Manor Court Healthcare Limited

Anson Court Residential Home

Inspection report

Harden Road
Bloxwich
Walsall
West Midlands
WS3 1BT

Tel: 01922409444

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Anson Court Residential Home is a residential care home providing personal care for up to 33 people across two floors. At the time of the inspection the service was accommodating 21 people, some of whom were aged over 65 and living with dementia.

People's experience of using this service and what we found
Relatives and all people we spoke with gave positive feedback about the staff and the home. However, we found shortfalls throughout the inspection which impacted on the safety and quality of care for people.

People had been put at risk of potential, avoidable harm. Checks had not always identified significant loss of weight for people, food was unsuitable for one person's dietary needs and the use of inappropriate moving and transferring techniques by care staff.

The service was not well led. At our last six inspections, we have had continuous concerns the governance systems were ineffective to monitor the quality and safety of the service. This has continued to be a concern at this inspection. The provider had not taken prompt action to make the necessary improvements. The quality assurance systems were significantly lacking and were not robust. The processes had not identified all of the concerns in the service. Records were not always complete. Care plan reviews were of poor quality and ineffective at improving care.

Risks associated with people's health had been identified. However, there was limited information within people's care plans for staff to follow to support people, particularly for people who may present with behaviours that could be seen as challenging.

The home had adequate processes in place to monitor infection control. Staff had access to a supply of personal protective equipment (PPE). Carpets and furniture were regularly cleaned. However, this had not prevented an unpleasant odour emanating around the home from a carpet in the main lounge area.

Medicines were overall administered safely. The auditing of medicines required some improvement to prevent the over stocking of some medicines. Protocols required some improvement to give staff the guidance they needed to support people unable to verbally tell people when they were in pain.

Incidents and accidents were being recorded on a regular basis and there was an analysis of the data to identify for trends to support the implementation of improvements to mitigate the risk of reoccurrences. However, not all outcomes were recorded to provide staff with guidance how to support people safely.

Training for staff had not been effectively monitored. We found shortfalls with training for a number of staff, particularly regarding training for first aid, dementia awareness and behaviours that may be seen as challenging.

Some work had started within the home to become more dementia friendly. However, there remained a significant amount of work left to be completed.

The overall dining experience for people required improvement. People who required support from staff to eat did not always receive this.

People and the relatives we spoke with, felt people were treated with dignity and respect. We saw some kind and caring interactions between people and staff. However, we also observed people were left for long periods of time with little or no stimulation or staff engagement.

The service worked with other health and social care agencies to monitor people's health and wellbeing, although timely intervention had not always been sought.

There were processes in place to safeguard people from abuse. Appropriate recruitment procedures ensured new staff were assessed as suitable to work in the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 15 February 2022) and was in breach of regulations. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations. The service has deteriorated to inadequate.

Why we inspected
This inspection was carried out to follow up on action the provider told us they had taken following the last inspection. It was also prompted, in part, due to concerns received about staff training, poor governance and risk. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make further improvements. Please see the safe, effective, caring, responsive and well-led key question 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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the home environment continued to be poor and did not support

people's autonomy. Staff had not recognised some of their actions when supporting people were not always respectful. People not always receiving personalised care and not always being treated with dignity and respect. Some people's nutritional needs were not being met and had been put at risk of potential avoidable harm. There was a lack of effective and adequate training for staff and inadequate governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below	**Inadequate**

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 Health and Social Care Act 2008.

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

Inspection team
The inspection team comprised of two inspectors.

Service and service
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.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

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 did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. Please refer to the well-led question of the report for further details. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information on the Healthwatch website. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and four relatives about their experience of the care provided. We spoke with four members of staff, the deputy manager, a company director and supporting consultants commissioned by the provider to support 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.

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

After the inspection
We contacted relatives and staff by telephone and continued to seek clarification from the provider to validate evidence found.

