Manor Court Healthcare Limited

Anson Court Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 26 October and 02 November 2017. Anson Court is registered to provide accommodation and personal care for up to 33 people, who are mainly older people with Dementia. At the time of our inspection 32 people were using the service. At our last inspection on 26 October 2016 the provider was rated as requires improvement overall because people's medicines were not always recorded and stored accurately and staff recruitment was not always carried out safely. We found the principles of the Mental Capacity Act (MCA) were not always being followed and the governance system operated by the provider was not always comprehensive and detailed. At this inspection we found recruitment systems had improved and the principles of the MCA were now embedded in practices at Anson Court. However, the recording of and storage of people's medicines had not improved and the quality assurance system in place had not improved which meant they were not now meeting the requirements of the law.

During this inspection we identified two breaches of the Health and Social Care Act 2008 relating to governance systems and failing to notify us of certain events. You can see what action we told the provider to take at the back of the full version of the report.

At the time of our inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Anson Court. However, we found the system operated by the registered manager did not always demonstrate people got their medicines as prescribed. Risks to people's health and safety were not always managed in a consistent way. Staff had received training in how to protect people from the risk of harm and knew what to do should they suspect any abuse had taken place. People told us and we saw there were sufficient staff to meet people's needs.

Staff told us they had received training to help them meet people's needs. People's rights were upheld through effective use of the Mental Capacity Act 2008. People told us they enjoyed the food at Anson Court and they received sufficient nutrition to remain healthy. When people's health needs changed or required reviewing we saw they had access to other healthcare professionals to support them.

People told us and we saw staff treated them with kindness and compassion. We saw people's privacy and dignity was upheld by staff. Staff understood the need and we saw they promoted people's independence. We saw people were encouraged to maintain relationships that were important to them.

People and their relatives told us they were happy with the care they received. Staff knew people's individual needs well and therefore people received care that was responsive to their individual needs. There were activities available should people wish to join in. The provider operated a complaints system which meant people could complain should they wish to.

The provider had failed to notify us when people were being deprived of their liberty in line with their legal duty. The quality assurance system operated by the provider was not effective at identifying the areas our inspection highlighted where improvements were required. People and their relatives told us the home was well led and they were happy living there. Staff told us they were supported by the registered manager and were involved in the running of the home.

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.

Improvements were required in the system operated by the provider to demonstrate people got their medicines as prescribed. Risks to people's health and safety were not managed in a consistent way. Staff knew how to protect people from the risk of harm. There were sufficient staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People were supported by staff who had been trained to care for them effectively. People's rights were protected as staff had applied the principles of the Mental Capacity Act 2005. People's nutritional needs were being met. Staff supported people to access other health professionals when required.

Is the service caring?

Good

The service was caring.

People told us they were supported by kind and considerate staff. People were given choices about the care they received. People's privacy and dignity was respected by staff. Staff promoted people's independence. People were supported to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in their care. People were supported by staff who knew their individual needs. People had access to activities which they enjoyed. The provider had a system in place should people wish to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had failed in their duty to notify us when they were depriving people of their liberty. The quality assurance system was not always effective. People told us the home was well led. The registered manager sought opinions from people and their relatives to improve the care people received. Staff were supported by the registered manager which led to a positive culture within the home.

Anson Court Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 October and 02 November 2017 and was unannounced. The inspection team consisted of one inspector and a specialist advisor. The specialist advisor was a pharmacist who had specialist knowledge of people's medicines. Before our inspection we reviewed information we held about the home including information of concern and complaints. We looked at statutory notifications we had been sent by the provider. A statutory notification is information about important events which the provider is required to send us by law. We spoke with other agencies such as the local authority to gain their views about the quality of the service provided. We used this information to help us plan our inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people who used the service and four of their relatives. We spoke with the registered manager and five members of staff. We carried out observations throughout the day to help us understand the experiences of the people who lived there. 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 looked at care records for seven people and a selection of people's medicine records. We looked at other records relating to the management of the home. These included staff files, accident reports complaint logs and audits carried out by the registered manager.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2016 we rated the provider as 'requires improvement' under the key question 'Is the service safe?' This was because the recording and storage of people's medicines was not always completed correctly. Improvements were also needed in the recruitment system operated by the provider. At this inspection we found some improvements had been made with regards to the recruitment of staff but in other areas the improvements had not been made which meant there were still areas where further action was needed to ensure people received safe care.

