Manor Court Healthcare Limited

Anson Court Residential Home

Inspection report

Harden Road
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Walsall
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Tel: 01922409444

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20 March 2019

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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 provides accommodation to 33 older people and people with dementia, that required support with personal care. At the time of this inspection, 32 people lived at Anson Court Residential Home and received support with personal care from the service.

People's experience of using this service:
We found that care and support was not always provided in a safe way. Risks to people were not effectively assessed to ensure peoples safety. There was a lack of governance systems and oversight which caused audits and checks to be ineffective. This led to people being at risk from multiple falls. The administration of medications and moving and handling practices were not consistently safe.

People were supported by staff who knew how to report concerns of abuse.

Care plans were task orientated and did not reflect people's choices or how to help them to make choices in how they were supported. The service relied on people's relatives to deal with cultural needs.

The dining experience was not positive. People did not receive effective support to eat their meals with people's meals being removed before they had finished. People's nutritional requirements were not met.

Improvements had been made to the environment. The provider had put in place a new wet floor shower room and had created a conservatory area that led to the enclosed garden. This enabled people to independently access the enclosed garden.

People were not consistently supported to access specialist health care services, such as dieticians, when they needed to. This meant that people's needs were not always met in a safe way.

Rating at last inspection: Rated Requires Improvement. (Report Published 7 March 2018)

•□Why we inspected: This was a planned inspection based on the ratings at the last inspection. The inspection took place on 19 and 20 March 2019.

•□At the previous inspection in October 2017, it was identified people's health and safety was not managed in a consistent way and records lacked detail, quality assurance processes did not effectively identify issues. At this inspection we found that this had not improved.
This is the third consecutive inspection where the provider has failed to achieve an overall "Good" rating.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Enforcement: Full information about The Care Quality Commission's (CQC) regulatory response to more serious concerns found in inspections and appeals, is added to reports after any representation and appeals

have been concluded.

Follow up: As we have rated the service as inadequate, the service will be placed in `special measures`. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the providers registration of the service, we will inspect again within six months. The expectation is that providers found to be providing inadequate care should have made significant improvements within this time frame.

If not, enough improvement is made within this time frame, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than twelve 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 always effective Details are in our Effective findings below.	**Requires Improvement**
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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by an inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of being a family carer for older people and people with dementia, who use regulated services.

Service and service type:
Anson Court Residential Care Home provides purpose-built accommodation and personal care to a maximum of 33 older people and people with dementia.

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

Notice of inspection:
This inspection was unannounced.

What we did:
We sent the provider a provider information return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information included in the PIR along with information we held about the

service. This included notifications received from the provider about deaths, accidents, incidents, and safeguarding alerts, which they are required to send us by law. We also contacted the local authority who commissioned services from this provider, to gain their feedback.

We spoke with four people that used the service and six relatives to gather their views on the service being delivered. We carried out a Short Observational Framework for Inspection (SOFI) to observe the interactions of people unable to speak with us. We also spoke with the nominated individual, the registered manager, deputy manager, activities co-ordinator and five staff members. We used this information to form part of our judgement.

We viewed a sample of files and records, including six people's care plans, incident and accident records, compliments and complaints received by the service, medication records and staff recruitment and training records. We also looked at records about the safety and maintenance of the environment that people were living in. We looked at audits and quality assurance work conducted by the service.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- At the last inspection it was identified people's health and safety was not managed in a consistent way. At this inspection we found that this had not improved. We found people's care plans lacked information on how to deliver safe care, to meet new or changing needs. One Persons care plan stated fluids should be `stage 1 syrup consistency`, this was not always followed by staff. This meant that people were exposed to risk of choking.
- At the last inspection, it was identified that falls information was recorded but was not analysed to show emerging risk. At this inspection we found that this had not improved. We found that people were experiencing multiple falls, which places people at unnecessary and unmanaged risk of serious injury.
- Staff competencies were not checked during or following moving and handling training. We observed moving and handling equipment was not being used safely. We saw the technique used for slide sheets and safety checks for wheelchair use were ineffective. The movement of people was not effectively planned, we saw that safe working areas were not created prior to the use of hoists. This placed people at risk of harm.
- The service could not demonstrate it was learning lessons when things went wrong. Systematic failings in the auditing process meant concerns about safety, raised during this inspection, were not identified. The Registered manager did not have a system in place for analysis of information to identify emerging risk. People were therefore exposed to avoidable harm.

