Manor Court Healthcare Limited

Anson Court Residential Home

Inspection report

Harden Road
Bloxwich
Walsall
West Midlands
WS3 1BT

Tel: 01922409444

Date of inspection visit:
25 August 2020

Date of publication:
05 November 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

About the service
Anson Court Residential Home is a residential care home providing personal care to 19 people aged 65 and over at the time of the inspection. The service can support up to 33 people.

People's experience of using this service and what we found

Incidents had occurred at the service where people may have required safeguarding. These incidents had not always been reported to the relevant agencies. Notifications of incidents had not been submitted to CQC as required by law.

Key risks to people's safety had not always been assessed, although staff were aware of how to manage these. Following the inspection, the provider sent evidence that they implemented risk assessments to cover the areas identified as missing.

Quality assurances systems were in place but were ineffective at identifying some of the areas for improvement found at this inspection.

There were sufficient numbers of staff to support people safely. Medicines were managed safely and the provider had implemented additional infection control measures in light of COVID-19.

People, staff and external professionals spoke positively about leadership at the service and felt the home was well led. People were given opportunity to feedback on their experience of the service and the provider worked effectively with other agencies to improve the quality of care provided.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (Published 07 January 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to the management of falls and monitoring of health conditions. As a result, 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. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well Led sections of this full report.

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

Follow up
We will continue to monitor information we receive about the service until we 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?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Anson Court Residential Home

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was completed by two inspectors and an assistant inspector.

Service and service type
Anson Court Residential Home 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.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with Covid-19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with three people who used the service about their experience of the care provided. We spoke with four visiting health professionals, two members of staff and the manager.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We spoke with three relatives over the telephone. We also spoke with three members of staff via telephone. We held a teleconference with the provider, nominated individual and manager to gain additional information and provide feedback.

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.

Systems and processes to safeguard people from the risk of abuse

● Potential safeguarding incidents had not always been identified or reported. Incident records showed that one person had been physically aggressive to others on seven occasions. The manager had not reported these as safeguarding incidents. We raised this with the manager who acknowledged that although they had sought external advice to support the person and ensure people's safety, they had not identified these as potential safeguarding incidents and provided assurances that these would be submitted to the safeguarding teams retrospectively.

● Staff we spoke with understood their responsibility to report any concerns of abuse. One staff member told us, "I would report any concerns and the managers would then do their own enquiries. I absolutely know they would act on it [my concern]".

Assessing risk, safety monitoring and management

● Risks to people's safety were managed in an inconsistent way. For some people, risks to their safety had been assessed and records provided detailed guidance on how staff should support them. However, for others, key risks had not been assessed. Following the inspection, the provider sent evidence that they had acted on the feedback from the inspection in relation to risks.

● Two people were known to pose risks to others and display behaviours that can challenge. Although staff were aware of this risk and how they should respond to this, there were no risk assessments in place guiding staff on how to support people safely.

● Although window restrictors were in place, these did not follow national guidance to ensure people were protected from falls from height. We raised this with the provider who informed us that the window restrictors had been replaced the following day.

Preventing and controlling infection

● There were safe infection control practices in place. The home had considered the risks associated with COVID-19 and had installed additional handwashing facilities around the home. Staff were seen to be wearing PPE as required and handwashing frequently.

● We identified some areas around the home that required improvement to improve infection control practice. This included a shower chair that showed evidence of rust, and extractor fans that required cleaning. The provider responded to these immediately.

Staffing and recruitment

● People told us there were enough staff to meet their needs. One person told us, "Staff are always here. Sometimes they come to you quickly and sometimes they don't. It depends on how busy they are but it's

not a long wait." A relative added, "Staff are always around. When [person] is in the lounge, there is always a staff member there."
● We saw there were sufficient numbers of staff available for people, and people were supported in a timely way.

Using medicines safely
● People told us they had support with their medicines in a way that suited them. One person commented, "They [staff] always do my medicine and make sure I get it at the right time."
● We reviewed records kept in relation to medicines. These indicated that medicines had been given as prescribed, and where needed, protocols were in place advising staff on when to administer specific medicines.

Learning lessons when things go wrong
● The manager and nominated individual displayed their keenness to learn lessons. Where accidents occurred, records showed that action was taken to reduce risk in future. For example, where people experienced falls, additional equipment and support from external professionals had been sought.

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.

At the last inspection, the provider was found to be in breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made the quality assurance systems and identified areas for improvement were being acted on. The provider was now meeting Regulation 17. However, further work was required on ensuring these systems consistently identified issues.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider was not meeting regulatory requirements. The home did not have a manager registered with CQC as required as part of their conditions of registration. The last registered manager left the service in October 2019. An application was made prior to the inspection to register a new manager. This application is currently being considered.
- Quality assurance systems had been updated since the last inspection and where these identified areas for improvement, action had been taken to improve. However, the systems in place had not identified the areas for improvement found at this inspection.
- For example, audits completed on the environment had not identified that window restrictors did not meet requirements. In addition, reviews on care plans had not identified that key risks to people's safety had not been assessed.
- The provider had not implemented systems to review incidents that occurred. This meant they had not identified any patterns for incidents or the lack of guidance for how staff support people during incidents.
- Following the inspection, the provider gave assurances that they were making improvements to their quality assurance systems.
- Notifications of incidents had not been reported to CQC as required. We found seven incidents between service users that we had not been notified of. We raised this with the manager who advised these would be sent in following the inspection.

The failure to notify CQC of incidents is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

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

- Where incidents had occurred, the manager had been open, transparent and shared these with the

relevant people. However, as the manager had no systems to review incident forms, some instances where people may have required safeguarding had not been identified or reported. This meant the provider was not always meeting the duty of candour. Following the inspection, the provider informed us they would be implementing systems to monitor incidents.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People, relatives and external professionals spoke positively about the leadership at the home. Comments made included, "I know [managers name]. They are very good. They have changed a lot of things here for the better", and "I think the service has improved over the last 12 months, especially since [managers name] took over. There is a feeling of calm now."

● Staff told us they felt supported by the manager and that staff morale had improved. One staff member told us, "[Managers name] is brilliant. It has changed for the better definitely, we are more supported by management." The manager told us and staff confirmed, the provider had sought counselling for staff who worked through the COVID-19 pandemic to support their well-being. Staff spoke positively about the effect this had on their well-being.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives told us they had been asked to feedback on their experience of the service. One relative told us, "We have had forms to fill in and say how we think the home is doing."

● People told us they informally had opportunity to speak with the manager and provide feedback and that this feedback was acted upon. One person told us, "I can always go to them [the manager], I have to admit, they have always been there for me…for all of us. Managers are there if you want them."

Continuous learning and improving care; Working in partnership with others

● External professionals gave positive feedback about the provider and management team learning and improving care. One professional told us, "From our perspective, there has been a lot of improvement. For example, the manager identified improvement was needed around oral care and with our support, changed their practices."

● Other professionals told us that the manager was keen to work with them to improve the service. The professional added, "The nice thing is [manager] is so willing, whatever we suggest, they say yes, lets do it. They are always positive."

● The manager provided examples of how they changed practice to improve people's health outcomes. For example, the introduction of calorific snacks throughout the day and review of menu's had led to an improvement in a number of people's health; demonstrated through regular weight assessments.