At our previous inspection in October 2016, we found improvements were required in the recording and administration of some people's medicines. At this inspection we found the required improvements had not been made. Although people told us they got their medicines when they needed them, we found the system operated by the provider did not always confirm what people told us. We looked at a sample of medicine administration records, including those kept for the administration of controlled drugs and we found that these records were not always able to demonstrate people were getting their medicines when they needed them. For example, we saw staff initials were missing on some people's medicine administration records, where staff should have signed to confirm people had had their medicines administered correctly. We also found that the back of the administration records had not been completed, which would have provided an explanation of why these medicines had not been administered. As a consequence we were unable to establish whether these medicines had been administered or not. We spoke with staff and the staff were not able to explain why there were these gaps in the administration records. We also found procedures to record the disposal and carrying forward of medicines were not consistently employed, which further hindered the provider in demonstrating medicines were being administered as prescribed.

When people had their medicines administered "as required", we found written information was in place to provide guidance to staff on how these medicines should be effectively administered.

We saw the monitoring of the temperatures of the refrigerator where people's medicines were stored was ensuring these medicines were being stored at the temperature required to effectively treat the conditions they had been prescribed. However, we discovered some poor practice with staff removing medicines from one dispensing container and placing them into another so that the medicines would fit better in the medicines trolley. This practice can increase the risk of people receiving the wrong medicine and medicines should only be administered from the container that they were dispensed into by the pharmacy.

Although people and their relatives told us they felt safe and staff told us how they managed people's risks to keep them safe we saw staff did not always deliver safe care in a consistent way. One member of staff told us they had corrected other staff when they saw them using unsafe techniques to move people and added, "I think it still goes on sometimes". Although we saw examples of how staff moved people in a safe way we saw this was not consistent across all staff which meant some people's risks weren't always managed in a safe way. During this inspection we saw on two occasions staff moved people in a way which caused a further risk of injury or harm. For example, we saw one person be lifted by staff placing their arms under the

person's armpits to help them stand. We asked staff if they had received training in how to lift people safely. They said they had, but didn't want the person to fall. Moving people using their underarms' to raise them from a seated position is an unsafe manoeuvre which can cause further harm and risk of injuries such as skin tears or worse. We spoke to the registered manager about the staff who told us the staff we saw were agency staff and they had checked they had received moving and handling training prior to working at the home. The registered manager took action and spoke to the staff about moving people safely. We saw staff moved people using safe techniques for the remainder of our inspection.

Staff were knowledgeable about how they managed people's assessed risks and what action they were required to take to minimise the risk of harm to people at Anson Court. For example, one member of staff told us how they managed one person's risk of choking by adding thickener to their fluids to mitigate their risk. We saw staff supporting this person with their fluids in the way they described to us. We found when people had assessed risks, records we looked at confirmed what staff had told us. We found when people had assessed risks the provider had ensured staff had the knowledge to support them, although some improvements were required to ensure staff supported people in a consistent way.

The registered manager had a system in place to monitor when people had falls. However, the system did not analyse the information or show any developing patterns. Instead it showed a list of people who had fallen, it did not highlight patterns such as time of day or if the accident was witnessed or unwitnessed. Monitoring patterns can provide registered managers with valuable information as to how they can prevent further reoccurrences. The registered manager told us they have a policy of if a person sustains three falls then they contact the team of healthcare professionals who specialise in falls prevention. We saw they had been contacted in line with their policy however further monitoring of accidents would enable the provider to monitor accidents more closely to prevent any further falls or accidents at an earlier date.

