good care. One person said, "[Staff] are kind and we always have a laugh." A relative told us they felt staff were caring and said, "From what we see, [the person] is looked after well." They told us how staff had been accommodating and welcoming into the home and told us how the person's partner was made to feel welcome. They explained, "[Staff] sorted out some craft stuff and colouring they could do together. They said there is no need for [person's partner] to bring a sandwich, they would give them food and have drinks here too."

Inadequate

Is the service responsive?

Our findings

The provider had failed to meet people's basic care needs. One relative told us how they had obtained equipment themselves to help the person with their care needs and said, "I've had a shower chair put in there, as [person's name] went 14 weeks without a shower." A further relative told us that when their family member had an injury and went to hospital they "Were sent to hospital with no carer, they was on their own, and they were in a state." They continued to tell us "They hadn't even sent their tablets with them! The [hospital] nurse asked for a list of tablets and [staff] said they hadn't got time to make a list! Disgusting!"

Staff could not deliver responsive care to people due to inadequate staffing levels. Relatives confirmed this, with one relative saying "I came in at about 11:30am, their room was in a shambles and [Person's name] was still in their pyjamas and hadn't had a wash." They continued to explain they had to support staff with caring for the person's specific health care condition as staff were not competent to do so. A further relative told us their family member had been living in the home since it opened and said, "[Person's name] has only had two showers since they had been in the home." They felt that staff should be "More persistent, and offer them at other times of the day."

We met one person at the home whose first language was not English. They were in the dining room and calling out. We asked care staff how they communicated with the person. A staff member told us they did this through the person's family when they visited. We asked how they managed when the family were not available, and whether there were any aids or visual prompts to assist communication so they could respond to their calls. The staff member told us they were not aware of this being in place. Therefore, the provider could not be assured that they were able to communicate and respond to people where they required assistance and their first language was not English.

People told us they did not always have the opportunity to do the things they enjoyed and that staff were not aware of their preferences. We spoke with one person who was in a communal area alone with the radio playing classical music. We asked the person how they were, they said, "I'm sick of this bl***y music. It's driving me crackers. I can feel myself getting more and more agitated." We heard of examples of people feeling isolated, with the only contact from staff being to complete their personal care. A relative told us, "There's no consistency. Nobody occupies [person's name]. I take them out and their happy." There were no planned events happening in the home and staff had reported that the activities co-ordinator had left.

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

The provider had a complaints procedure for people, relatives and staff to follow should they need to raise a complaint. People and relatives told us they knew how to raise a complaint if they needed to. One relative said, "If we have any concerns we are confident that we will tell the staff or manager." We looked at the provider's complaints records, the manager showed us a new complaints tracker which was about to be introduced; they advised this would be used to monitor and identify trends and will be sent to head office on a monthly basis.

We looked at the provider's complaints since the service opened and saw that 16 complaints had been recorded, four of these were opened in June and were still under review. All complaints we looked at were about care, such as medicines being missed, care plans not being followed and poor personal care provision. We could see that the complaints had been investigated by previous managers but there had been no involvement from senior managers or monitoring to ensure sufficient action had been taken and lessons had be learnt to improve the service.

Inadequate

Is the service well-led?

Our findings

Chelmunds Court registered with us in November 2017. At the time of our visit a third new manager had been recruited and had worked at the home for two weeks. They told us they would begin 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.

Prior to our inspection we had received information which informed us the home was not well- led. All managers we spoke with during our visit acknowledged the quality of care people received had fallen below the provider's expectations. They told us this was due to poor leadership and poor communication. The provider's head of quality and governance told us, "We are learning lessons because things have gone wrong. We are all committed to working together to make things better."

In response to the concerns identified prior to our inspection, the provider, local authority and the CCG had taken the decision not to admit further people into the home until improvements were made.

The provider had inadequate quality checks in place. Serious concerns had consistently been raised from people, relatives and staff since the home opened in November 2017; however the provider's systems were ineffective to identify and respond to this. The provider was heavily reliant on the home manager to ensure the service was running effectively. Previous managers had not escalated the concerns to senior management who remained unaware of the level of concern. For example, the complaints received had only been responded to by the managers within the home, and had not been escalated following the provider's policy. The provider's own systems and checks had not identified this need earlier.

The provider had not involved people in the running of the service. For example, the menus had been created by the chef without the involvement of people. People did not have a choice of the types of food they would like. Such as breakfast times the option was cereals or toast. A relative said, [Person's name] loves a bacon sandwich, but they do not get it here." Staff told us that a cooked breakfast used to be available to people but not anymore. The chef told us they had removed this option to promote people's health however there had been no consideration to offer a variety for people.