Inadequate

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 deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Since our last inspection in November 2021, we saw three people had lost significant weight over the last six months. The provider had failed to identify the weight loss and no action had been taken to check people were not malnourished or the weight loss was being caused by other health conditions. This meant people were put at risk of potential, avoidable harm because any underlying health condition, contributing or causing the weight loss, had not been considered or referred for further consultation with health professionals, such as the GP or dietician.
- One person who had lost weight had a separate health condition that could be a cause of unintentional weight loss. The risk of weight loss had not been identified or considered in the person's care plan. This meant the person's weight was not being effectively monitored and no action had been taken to ensure the person's health condition was being managed safely. For example, the risk of harm to people with a food intolerance had not been effectively assessed.
- Prior to the inspection we had received information of concern relating to the moving and transferring of people who required the support of a hoist or similar equipment. Conversations with staff confirmed unsafe practices had been used to move two people. One staff member told us, "At the moment [person] is standing on one leg and we are weight bearing them but only very slightly. An alternative way is with the handling belt but I've not recently had training for the handling belt, previous ones were awkward (to use). I'm sure [person] is waiting to be assessed (for the hoist). The only way we transfer [person], they will weight bear, not too long though, and we more or less have to carry and lift them sometimes." This action had put the people and staff at risk of potential, avoidable injury.
- A situation had developed in the home which had the potential to put people at serious risk of harm. Two people told us how unpleasant it was at night for them with people banging on their bedroom doors trying to get in. A relative told us, "It's like living on a knife edge" when they visited the home. A number of incidents had occurred and staff did not have the necessary knowledge and skills to support the people involved safely. Post inspection, we received a further two notifications of incidents that had put one person in particular at significant risk. The staff had 30 minute observation checks in place which had not been effective at mitigating and reducing the risk.

We found evidence people had been put at significant risk of avoidable harm and this was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately following the inspection site visits, the consultants took the following action. Referrals were submitted to health professionals for those at risk of weight loss. People had been assessed for the hoisting

equipment. Staff had received training on how to use the hoist and new equipment was purchased. One person was supported by the service and relevant agencies to relocate to a more suitable placement.

● At the last inspection we identified improvement was required when assessing health risks to people. The risks posed by significant weight loss had not been identified. We also found risks associated with managing behaviours had not been consistently recorded in people's care plans. This meant staff were not provided with clear guidance on how to support people in a consistent and safe way.
● At the last inspection we identified window restrictors did not restrict all windows from opening 100mm or less in line with the Health and Safety Executive (HSE) guidance (Falls from windows and balconies in health and social care HSIS5 (hse.gov.uk). At this inspection all the affected windows had been restricted to the legal opening requirement of 100mm.
● Fire-fighting equipment had been checked. Regular fire alarm testing was completed on a weekly basis. People had personal emergency evacuation plans in place and staff knew what action to take in the event of an emergency. The service had a recent fire risk assessment completed since the last inspection.

Using medicines safely
● Protocols were in place for medicines prescribed for people on an 'as required' basis. However, they required more information for staff on how to support people with de-escalation techniques. Additional information was also required to support staff with signs, noises and behaviours people may display that could indicate they required pain relief.
● We found best interest decisions had been made for people that required their medicines to be administered covertly. However, there were no protocols in place for staff to follow on how to administer the medicines safely. For example, there were no requests for a pharmacist's input to check the medicines could be mixed with the food and drink staff were using.
● There was an overstocking of some 'as required' medicines. The amount of medicine in stock was correctly accounted for. However, no action had been taken to stop the over-ordering of medicines no longer required.
● One person found a half-chewed tablet on the floor and gave it to the inspector. It could not be confirmed what the tablet was, who it had been administered to or how long it had been on the floor.
● Medicines were being safely stored.

Preventing and controlling infection
At the last inspection we had identified a breach of regulations around the service's infection control practices. At this inspection we found there had been enough improvement to meet the required standard and the service was no longer in breach of this section of the regulation.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The provider had engaged the services of a professional company to update their policies. However, there were some infection control practices and keeping up to date with government guidance that required some improvements.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. There had been some action taken to improve the layout of the home environment, however there remained some areas for improvement such as making sure bath chairs were cleaned thoroughly immediately after use.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
The provider was facilitating visits for people living in the home in accordance with the current guidance. However, the provider may wish to revisit the guidance. Relatives we spoke with were unsure why they were unable to visit their family member in their own bedrooms.