At our previous inspection we found the recruitment system operated by the provider did not always ensure people recruited were safe to work with people who lived in Anson Court. At this inspection we asked staff about the recruitment process and we looked at three staff files to ensure the recruitment system operated by the provider was safe. Staff told us they had to bring in documents and other paperwork to demonstrate they were suitable to work with people in Anson Court. We looked at three staff files and found in one of them the registered manager had not addressed the gaps in their employment but were in the process of doing so. We saw disclosure and barring checks (DBS) had been completed prior to staff commencing their role. DBS helps employers to make safer recruitment decisions and prevents unsuitable people being recruited. The provider had a safe recruitment system in place which ensured people were safe to work with vulnerable people.

People were protected from the risk of harm because staff had received training in how to protect people from potential abuse. One member of staff said, "Safeguarding is about making sure vulnerable adults are protected". Staff knew what to do should they recognise any signs of potential abuse. Staff were confident should they need to raise any concerns of this nature with management that they would take immediate action to protect the person from any further risk of harm. Staff knew where to go to report any suspected abuse if management did not respond to their concerns. One member of staff said, "I would whistle blow. I would come to yourselves and tell you". The registered manager knew what action to take should any abuse be suspected and had raised these concerns with the local safeguarding authority, and notified ourselves in line with their legal obligations where any suspected abuse had taken place.

People and their relatives told us there were sufficient staff to meet their needs. One person said, "I ring my

bell in the night. They come then. I feel safe because there are staff". Another person commented, "There is enough staff". A relative told us, "I think there could always be more staff. But [Name of person] is safe. I feel confident with the staffing levels. We received mixed views from staff about the staffing levels. One said they thought there was sufficient staff and another commented that the staffing levels hadn't changed for a number of years but people's needs had and the staffing levels had not been addressed to meet this. We asked the registered manager how they calculated staffing levels and they told us they did not have a system in place which looked at the needs of people living in Anson Court. We saw there were sufficient staff to meet people's needs during our inspection. For example, we saw staff ensured there was always a member of staff in the lounge to support people there before they left to support others with their care.

We recommend that the service explores relevant and up to date guidance on how to assess staffing levels based on people's individual dependency needs.

Good

Is the service effective?

Our findings

At our last inspection in October 2016 we rated the provider as 'requires improvement' under the key question 'Is the service effective?' This was because the rights of people who lacked capacity to make their own decisions were not always protected because the principles of the Mental Capacity Act 2005 had not been followed. At this inspection we found the required improvements had been made.

The Mental Capacity Act (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At the last inspection we found when people who lacked capacity to make decisions about their medicines and were given them disguised in food or drink the provider had not ensured people other than their doctor was involved in the decision. At this inspection we found staff had consulted with others involved in people's care when they were given their medicines disguised in food or drink which meant the decision had been made in their best interests. Staff told us they had received training and demonstrated that they understood how the principles of the MCA affected people's care. One member of staff told us, "Decisions should be made in people's best interest [when they can't make the decision for themselves]". We saw the provider had ensured people's capacity had been assessed prior to any decisions being made without them and in their best interest. People could not tell us if staff asked for their consent before delivering care, however staff told us they understood consent had to be gained from the person before providing any care. We saw numerous examples throughout our inspection of staff seeking people's consent before providing any care. For example, we saw one member of staff ask a person if they could clean their mouth with a wipe before doing so. This meant the principles of the MCA had been embedded into the practice in Anson Court.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLs). The MCA DoLs requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty so they remain safe. The registered manager understood their responsibility in protecting people when their liberty may have been restricted and had applied to the local authority to ensure the legal safeguards were in place. We saw where authorisations were in place staff were working within the guidelines. Staff were aware when people were being deprived of their liberty and how it affected their care. For example, we saw one person was trying to leave the home via the front door. A member of staff told us, "They can't leave the home alone as they have a DoLs in place to ensure they are safe".

