Quantum Care Limited

Anson Court

Inspection report

Anson Court
Shackleton Way
Welwyn Garden City
Hertfordshire
AL7 2FF

Date of inspection visit:
13 March 2018

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12 April 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 13 March 2018 and was unannounced. This was the first inspection since they were registered with the Care Quality Commission on 14 November 2017. Many of the people and the staff had moved from another of the provider's location to this new purpose built building.

Anson 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.

Anson Court provides accommodation for up to 75 people. Some of these people live with dementia, old age and physical disability. The home is not currently registered to provide nursing care but an application was in progress to provide nursing care at the time of the inspection. At the time of the inspection there were 45 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

The service was run by a management team that knew people well and had a people first outlook. There were quality assurance systems in place and these identified shortfalls allowing for appropriate remedial action to be taken. People, relatives and staff were positive about the management of the service.

People's care needs, for all aspects of their lives, needed to be met consistently. Care records at times had gaps that did not allow for effective review of people's wellbeing. There was also a need for further development was needed in relation to activities. People's feedback was sought, although this had only commenced recently.

People felt safe and were supported by sufficient staff who had undergone appropriate recruitment process. Medicines were managed safely and risks were identified and management plans were in place to mitigate these risks. The management team shared learning from any events such as medicine errors, themes from incident analysis or complaints.

People were supported in accordance with the principles of the Mental Capacity Act. People were supported by staff who were trained and had opportunities for supervision.

People were encouraged to eat a healthy and balanced diet and there was appropriate access to health and social care professionals. We found the design of the building promoted a friendly and welcoming environment.

People were supported by staff who were respectful and kind. We found that privacy and dignity was promoted in most instances. Confidentiality was maintained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe.

People were supported by sufficient staff who had undergone appropriate recruitment process.

Medicines were managed safely.

Risks were identified and management plans were in place to mitigate these risks.

The management team shared learning from any events.

Is the service effective?

Good

The service was effective.

People were supported in accordance with the principles of the Mental Capacity Act.

People were supported by staff who were trained and had opportunities for supervision.

People were encouraged to eat a healthy and balanced diet.

There was appropriate access to health and social care professionals.

The design of the building promoted a friendly and welcoming environment.

Is the service caring?

Good

The service was caring.

People were supported by staff who were respectful and kind.

Privacy and dignity was promoted in most instances.

Confidentiality was maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs, for all aspects of their lives, needed to be met consistently.

Care records at times included gaps that did not allow for effective review of people's wellbeing.

Further development was needed in relation to activities.

People's feedback was sought.

Is the service well-led?

Good

The service was well led.

The service was run by a management team that knew people well and had a people first outlook.

There were quality assurance systems in place and these identified shortfalls allowing for appropriate remedial action to be taken.

People, relatives and staff were positive about the management of the service.

Anson 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the provider information return (PIR) submitted to us. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

The inspection was unannounced and carried out by two inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with 12 people who used the service, four relatives, eight staff members, and the registered manager, the newly appointed manager who will be taking over from the current registered manager, the regional manager and the nominated individual. We received information from service commissioners and health and social care professionals. We viewed information relating to six people's care and support. We also reviewed records relating to the management of the service.

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 due to their complex health needs.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person said, "I think it's nice here I was a nurse so I know what's what, I was here when it opened, I feel safe here because the staff are so lovely and helpful and I no longer felt safe in my home." We observed people respond to staff and they were comfortable with them. Relatives told us that they felt people were safe. One relative told us, "[Name] is definitely safe because staff do everything they are supposed to."

People were supported by staff who had a clear understanding of how to keep people safe. Staff received regular training and updates. We found that the management team had reported any concerns appropriately.

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly. Risk assessments were in place for areas including falls, skin integrity, the use of equipment and choking. These assessments identified potential risks to people's safety and the controls in place to mitigate risk. All accidents and incidents were recorded on the provider's internal system and reviewed to ensure all remedial actions had been taken and the risk of a further incident was reduced. This helped them to identify themes and trends and enable them to take any additional action.