Learning lessons when things go wrong
● Incidents and accidents were recorded. There was an analysis to identify for trends and implement action plans to mitigate against future reoccurrences. However, actions were not always taken to reduce risks going forward. For example, we found that people's care plans and risk assessments were not always updated to support staff following incidents.

Staffing and recruitment
● We found staff were busy and did not always have time to sit and engage in meaningful conversation or activities with people. However, there were enough staff on duty to support people with their day to day care needs.
● There were recruitment checks in place to make sure staff were safely recruited.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding incidents were recorded and showed referrals had been made to the local authority safeguarding team. However the provider did not ensure that people were not put at risk of abuse as following the inspection site visits, three safeguarding alerts were raised with the local authority.
● Staff were aware of their legal responsibilities to keep people safe from risk of abuse. They knew how and who to report concerns to.
● People and relatives we spoke with told us they felt the home was a safe environment for people to live in. One relative said, "Yes, I think [person] is safe. There are double doors which are locked and you have to have a number to get out. There's a lovely area in the garden which is safe as well."

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection, this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

● One person had been prescribed food supplements but had continued to lose weight. Records did not always show the person was supported in taking the food supplements. The person's food intake was low with no food being taken at all on some days. The person's care plan stated they needed staff to support them with eating. One staff member told us, "[Person] is a bit down with their eating and they (staff) do need to encourage [person] to eat. We try to give them extra snacks and biscuits to build them up but [person] needs more attention to try and have someone sit with them a bit to try and encourage them to eat a bit more to put weight on as their weight has dropped." We saw the person walked constantly around the home without any support from staff to try and eat. Records we looked at showed the provider had failed to identify the person had continued to lose weight. The person was not eating regular amounts of food and no additional action had been taken by the provider to refer the person to the appropriate health professionals. We were told by a company director that the previous consultants, which were no longer involved at the home, had identified the person's weight loss in April 2022. We saw the consultants had made the referrals for additional support for the person

● Another person had lost a significant amount of weight since our last inspection in November 2021. The person was not being monitored for their dietary intake and the service could not demonstrate how often the person was eating. The person had been weighed twice since November 2021. Their weight loss was recorded, although the amount of weight lost differed from record to record. We found no action had been taken to investigate the weight loss or any referrals made to health professionals.

● Another person had specific dietary requirements. We found the person had not always received appropriate meals and the food given had the potential to cause stomach discomfort and pain. We found the cooking processes in place had the potential for cross contamination. The person was also unable to explain if they were in pain and would demonstrate their pain or upset through noises, facial expressions and sometimes an anxious demeanour. We reviewed the person's 'as required' medication and found they had been administered medication for their demeanour on a daily basis. No additional action had been taken to refer the person to appropriate health professionals to check their diet or to examine the reasons for the person's anxiety.

● Since the last inspection, the provider had introduced a 'white board' into the main dining area with pictures of certain foods attached. The pictures were randomly placed around the board in a confusing layout. It was difficult to establish what were the choices of meals available for that day. On the second day of our inspection, the date and menu options on board had not been updated. This could lead to confusion for people living with dementia.

● The meals looked and smelt appetising. However, people that required some support to eat did not

receive it.
● We saw one person walking around the home with a plate of chips; they left the chips and continued to walk around the home with the cutlery. A staff member removed the cutlery from the person but had not made any attempt to find out if they had eaten their meal. On checking the person's records, we found they had not.
● We saw another two people in the television lounge area had not touched their meals. One person had tried to eat but was unable to use the cutlery properly. A staff member came into lounge and took the untouched meals away without asking if the people wanted anything else but did offer a pudding. One person told the staff member they did not want or like the pudding. The staff member did not offer any alternative and gave the person a pudding asking them to 'just try it'.

We found no evidence people had been harmed, however, people had not been supported effectively and consistently with the nutritional needs and was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw improvement was required for people during their lunchtime mealtime experience. Staff had started to bring people into the dining area from mid-morning for lunch. Another staff member explained to people what was on the menu and asking what they would like to eat. Once the lunch orders had been taken, staff returned to the dining area and started to encourage people to move back to the lounge area. Most of the people that were moved out of the dining area looked confused and disorientated and did not know what was happening.
● People were offered and provided with drinks throughout the day.