People were unable to comment about the training staff had received but all who were able to told us they were happy there. Relatives told us they were happy with the care their family member received. One relative told us, "[Name of person] is safe because the staff are exceptional". Staff told us they received

training which helped them to support people in the home. One member of staff told us about the dementia training they had received which helped them to understand how dementia affected different people and how it was important to help people living with dementia to remain as independent as possible. Another member of staff told us they were always receiving training and it helped them in their role. One senior member of staff told us how they had been encouraged to develop further in their role and was commencing a course on the principles of care planning, as it had been recognised care plans required updating with more information. Staff told us when they started their role they received a good induction which provided them with the skills and knowledge to provide effective care to people. They told us they spent time shadowing more experienced staff when they first started their role in order to develop and understand the skills they had learnt but also to get to know people and learn their individual preferences and routines. Staff had received training in order to support them to provide care for the people living at Anson Court.

People told us they were happy with the food they received. One person told us, "I like the food. I get choices". We saw people were offered choices at breakfast and at lunchtime. For example, one member of staff asked one person what they would like on their toast and gave them two choices. We saw people had choices of where to eat their food and when people required support to eat their food staff were available and support was given in a dignified way. We saw fresh fruit and vegetables were offered to people on the menus. We saw people enjoyed the food and especially the home made cakes prepared for them by the cook. We spoke to the cook who was aware of the people who had special dietary requirements, for example those who had their food blended to a smooth consistency to ensure their risk of choking was reduced. The cook was also aware of people who had any specific health related diets. For example, they told us how they catered for one person who had a specific health condition which meant their sugar intake was monitored. We saw staff offered people choices of hot and cold drinks throughout the day. We saw people were asked if they were still hungry following their meal and asked if they would like more. People were supported to meet their nutritional needs in order to remain healthy.

People were unable to share with us if they were supported to access healthcare professionals. Relatives told us they were kept informed when healthcare professionals were involved in their family members care. Staff knew about people's health needs and gave us examples of how they supported people to access other professionals. We spoke with two healthcare professionals who visited the home on a regular basis. They both confirmed they were happy with the care people received and when they left instructions for staff to follow they were carried out by the staff which meant people recovered faster. This meant people received support from the appropriate health care professionals when required.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person said, "The staff are very nice. I get on with them all". All the relatives we spoke to praised staff for how they supported their family member. One relative commented, "The staff are exceptional". We saw people were comfortable with staff and laughed and joked with them and their family members. We saw numerous examples of how staff interacted with people in a positive way. For example, we saw a member of staff singing with a person whilst walking down the corridor. We saw staff spoke to people using affectionate language. For example, one member of staff helped one person to move hair from their face and said to them, "I can't see your lovely face handsome". We saw staff treated people with kindness. For example, one member of staff asked a person if they would like a clip in their hair. We saw another member of staff offered a person a cushion to protect their head when they slept upright in a chair. We saw all staff, including ancillary staff, interacted with people in a positive manner which meant there was a happy and pleasant atmosphere for people living in Anson Court. We saw positive relationships had developed between staff and the people they care for as a result of the kindness staff had shown to people. We saw the provider had considered people living with dementia in the decoration of the building. We saw carpets and different coloured walls, so as people can distinguish between the two along with different coloured hand rails to make it easier for people living with dementia to find.

People were unable to share with us if staff respected their privacy and dignity. Staff understood the need to treat people with respect. A relative told us, "They always respect [Name of Person] dignity". We saw numerous examples of how staff treated people with respect which meant their privacy and dignity was maintained by staff. For example, we saw one person was struggling to eat their lunch unaided and had managed to get food over their face. We saw staff quietly mentioned this to them so as not to embarrass them and offered them a wipe to clean their face. We saw numerous examples of staff offering to support people with changing their clothes when there was food or other spillages which may cause distress to the person because their dignity was not upheld. We saw individuals' privacy and dignity was considered by staff when recording personal issues in their care records. For example, we saw in one person's care records where staff were to change them or offer any care so as their dignity was maintained. We saw the provider had considered people's privacy and had built a new room which was to be used for people to meet with family members away from other people living at Anson Court if they preferred to meet in a smaller room together. This meant people's privacy and dignity was maintained by staff.