There were regular checks of fire safety equipment and fire drills were completed. There were appropriate evacuation plans in place for people living at the service, taking into account the time it would take to complete this. Staff knew how to respond in the event of a fire. The provider ensure that other checks, such as electrical or health and safety assessments, were also completed to help maintain people's safety. There had recently been an inspection by the fire service and the service had passed without recommendations being made.

Most people told us that there were enough staff to meet their needs. However, one person said, "In the evening there are not enough staff around, I have asked about this but they say they are over staffed." Staff told us that at times, on some units, additional staff were needed to meet people's needs in a timely fashion. This was due to the number of people who needed two staff to support them and at times only two staff were on the unit. However, most people told us that staff responded to them when they needed it. Relatives told us that there were enough staff available to meet people's needs. Throughout the course of the inspection we noted that there was a calm atmosphere and that people received their care and support when they needed it and wanted it. The service was not yet at full occupancy and the management team told us that staffing levels would fluctuate depending on numbers of people in the home and their individual needs. We did note that on one unit staff were busy when a person wanted to go to the toilet. A staff member told the person they would need to wait but we advised the staff member to seek support from another unit so that the person did not have to wait. We discussed the need for staff to think about people's needs being met in a variety of ways with the management team and they agreed staff needed to develop their thinking in this area to include contacting other units for support rather than just accepting people should wait.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable for working in a care setting. They ensured all required documentation was received before a member of staff commenced employment. This included written references and criminal record checks.

People's medicines were managed safely. Medicines were stored safely and administered by trained staff. We checked a random sample of boxed medicines and those in the pharmacy blister packs and found that stocks were accurate with the records. Control measures were in place to ensure these were managed safely. Staff received regular training. There were plans in place for medicines prescribed on an as needed basis.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. A relative told us, "I think the home is very clean and impressive." Staff worked in a way that demonstrated they were familiar with infection control. One staff member said, "You have to wear gloves and apron, then dispose of them in the proper way, in the bins provided." We saw that staff used gloves and aprons appropriately and the home was clean and fresh on the day of our inspection. However, we did note that one person had an open bowl that they were using to spit into. We raised this as a potential infection control risk with the management team who told us they would ensure the person had a pot with a lid.

Lessons learned were shared at team meetings, supervisions or as needed. We noted that any issues were discussed and remedial actions put into place. For example, better control measures for checking for errors in relation to medicines and more robust record keeping.

Good

Is the service effective?

Our findings

People and their relatives told us that they felt staff were skilled and knowledgeable to support people living at the home.

Staff received training to support them to be able to care for people safely. This included training such as moving and handling and safeguarding as well as specific training modules such as communication, dementia care, infection control, MCA and first aid. Staff told us that they felt supported and were able to approach the management team for additional support at any time. Staff we spoke with confirmed they had had an induction of two weeks. One staff member said, "I had a good induction, with lots of training and support before I worked on my own." They said, "Experienced staff showed me how to work properly." We saw staff supporting people to move with the use of a hoist and they were competent. We noted that training updates were in progress on the day of inspection.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The management team demonstrated a clear understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They had awareness of what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful and they had their human rights to freedom protected. The appropriate applications and documentation was in place. Staff had an awareness of MCA. One staff member said, "It's about making sure people are assessed properly and their rights of choice are protected." We saw in care plans there had been capacity assessments completed for things such as bedrails. We saw documentation that confirmed best interest meetings had been completed to discuss people's options which ensured decisions made were in the persons best interest and least restrictive.

Staff offered people choices each day even when they were assessed as not having capacity to make some decisions. Staff acknowledged that this did not mean they could not make any decisions and how they wanted to spend their day, when to get up, what to eat and wear were all decisions discussed with people. Staff understood the importance of choice. They were able to verbally demonstrate how they offer people choice. One staff member said, "I will hold up two lots of clothes and say, what one would you like to wear today." People confirmed that they could get up and go to bed when they wished. We noted that a staff member kept popping in to a person to encourage them to get up, they gave the person options but respected their choice when they chose to stay in bed.