Staff support: induction, training, skills and experience
● We had received information of concern staff had not completed the appropriate moving and handling training. At the time of the inspection, training had been introduced to staff and most of this training had been or was in the process of being completed. However, staff we spoke with confirmed they had used unsafe moving techniques because they were unable to use the equipment. There was confusion over which person had and had not been assessed to use the equipment. Some staff did not know where the hoist was and those that did told us it was out of order.
● Staff told us they had not received any training to support people with behaviours that challenge. One staff member said, "We've had no training, never had any advice or anything because we don't come across (this type of behaviour). I suppose we could have a course on how to restrain people or defend yourself to help us in the future. I walk away because if you stay you make the situation worse, let people calm down and another staff member or you approach them. We try to keep people calm and look after them as best we can."
● Staff did not have the experience, training or knowledge to support people who became anxious and displayed an unsociable demeanour, due to their dementia, safely. This meant people and staff were put at risk of avoidable harm because staff did not know de-escalation techniques or how to calm a situation down. Staff we spoke with all told us they would tell the senior so the person could have their 'as required' medicine. Records looked at showed only three of the 18 staff had completed some level of coping with aggression, challenging behaviour type training.
● Records looked at showed staff had not received recent training to support people living with dementia. Out of 18 senior and care staff only six had completed dementia training.
● Some staff had been asked to 'step up' into roles they were not trained for. For example, some staff were requested to stand in as a temporary cook, when they had not received the appropriate training to prepare specialised diets to meet people's food intolerances. This put people at risk of potential harm because they were eating meals they had an intolerance to.

● Some staff had been asked to review and update care plans without the necessary care planning experience and training. This meant the care plans were vague, not always reflective of people's needs and information was missing altogether.

We found no evidence people had been harmed, however, staff had not received appropriate support and training as necessary to enable them to carry out their duties and was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection site visits, the consultants took the following action. Training has been reviewed and face to face training has being implemented for staff, including additional training for staff working in the kitchen. Additional training is to be arranged to support staff in dementia awareness and understanding behaviours. All care plans and risk assessments are to be reviewed.

● Staff new to the service told us they had completed their induction training and shadowed more experienced staff for three to four shifts before working on their own.