People were unable to share with us how staff supported them to remain independent. However, staff understood how important it was to ensure people living with dementia maintained their life skills wherever possible. A relative told us, "This is the best place [Name of person] has ever been. Staff have encouraged [Name of person] with their independence. They [Person] have been hoovering which helps them to remain independent." We saw staff promoted people's independence wherever possible. For example, we saw one person asked a member of staff for support and the member of staff reminded them they were able to complete the task themselves which they then did happily. This meant people's independence was respected by staff.

People were encouraged to maintain relationships that were important to them. One person told us how they were very happy living at Anson Court but they could also go out with family to visit other family members and this was important to them. We saw staff and the registered manager were happy and relaxed the company of friends and relatives and we saw them chatting together throughout our inspection. Relatives told us they felt comfortable visiting Anson Court and were always made welcome by staff and the registered manager.

Good

Is the service responsive?

Our findings

All the people and their relatives told us they were happy with the care they received whilst living at Anson Court. People were unable to share with us if they were involved in making decisions about their care. Relatives told us where possible they were involved in the planning of their care and involved in the care their relatives received. One family member told us how staff involved them in their family members care by calling them to give them the opportunity to sit with their family member when they became agitated and this helped their relative to calm down. Another relative told us, "I am involved. They telephone you to let you know everything. The staff are exceptional". They continued telling us they had been invited to reviews to be involved with the care their relative received, but had the choice to attend or not. We saw family members had been involved in the development of their relatives care plan. For example, they had been asked questions about their relatives past and what they liked to do and what was important to them. We saw one relative had assisted staff with their family members care plan, as they commented about their sleep pattern which would enable staff to support the person, as they required maintaining their particular routines.

People who were able told us the care they received met their individual needs. One person told us, "I can get up when I want". Another commented, "I do what I want here". Many staff had worked at the service for many years and were knowledgeable about people's routines and their backgrounds. We saw staff responded to people when they recognised they needed further support. For example, we saw one person became upset as they were missing their family. A member of staff walked with them and then sat with them and discussed all their family and what they were doing and when they could expect them to visit. This left the person feeling calmer and more relaxed. We saw staff exchanged information about people at the end of each shift and passed on any changes with people's behaviours of just how people were feeling on that day. For example, we saw one person's details were handed over at this time to the staff coming on duty about how one person had not eaten or drank much and staff coming on duty needed to monitor this more closely. This meant staff were aware of each person's individual needs and up to date with how their needs had changed. We saw if people had specific spiritual needs these were acknowledged. An example being that the registered manager had invited a local vicar to speak and join in a church service in the lounge, we saw people enjoyed spending time singing and praying with the vicar. People were supported to have care which met their individual needs.

People had mixed views about whether they had the opportunity to follow their own interests and hobbies. One person told us, "Well I look at books. There's nothing else to do". Another person told us they enjoyed playing games sometimes. People told us they enjoyed singing and playing games, some preferred to go out with their relatives. On the second day of our inspection we saw people enjoyed joining in with games with staff to support them in one of the lounges. We saw some people chose not to join in and staff respected their decision. The registered manager told us they used to have an activities co-ordinator who spent time with people asking them what they wanted to do however, at the time of our inspection they were recruiting to the position and once this was filled activities would increase again. We saw an activity timetable was available for people should they wish to join in and this was put in place by an external person who was employed by the service to do activities with people twice a week. The registered manager gave us an

example of how one person liked to play dominoes and was able to teach others and visiting students who came into Anson Court how to play. People had the opportunity to spend leisure time with friends and family and join in with organised activities should they wish.

People were happy with the care they received but were not able to share with us what they would do should they needed to complain. Relatives told us they had not needed to complain but told us they knew what to do should they need to. One relative said, "I would go straight to the manager". We saw there was a box for people to put their complaints and any suggestions they may have about how to improve the service. We saw complaints were recorded in a "grumbles book" and the complaints procedure was written in the service user guide. The registered manager ensured that the complaints procedure was displayed in the reception area of the home as well. No complaints had been received since our previous inspection. There was a complaints procedure in place and people felt comfortable raising any concerns with the management should they need to.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in October 2016, we rated the service as "requires improvement" in this area because some of the records seen lacked details. On this inspection we found some improvements had been made but improvements were still required to achieve a rating of "good" in this area.