The home was designed in a way so that people could move around easily, whether this was independently

or with the use of mobility aids. Equipment was well situated in bedrooms and bathrooms to enable people to be independent where possible. There were comfortable communal lounge areas and sufficient dining tables so people could enjoy a meal together if they wished. There were also smaller areas that people could sit quietly in. There was an accessible and well-designed garden that people had enjoyed in the better weather. People were able to move freely around the coffee area in the main reception of the home and spend time with people attending the day centre. The environment throughout was stimulating, fresh and imaginative, with themed areas throughout of planes and transport from the yester years. People's bedroom doors were painted in a range of vibrant colours and memory boxes depicting the person's past life and interests had been created outside some people's rooms. We saw that people had been able to personalise their rooms with furniture from home, to enhance the homely feel to their rooms.

People were supported to enjoy with a variety of food and their individual likes, dislikes and dietary needs were well known by staff. However one person said, "The food is okay, don't usually get a choice of food sometimes they tell you what it is and they would get you something else if you didn't like it." Another person said, "You can always have a cooked breakfast, but I usually have toast." A third person told us, "Sometimes you get taken out for meals which is good." A fourth person said, "We are quite happy with the food here, we sort of get a choice. I often look and see what the others are having before deciding." We noted that people were given a verbal choice and although there were menus around in most cases, these were not always accurate to the day and some people living with dementia could benefit from a visual prompt. Also the presentation of pureed meals was unimaginative and bland. It was difficult to interpret what the person had been given by scoops of brown, green and white food. We discussed this with the management team who had already identified the need to present pureed meals in a different way. People were offered dessert and were then offered tea or coffee. People were asked if they had finished before the plates were cleared away. We noted there was good conversation between the people during lunch and it was a sociable experience for many.

Assessments had been undertaken to identify if people were at risk from of not eating or drinking enough and if they were at risk of choking. We observed staff supporting people appropriately. People's intake and food choices were recorded where people were at risk. However, staff did not always record an action when needed if a person had not consumed the required quantity of fluid. We saw that snacks and drinks were available all day and high calorie snacks and shakes were provided to people who were losing weight as identified on the management tracker.

People's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary. For example, GP, speech and language team (SALT) and a chiropodist.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person who had recently moved into Anson Court said, "I am blessed that they are here." Another person told us, "The care is very good and all the staff who help me are kind and gentle." We noted that people were relaxed in the company of staff. Relatives told us that staff were kind and attentive. One relative said, "My experience of the home is one of good care." Another relative said, "They are caring and kind."
We saw that when visitors arrived staff knew them and welcomed them in, asking how they were and offering refreshments. One visitor was offered a cooked breakfast as they joked they fancied one. Relatives and friends of people who used the service were encouraged to visit at any time and felt welcome.

Staff were calm and friendly with people and we observed them interact with people in a warm and caring way. Staff listened to people and gave people time when it took time for them to verbalise what they were communicating, even when this meant repeating themselves. There were plans giving staff guidance on each person's communication. All staff used people's first names and we observed them often talking about their lives. Some people felt that staff should have more time to sit and chat with them.

Staff respected people and supported them with dignity. Relatives told us that they were happy with how people were treated. One relative told us, "This one [care home] is always clean. One of the nice things is [person] can go into the day centre whenever [they] want to, [person] is very sociable, [they] will talk to anyone. We can make [them] a cup of tea whenever and visit at any time. You need to look at the people working here and the way the residents are dressed, their hair and their dignity 'why would you put [person] somewhere [they're] not looked after?" We noted that staff promoted privacy. Staff always knocked before entering a room or asked before doing something for a person.

Reviews of people's care involved people and relatives told where appropriate. People living at the service, and many of the staff supporting them, had worked together for a number of years in the previous location. This was evident in how people responded to staff and the awareness staff had about people's needs, life histories and preferences. They were able to tell us about people's health, families and important relationships and their interests.

People told us that their religious needs were met. This included visiting practitioners of their chosen faith, attending a venue of their choice outside of the home and any dietary requirements.