Adapting service, design, decoration to meet people's needs
● At the last inspection we found improvement was required to the decoration of the home to make the environment more accessible for people living with dementia and promote their independence. At this inspection we found work had started on some improvements, for example some bedroom doors had been painted a different colour. However, continued improvement was still required to the decoration of the home. For example, removing old and worn out material covered chairs that were difficult to clean. A carpet in the main television lounge that omitted an unpleasant odour of urine needed to be replaced. One staff member told us, "We are constantly cleaning that carpet, we do it regularly but it still smells and it needs to be thrown out." Another staff member said, "The home has got better but the carpets are disgusting."
● We found there had been some improvement to the layout of furniture in the main television lounge. The lounge chairs had been repositioned and we saw this had encouraged conversations between people because they were seated closer together and improved their view of the televisions. However, on the second day of our inspection the chairs were back along the edge of the room. We were told staff had not put the chairs back following an activity because 'they' (the staff) did not like the new layout.
● People had access to a garden area. However, health and safety checks on the garden had not identified some of the garden furniture was broken and an ashtray in the resident's smoking area was full of discarded cigarette ends.
● There were suitable visiting areas available for people to meet their loved ones such as a quiet lounge or visiting pods.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed prior to them moving into the home. These assessments considered people's medical history and current care needs. Improvement was required to make sure the assessment process was more robust at identifying people whose care needs could not be met by the service. For example, people who required a high level of dementia support and could become restless, anxious and upset with unsettled demeanour.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We saw evidence to support people had access to healthcare services. Records showed people had been seen by health professionals such as visiting nursing staff and GP. However, there had been no action taken, by the provider, to make the appropriate referrals to support people with significant weight loss.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Where there were concerns over people's capacity, mental capacity assessments had been completed.
- Staff we spoke with gave examples how they sought consent from people before providing them with support.
- Where DoLS authorisations had been granted, they were being reviewed and processes were in place to submit new applications when expired.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection, this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives told us they felt people were treated with dignity and respect. However, we saw instances when this was not always the case. For example, we saw one staff member leading a person by their arm into the dining room at a walking pace the person had difficulty keeping up with.
- We visited one person's bedroom and found there was a strong odour of urine within it.
- People living in the home were mainly supported as part of a group and had limited opportunities to do things to develop their own individuality. For example, we were told one person like gardening but we could not see from records or conversations with staff, how the person had been supported or encouraged to follow this interest.
- Some improvements within the home had started to take place. However, the offensive smelling carpet had remained. By not replacing the carpet this demonstrated an insensitive approach to creating a caring and respectful environment for people to live in. As well as the general state of the home environment we identified some small, easily fixable issues that could be addressed quickly. For example, we found some effort had been made to personalise people's bedroom doors (on the first floor) with photographs and memorabilia familiar to the person. However, this had not been completed across the home and some people continued to have difficulty locating their own bedrooms.
- There was a lack of recognition that some people required support to eat their meal leaving them to struggle and spill their food, or not eat anything at all.
- We saw one staff member talk loudly to one person (who was hard of hearing) in a crowded dining room, explaining they needed to 'stand up for pressure relief'. We could see the person looked confused and did not stand up. The staff member was then heard to say, "[Person] doesn't want to, (move or stand up) we'll have to leave them."
- Interactions by staff were task-based rather than focused on the needs of people. For example, staff members were seen to stand over people, when they did provide support with their meals, rather than spending time and sitting next to them.
- Records regarding people's care and treatment were stored securely. However, we were told by one relative and one person living at the home, about a confidential situation they should not have been made aware of. They told us staff had explained to them the personal circumstances of another person living in the home. This was not respectful to the person's situation and breaching their confidentiality.

We found no evidence people had been harmed. The home environment continued to be poor and did not support people's autonomy. Staff had not recognised some of their actions when supporting people were

not always respectful. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with told us staff were kind and friendly. One person said, "I'm very well looked after, the staff are all lovely and take good care of me." Another person told us, "It's very good (at Anson Court) I'm looked after, I couldn't manage at home on my own."
● Relatives told us they were very happy about the support people received. They told us they found staff were knowledgeable about their family member's needs, were caring and kind towards people and themselves. One relative said, "Yes definitely (treated with dignity and respect). The staff know [person] very well and tell me things about their likes and dislikes that only I would know."

Supporting people to express their views and be involved in making decisions about their care
● People who could tell us and some of the relatives confirmed they had been involved in decisions about people's care.
● Staff we spoke with demonstrated in their answers how they supported people to make choices.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to provide person centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

● The recently reviewed electronic care plans were in date. However, we found several concerns relating to the quality of the care plans and risk assessments. Care plans and risk assessments not always containing enough detail to ensure people were supported safely and not reflecting the support required for people. For example, a serious incident had occurred involving one person and this had not been reviewed and added to the person's care plan. This meant staff were not given direction or guidance on how to effectively support in a person-centred way.
● At the last inspection, we identified staff had been instructed to ask people, who had the ability to look after their own personal care needs, whether they had opened their bowels each time the person went to the bathroom. There was no medical reason why staff would need to know or ask this question and indicated a task-based approach to monitoring people's personal care as opposed to a person-centred approach. At this inspection we found this practice had continued.
● The provider's own action plan stated flash cards and picture menus were used to support people to make decisions. For example, what they wanted to eat. During the two days on site, we did not see these visual aids being used. People were asked what they wanted for lunch and it was clear from some people's responses and reactions, they did not know how to answer the question.
● There was a planned, weekly, activity programme displayed in the corridor. On the first day of our inspection we saw the staff start a group activity. The CD player became stuck with loud music being repeated. This noise continued for six minutes. Staff walked past the room and did not try to switch the music off or reset the CD player. Some people visibly looked confused.
● Over the course of the two days we were on site, people were left sitting for long periods of time without any additional stimulation or interaction from staff.
● Some staff took time to chat with people. Yet we also observed people were walking around the home, confused about where they were and with little or nothing to occupy their time or engage them in meaningful interactions. One person told us, "I'm going brain dead (with nothing to do)."