Using medicines safely

- At the last inspection it was identified that improvements were required in the system operated by the provider, to demonstrate people got their medicines as required. At this inspection we found that this had not improved.
- We found people were not always getting their medications as prescribed and when they did staff did not consistently record administration of medication. Protocols for `as and when required medication` were not in place. Insufficient information was available to enable staff to administer this medication safely. We found that the reason for using `as and when required` medication and the outcome experienced by the person, were not recorded. This meant that medication reviews may not be effective. This could lead to people's symptoms not being effectively managed. The deputy manager acknowledged that this was an issue and agreed to make improvements"
- Medication storage was not consistently safe. We saw prescribed drinks, liquid medicines and equipment used in administration, including medicine cups, spoons and syringes, were not safely secured. People were seen to touch and handle the items, unseen by staff. This places people at risk of harm.

The was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

•□People told us they felt safe. One person said, "I've never felt unsafe". Another said, "It's not unsafe here I wouldn't change anything".

•□Staff knew the correct procedure to protect people from risk of abuse. Staff told us they had received training in how to protect people and the training records reflected this. One member of staff told us, "If I suspected abuse I would go straight to the manager, then whistleblowing if needed". Whistleblowing is where staff can anonymously raise concerns to the appropriate place, such as the local authority safeguarding team.

Staffing and recruitment

•□People, relatives and staff all told us that there was enough staff to meet people's needs. One relative told us "The team is amazing, but we have two that we consider as our `go to` staff members". One staff member told us, "We have the same amount of staff on duty at the weekend as we have during the week". We found staff responsiveness to people's needs was inconsistent.

•□The registered manager followed a safe recruitment process. Staff had been required to produce references and complete a check with the Disclosure and Barring Service prior to starting work.

Preventing and controlling infection

•□Staff told us they had received training in infection control and the training records supported this. Staff told us that personal protective equipment was available to them and we saw this in use.

Requires Improvement

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

RI:The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- Staff received induction training. Our observations and the information within training records indicated there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's care needs.
- Records stated nine staff had not been trained in person centred care, 13 had not been trained in diet and nutrition and 11 had not been trained in safeguarding. We could not find evidence of staff receiving training in assisting people to eat. This means that people are receiving support from staff that may not suitably skilled to support them.
- We found there was a lack of competency assessments prior to staff putting training into practice. Staff attended moving and handling training. We observed staff using hoists, wheelchairs and slide sheets. We saw that these staff lacked confidence in the use of these items. We saw all of these items being used in an unsafe and ineffective way. This placed people at risk of harm. One staff member, speaking about moving and handling training, told us "It would be better with practical, we could try out the different hoist slings".
- We observed moving and handling coaching where staff were using a slide sheet. This coaching was not effective as poor and unsafe practice was not addressed.
- We found that periodic competency assessments, of staff practice, did not take place.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- Care plans were task orientated. They did not contain information about choices made by people, in how their support would be delivered, or how to support people to make choices. This meant that support was not person centred
- There was no evidence of how choice was made by people where English was not their spoken language. We saw a member of staff, unsuccessfully trying to understand what one person was saying to them about their dinner. The person became agitated and eventually the member of staff moved away, without resolving the issue.
- Care plans did not have sufficient risk assessment information to enable people to receive safe care.
- There were mixed responses from people about the food. One person told us, "I wouldn't say the food is excellent, I haven't been asked what I want, what I have been given suits me". Another person told us, "The food is very good, choice, not really no, if you don't want it they will give you something else". A visitor told

us, "The food is basic, it's very good, there's two choices for the main, they get the choice at the table and sometimes [person] doesn't get a choice". Our observations confirmed that a choice of food was not always available to everyone.