People did not directly comment about the management of the service; however relatives expressed they lacked confidence in the leadership of the service. One relative said, "It's getting there very slowly, but some days it's back to square one… I haven't got the confidence yet to go away for a few days." Another relative said, "There's been no improvement in the last week though I thought there might be."

A manager told us, "We need to build up trust with people and their families, they feel let down. Bridges need building." At the time of our visit individual meetings had begun to take place with people and their families so they could share their individual experiences. A manager said, "We know what people are unhappy about, be assured we will address it."

The provider had not listened or supported their staff group. One staff member said, "The manager always goes up to the nursing floor, but nobody has been down here. I think that's because it's worse up there, but we do need support." Another staff member said, "There is still no support from leadership. We are under staffed and there is a lack of things for people to do."

The deputy manager told us they had not been supported in their role to effectively manage the service. They told us they had not undertaken effective management training in order to fulfil their role and said, "I was expected to complete audits but I've never been shown how to do them so I wasn't sure if I was getting them right or not." They continued to tell us how they had not been supported whilst providing 'on-call' support and said, "One weekend I had over 20 calls, it was just too much, it was me looking after the place, there was no support for me, I was exhausted."

Managers were aware staff morale was low. To increase morale and support staff we saw the provider's human resources manager was at the home during our visit. They told they were holding 'drop in surgeries' which meant staff had to the opportunity to talk to someone in confidence about how they were feeling. One of these meetings took place during our visit; however we had not spoken with any staff who had used this service during this visit.

New processes such as, 'daily walk arounds' undertaken by management had been implemented shortly before our visit. They explained this was to make sure people received the care and support they needed. However, from listening to people and relatives, this was not yet effective as there had been recent incidents where people's care needs had been neglected. Daily meetings with managers, nurses, care team leaders and the heads of different departments in the home had been implemented as a way to improve communication. However, this was to discuss appointments on the day, and the provider had not considered whether there were sufficient arrangements in place for future appointments.

The provider's system for reporting, recording and taking action to mitigate further incidents was ineffective. Monthly audits of accidents and incidents took place however these did not look for patterns and trends to identify if further action could be taken. Where there were patterns and trends, such as a person falling four times that month, the audit stated that no patterns or trends had been identified so no further action had been taken. Ineffective audits puts people at risk of potential harm, as areas for improvement have not been highlighted or addressed to mitigate risk.

The provider had not reviewed the complaints that had been received. The provider had failed to ensure the complaints investigation was in line with their policy and to assure themselves that the action taken was proportionate. The provider could not evidence that patterns and trends had been identified to understand how improvements could be made to the service, or that learning had taken place and shared with the staff group to improve performance.

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

The provider was not keeping us informed of all incidents that they are required to inform us of. Such as, people missing their medication, whereby the provider stated they had sent safeguarding referrals 's to the local safeguarding team.

This was a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009. Notifications of other incidents

The provider had acknowledged there had been significant failings at the home. All managers we spoke with during our visit acknowledged the quality of care people received had fallen below the provider's expectations. They told us this was due to poor leadership and poor communication. The head of quality and governance told us, "We are learning lessons because things have gone wrong. We are all committed to working together to make things better." The manager told us there were many things to put right and time was needed to turn the service around. They told us that initial steps of monitoring and mentoring the staff were priority, to ensure people were being supported and cared for safely.

Meetings had been arranged between managers and staff in an attempt to improve communication between them and to also outline the provider's expectations and standards to drive forward improvement. The manager said, "We are treating today as day one, we are moving forward, making things better. All staff will attend a meeting so they know of our plans." The first of these planned took place during our visit.

Managers told us they were working in partnership with the local authority and the CCG to improve the quality of care people received. We reviewed the improvement action plan that was in place, which was being closely monitored to ensure improvements were made to benefit people. For example, daily conference calls took place between external partners and the home's managers to review and evaluate progress and further face to face meetings were planned.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care that was inline with their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People did not receive care that maintained their dignity and prompted respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed in a way which kept them safe. People's identified risks were inconsistently managed. People were not always assisted to external healthcare appointments where these were required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have assurances in place to demonstrate people had sufficient food and fluids to keep them healthy.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were not sufficient numbers of staff with the knowledge to support people in the right way.

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 The provider did not have effective systems in place to be assured the service was delivering good quality care.

The enforcement action we took:

NOP for positive condition - to be confirmed after MRM