People were encouraged maintain relationships in whatever form they took. This included with family members and friends. People's records were stored in the office in order to promote confidentiality for people who used the service. However, some records were in the kitchenette areas left on the counters. This was an area that needed to be addressed to ensure people's confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they were happy with the care provided. One relative said, "The interaction I see is good, I have seen staff put my [name] to bed and I was pleased with the care." Another relative said, "[Person] is always clean and well dressed."

People's care plans were detailed and person centred. In addition to life histories and family and friends information, they included information that enabled staff to promote independence where people were able and provide care in a way people preferred. However, this did not always occur. For example, one person was noted to like certain items around them and they did not have them within reach and another person had requested for things such as their curtains being opened and this did not always happen. They said, "'I cannot close my curtains I can't do it anymore by myself. I've asked them over and over again, it doesn't always happen.'' Some plans had areas that had not been reviewed and we noted that this had been identified by the management team as an area they were working on. We also found on one of the records we reviewed, a plan had two additional first names recorded which indicated that the staff had used a template and not read through to ensure it was accurate to the person who the plan as about.

Some information was also contradictory. Staff told us that a person had been unwell for a number of weeks and not eating or drinking well. However, a review of their food and fluid charts showed that they were eating and drinking. We also saw that fluid charts were not always completed with required actions for reduced fluid intake. In addition, charts used for repositioning people while in bed did not always reflect the position they had been in or changed to. This increased the risk of a person being put onto a side that was of higher risk more frequently. For example, if they had a pressure ulcer on their sacrum or heel, these areas would need to be used less often.

Staff told us that they recorded the care delivered and that there was communication at regular handovers. One staff member said, "I write down what we have been doing every day and also look back to see how they have been whilst I have been off."

During the inspection we observed staff being prompt in supporting people and responding to their needs in a way that indicated they knew people well. However, on one occasion, one person had vomited and was seen to vomit again and they did not have their call bell in reach. We had to seek support for the person. When we checked on them later, after staff telling us they were unwell and seeking medical input, we found they again did not have their call bell. We also found that at times people were not given their hearing aids or dentures. We found that one person had suffered a toothache for five days. A GP had visited and advised a dentist be called. At five days after the initial pain and five days of not eating as they were in pain, we had to prompt staff to give the person pain relief on the day of inspection. We were told by the management team that the care team manager was aware of medicines available from their supply store and these had been given in the absence of prescribed medicine. However, staff responsible for the person on the day of inspection was not aware of the availability of pain relief and their care notes and medicine records did not reflect that these had been given. Following the inspection we were provided with records that showed paracetamol had been given twice daily on three days prior to the inspection. This meant that due to

ineffective communication between staff and the infrequent administration of the homes supply of paracetamol, the person may have experienced pain unnecessarily.

The service did not provide nursing care at the time of inspection but an application was in progress to provide this service. A member of the management team told us that they had plans to work with the local hospice to ensure that they could provide very good end of life care for people. This was planned for the future. At the time of the inspection we found that people had their wishes documented in their support plans. Some people had 'Do not attempt to resuscitate' (DNAR) records on file. However, staff were clear who this related to. We discussed the need for staff to be aware of this information as a matter of urgency and the management team agreed they would look at ways to inform staff in an instant while promoting confidentiality.

People and their relatives told us that there wasn't much to do in the home. There was an activity plan in place which was delivered by one activity staff member and newly appointed activity staff were in the process of commencing work at the service. Staff told us that there wasn't much in the way of activities regularly for people as care staff did not have the time to deliver this. We didn't see any activities being participated in but we did not some people having their nails done and another person cleaning round some tables on one unit. However, we found that activities in and outside of the home needed to developed to ensure it was reflective of hobbies, interests and preferences. The management team were aware of this and had arranged for some staff members to attend a training course in relation to exercise and getting people moving. A member of the management team told us, "It's our hope that this will help people get involved and feel more energised." The service had a shop which was run by a volunteer and a staff member told us there was a shop trolley on a Monday. However, the shop wasn't open on the day of inspection and a person told us it was not open often.