•□At lunch time we saw that the tables were bare. Staff told us people could ask for condiments, we did not see condiments offered. The menu on the wall was incorrect. The service did not meet dietary religious requirements. We observed tables were being cleaned around people that hadn't yet finished their meals. No encouragement had been offered to these people and their meals were now cold. We saw people's meals were taken away from them without asking first and checking the person had finished.

Adapting service, design, decoration to meet people's needs

•□We saw that people had put pictures on the outside of their doors and personalised their rooms as they wanted. People told us that they like their rooms, one person said, "My room is alright, it's just a room to me, I haven't personalised it", another said "my room looks over the garden I have my pictures in it I am quite happy".

•□The provider had put in place a new wet floor shower room and had created a conservatory area that led to the enclosed garden. We saw that people used the conservatory area to sit and look out into the garden or to talk with visitors. People were seen to independently access the enclosed garden via the conservatory. We could see that people were enjoying the new area.

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support

•□The service did not consistently involve external agencies as quickly as they should. One person had been seen by the speech and language therapist, (SALT), in November 2017 and there was no evidence of a subsequent update. Staff were found to be following the agreed support plan on an undirected as required basis. The SALT team had not been advised of this change.

•□The Registered manager told us the falls team were no longer available to the service. The service had failed to find alternative arrangements or processes to help people experiencing repeated falls.

•□People were supported to access health care services such as their GP and Dentist.

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 with appropriate legal authority. In some 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that the service was working within the principles of the MCA.

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

RI:People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated inconsistently by staff. The service relied on people's relatives to deal with people's cultural needs. We observed that communication between staff and people who do not speak English, was ineffective. Staff did not use any communication aids, such as pictures. The person was seen to be confused and frustrated when staff were interacting with them.
- We observed kind and caring interactions between staff and people. Staff were appropriately affectionate and used humour to engage people. One person told us "Staff are lovely I like [staff] particularly, they are all very helpful". A visitor told us, "They understand my [relative] gets very emotional they are very understanding". One relative told us "If this is the quality of life, I have won the lottery", another relative described the care as "The best they can give us, a great comfort, never had a bad experience".

Supporting people to express their views and be involved in making decisions about their care

- There was no evidence in care plans and risk assessments to show that people had been supported to express their views or been involved in decisions taken about their care. One staff member told us that people would not be able to express their views.

Respecting and promoting people's privacy, dignity and independence

- We observed that dignity was not consistently respected. We observed that one person required the toilet, the member of staff asked them to wait for an additional staff member to arrive, the person did not want to wait and tried to get up. We observed staff positioning themselves to the side of the foot rest preventing them from getting up and distracting them by offering a drink.
- People were seen to be independently accessing the garden, via the conservatory.
- People independently walked in and out of the conservatory and along the corridors, others were waiting for visitors in the reception area. We could see that people were enjoying this level of independence.

Requires Improvement

Is the service responsive?

Our findings

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

RI:People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
- Staff reviewed care plans but there was no evidence of how this process involved people and their relatives or how this was communicated to them.
- We saw that care plans did not reflect the voice of the person or their current needs.
- There was an activities coordinator and a range of activities were available. Information regarding people's interests and hobbies was insufficient to enable a person-centred activity plan. One person told us, "I think I would like to go out for a walk but they don't do that here", a visitor told us, "We've never seen [relative] doing activities they always just sit in the lounge".
- We noted that the television was on in the lounge. A warning was made by the broadcaster that some people may find the following programme distressing, staff made no effort to establish what people might like to see.
- We found the service were not complying with Accessible Information Standards (AIS). The service was not considering one person's particular characteristics, in how their needs were met. Religious requirements associated with nutrition and hydration were not met by the service. A relative told us "Improve the food and language problem". This situation placed an added responsibility on relatives who were providing food.

Improving care quality in response to complaints or concerns
- The registered manager told us there had been no formal complaints received by the service since our last inspection. People and relatives we spoke to supported this.
- People and visitors knew how to raise complaints or concerns, one visitor told us, "I know I could take it up immediately, all the staff are approachable".
- We saw cards expressing thanks to staff for looking after relatives and loved ones.