We found no evidence people had been harmed. However, people were not consistently receiving person-centred care and this was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

● People were supported to keep in touch with family and friends. This included pre-arranged visits to the home. One family member told us, "I have nothing but praise for the staff, they are absolutely wonderful and do a great job."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care records showed there had been some consideration given to people's communication needs. However, we saw this had not always been effectively followed in practice. For example, staff not using flash or picture cards.

Improving care quality in response to complaints or concerns
● There had been no complaints raised with the provider. There was a complaints process in place that would investigate concerns if they were to arise.
● Relatives told us if they had any concerns they felt comfortable to raise these with the staff.

End of life care and support
● At the time of the inspection no one was currently receiving end of life care.
● There was information in people's care records to show discussions had taken place with some people and relatives about their wishes and preferences in respect of end of life care.

Inadequate

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 inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to make sure there were effective governance processes in place to monitor the quality and service delivery. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulations.

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

- Significant shortfalls were identified at this inspection. Systems and processes to monitor the service were not robust. This meant they were not always effective, did not drive improvement and did not identify the issues we found at this inspection. There were breaches in relation to dignity and respect, meeting nutritional and hydration needs and staff training. There were continued breaches in safe care and treatment, person-centred care and governance.
- We have continued to take enforcement action to drive the changes needed. However, the provider had continued to fail to make the necessary improvements.
- Since the last inspection, the provider engaged the services of two independent consultants. The first consultants in April 2022 and the second consultants in May 2022. Up until this time, there remained a lack of consistent and effective management and leadership. There has been no registered manager since October 2019.
- Quality assurance checks had failed to identify some of the garden furniture was broken and the ashtray used by people was full to capacity.
- Medicine audits had not identified the issues around overstocking of 'as required' medicines.
- Reviews of care plans and risk assessments had failed to identify people's weights were not being accurately or regularly monitored, recorded and referred to health professionals. The provider's own internal monthly audit to CQC reported all people's weights were being completed and monitored when this was not the case.
- A monthly report required to be sent to CQC had not been submitted since the last inspection. Following this inspection, the consultants managing the service sent CQC a monthly action plan and the outstanding monthly reports. We were told the reports had been completed each month but had been submitted internally between the home manager and the then NI but not sent to CQC. This meant the governance processes the provider had in place to submit the monthly reports was ineffective.

We found no evidence people had been harmed. However, the continued failure to address inadequate monitoring of governance processes to make the necessary improvements to the service was a continued

breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not return the Provider Information Return. This was emailed on 12 January 2022 with a deadline for submission by 12 February 2022. It is a requirement all providers complete this document to update and inform CQC of key information about the service, what it does well and improvements they plan to make.
● Since the last inspection the provider employed a new Quality Assurance and Compliance Officer. Internal reports from March 2022 to May 2022 had identified some areas for improvement and listed the action taken.

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
● CQC had been informed of all notifiable incident and events, as the provider is legally required to do so.
● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents and incidents occurred. Relatives confirmed they were kept informed and updated if their family member had been injured in any way and received apologies where appropriate.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us they felt supported by the deputy manager and consultants. However, staff did not feel supported by the provider. Comments included, "I don't feel supported because I think the person who owns the place (Anson Court) doesn't listen to what we want. All they want is their way or no way. When we explain what we can and can't do they're not interested; we do need people we can go to and communicate with." "The owner doesn't listen about what needs to be done. They won't spend the money and it's the residents' home. They need to let us get the home back on track and how it should be run but they won't let us do that. It frustrates me. It's like walking on eggshells and we shouldn't be feeling scared what they (the provider) are going to say to you."
● Systems and processes were reintroduced in April 2022 to ensure staff had access to supervision. Staff confirmed there were team meetings.
● The provider sought feedback on the quality of the service using quality assurance surveys sent to people and relatives.
● All the relatives we spoke with told us they were kept informed of any change to their family member's health needs.

Working in partnership with others
● Care records showed the service worked in partnership with health and social care professionals such as the community nurses and GP.