People told us that they felt able to speak to care staff if they were worried about anything. Family members told us that they could speak to the Managers. Although some said there seems to be a lot of changes in staff or management. There had been two complaints received since the service opened and these had been addressed and closed. Relatives told us that they knew how to raise concerns but had not needed to. One relative said, "We were told how to complain when [name] first moved in." We saw that the complaints process was accessible to help people and their relatives.

People and their relatives were asked for their views through meetings. Regular resident meetings were planned so that people could give their views on menus and activities and were asked for their views on the service. There were plans for a survey to be completed in the future. However, one person told us that they were frustrated with questions they had raised. They told us, "Every time I ask about the cinema they say it's not ready yet, I really like films and it would give me something to do. They say the chairs haven't arrived yet. I've been waiting 6 or 7 weeks now. The shop is never open, it says 10 till 3 pm but it's never open or rarely I don't like to keep asking but miss my chocolates and toiletries I could get there. I don't always get my newspaper even though I pay for it, sometimes I have to ask for it. I think I'm supposed to have monthly meeting with the residents and relatives/carers but that doesn't seem to happen either." We noted that many areas such as the meetings had only recently commenced. The management team told us that now the service was up and running they would be giving more attention to the areas raised in this person's feedback.

Good

Is the service well-led?

Our findings

The registered manager at the service was the nominated individual for the provider. They had registered as the manager in the absence of a permanent manager as it is a condition of their registration. The service had been supported by two interim managers from within the organisation during this period. The deputy manager who was well known to people and staff had recently left and the service was recruiting for a deputy manager with a clinical background. The new manager in post had started just the week before our inspection so was supported by the current registered manager and regional manager for the inspection. Although they were new to Anson Court, they were not new to the provider and the home they had been previously working at had been rated Good by a recent inspection. This demonstrated that they had the necessary skills and knowledge to develop and also sustain good practice in the home. We found that they were known throughout the home and staff stated that they were comfortable around them. We noted that the regional manager was also known throughout the home and they knew the people they were speaking to well, checking up on how they were and how things were going.

People were complimentary about the running of the home and the management team. However, one person said, "If I ask to speak to a manager I can usually do so but they seem to change a lot, there's quite a turn over." Another person said, "I came here because of the poor attitude of staff in my previous home I want to stay here, I'm quite happy the staff have a much better attitude here." We noted that people were comfortable speaking with members of the management team and they management team knew people well which indicated they spent time in the units on the home.

Relatives were also positive about the management team and how the service was run. One relative said, "The manager always completes their rounds and knows everyone's names." Another relative told us, "The manager is approachable and a team player."

There were quality assurance systems in place. These had not been used internally as regularly as planned prior to the arrival of the new manager but the regional and quality team had been providing checks and oversight. As a result any issues found were addressed. For example, any shortfalls in management of medicines were addressed and themes relating to unexplained bruising were investigated and reported appropriately. As part of our inspection we found that medicines were being managed safely, staff were aware of what they must do to ensure the safe practice and additional training had been given to staff to ensure safe practice in relation to moving and handling. We noted that there had been no recent unexplained bruising or errors relating to medicines.

The issues identified as part of the inspection, for example some gaps in record keeping, were discussed with the management team who had already identified these areas as needing further development, and had implemented action taken to ensure the shortfalls did not occur again. Staff had been reminded of the need to ensure records were completed consistently through meetings. Part of this was the improvement of care plans and updates to care plans and we found these had been reviewed prior to the inspection.

The management team worked with the local authority to ensure they were working in accordance with

people's needs and obligations within the commissioning contract. The service was also supported by a local care providers association who provided support with activities and training to help keep knowledge up to date.

Team meetings had been introduced where the management team and staff discussed changes to practice and any issues. The meetings included information to help staff remain informed about changes to the home and future plans. For example, new systems to address shortfalls found on quality checks. . There were also reminders about policies, safeguarding and whistleblowing and ensuring records were up to date. We noted that some of the issues in relation to records remained but the issues had reduced and these were being monitored by management.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken. They told us, "If I looks like I'm reporting a lot, I make no apologies, it's the right thing to do."