End of life care and support
- People and their families were encouraged to consider end of life care planning. One relative we spoke to said, "We have agreed end of life care for [relative]".

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- At two previous inspections, in October 2016 and October 2017, we rated the service as "Requires Improvement" because records lacked details and the providers quality assurance processes did not effectively identify issues. At this third inspection we found that this had not improved.
- We found systematic failures in the providers audit processes, quality assurance continued to be ineffective and did not pick up on issues identified at this inspection. These included care plan audits, risk management, staff competency and medicines. The lack of robust quality assurance meant people were at risk of receiving poor quality care.
- Numerous concerns were identified within records. These included a lack of incident and accident analysis, lack of details in relation to critical information on medicine records, and a lack of staff competency assessments. Not keeping records that are fit for purpose put people at risk of harm from receiving inappropriate care or treatment.
- Prior to this inspection the provider had been prompted by the CQC to notify of events and occurrences that affected the health, safety and wellbeing of people using the service.
- It is a legal requirement that the overall rating from the last inspection is displayed within the service and on the providers website. The provider did not have a website and at the time of this inspection the rating was not displayed in the service. The Registered Manager amended this immediately it was brought to their attention.

Continuous learning and improving care

- Incidents did not prompt learning to improve outcomes for people using the service. The systems and processes in place were not adequate and failed to identify either risks or emerging risks. Action plans from audits conducted by the service did not pick up issues identified on this inspection.
- There was an internal action plan in place following the last inspection. This had not been followed through and the Manager who could not provide evidence of actions taken or lessons learned.
- The falls analysis information did not give an overview of patterns, trends, or emerging risk, this meant that there were no preventative strategies identified to keep people safe.
- Medication audits did not identify numerous recording errors and omissions, which meant people may not get their medications as prescribed and leaves them at risk of harm.

Planning and promoting person-centred, high-quality care and support with openness;

•□Care plans were not person centred and there was no evidence of people's involvement or their choices in how services could be delivered to meet their needs.

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

•□Communication with people who had differing languages to English, was not adequately managed. This led to one person suffering frustration. The service had engaged a student, speaking the same language as the person, to come into the home one day per week, however, for the rest of the time there was nothing in place to enable staff to understand how the person felt, or their choices and preferences in how their support was delivered.

•□The last residents meeting took place on 21 January 2019. There was no evidence of any contribution by residents or how they were supported to attend. This could mean that the views and choices of residents are not being considered.
•□The last staff meeting took place on 17 January 2019. There was evidence of information and reminders being given to staff but no evidence of staff contribution or how their views were being considered in the overall management of the service.
•□The registered manager conducted a survey of residents in July and August 2018. There was an overview of people's views. Four actions had been identified but there was not a supporting action plan or further evidence of how people's views had been addressed or outcomes communicated to people.

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

How the provider understands and acts on their duty of candour responsibility;

•□Duty of candour responsibilities were not always acted on in reasonable time scales. A relative told us they had waited since January 2018 until March 2019 for the provider to act on their duty of candour responsibilities.

Working in partnership with others
•□We saw that the service communicated with the GP, District Nurses, Dentists'. Communication with specialist professionals was not always timely enough to meet people's needs.

•□The registered manager and nominated individual informed us they were going to take action to meet the required improvements identified during this inspection and we look forward to reviewing these changes at the next inspection.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's health, safety and well being was not managed in a consistent way. Peoples care plans lacked information on how to deliver safe care. People were not always getting their medicines as prescribed. Administration of medicines was not consistently recorded. Protocols for the use of as required medicines were not in place. Medication storage was not consistently safe.

The enforcement action we took:

Requirement.
The provider must ensure people's health and safety is managed in a consistent way, people's care plans must contain sufficient information on how to deliver safe care. Clear medication processes and procedures must be put in place and followed by staff to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance systems and processes in place to assess, monitor and mitigate any risk, relating to the health safety and welfare of people using the service and others.

The enforcement action we took:

Requirement
The provider must use effective governance systems and processes to assess monitor and mitigate any risks relating to the health safety and welfare of people using the service and others.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet people's needs.

The enforcement action we took:

Requirement
The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet people's needs.