Organisations registered with the Care Quality Commission (CQC) have a legal responsibility to notify us about certain events about incidents that had taken place. A statutory notification is a notice informing CQC of significant events and is required by law. Although we saw the provider had sent us notifications for certain events as required by law, for example when people have received serious injuries, we became aware of the provider lawfully depriving 15 people of their liberty. The provider had not ensured they had notified CQC of these authorisations. The registered manager told us they would send us them following the inspection.

This is a breach of Regulation 18 Care Quality Commission (Registration) 2009.

At our last inspection we found the governance system had failed to identify areas such as where improvements were required in the system used to audit people's medicines and the lack of detail in some people's care records. At this inspection we found the audits of people's medicines were still not effective at identifying areas of concern. For example, the last audit completed by the registered manager in July 2017 and had not found any discrepancies. However, we found errors such as no opening dates on people's medicines and no audit trail of controlled drugs. We also found people's personal items such as cigarettes stored in the medicines trolley and their audit had not highlighted these errors. We found the Provider operated a quality assurance system which included audits of electrical equipment, mattresses, pressure relieving equipment and infection control audits. However, it did not include audits of people's care records and we found a concern regarding one person's care which had not been highlighted to staff. We also found records were written in a task focussed way and did not always include information about people's own choices and preferences. We found some information which would support staff with their role was not present in people's records. For example, one person's risk assessment did not include which hoist and which sling staff should use to move the person safely. We found there was no system in place to ensure staff including agency staff were competent in their role with regards to moving people safely. Despite our previous inspection highlighting the governance system required improvements we found the system operated by the provider still did not identify areas where improvements were still required.

Regulation 17 states systems or processes must be established and operated effectively to assess, monitor, and improve the quality and safety of the people who use the service. The above evidence means the provider is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw as part of the quality assurance system such as lifts and other large equipment was regularly serviced to ensure its safety for the people who used it. We saw action had been taken when audits had highlighted areas where improvements were needed action had been taken to address the concern. For

example when a recent mattress audit identified a mattress was required it was immediately replaced.

People and their relatives told us they were happy living at Anson Court and felt the leadership was good. One relative said, "I think this place is very well run. I would recommend this place to anyone. It's homely, friendly and has brilliant staff". They continued telling us the staff answer all your questions and kept them informed when anything changed. Another relative told us", This is the best place, that [Name of person] has been. I would definitely recommend it. It's not the poshest place in the world, but the care is the best".

Staff told us they received support from the registered manager and had regular supervisions and were involved in regular staff meetings which kept them informed about changes in the service. Staff told us they felt at ease approaching the registered manager should they need any further support in their role such as more training to understand a subject. Staff told us they were given the opportunity to make suggestions about how the service is run. One member of staff commented, "We all work as a team. I love this place". Another member of staff commented, "I love it here. These people are like family to me. I love my job".

We saw the registered manager involved people and their relatives in the running of the service by holding regular meetings. Some relatives were aware of the meetings but told us they chose not to attend. We saw questionnaires were sent to people and their relatives to ascertain their views on how the service could be improved. We saw 18 out of 20 said no improvements were required and had positive comments about the service.

We saw the registered manager promoted a positive culture within Anson Court. They spoke to people, their relatives and staff throughout our inspection and spent time in the lounges with staff and asking people how they were. One person told us, "[Name of registered manager] is nice. She comes and chats to us all". The registered manager told us they tried to promote a positive and inclusive culture within the home by employing people from different backgrounds and cultures. By spending time on the floor people can approach them with any difficulties. They also told us they tried to accommodate the wishes of the staff, so as a group the staff were happy working at Anson Court. The registered manager told us they continually tried to improve the service and had implemented a tea station this year for people who could make their own drinks and for friends and family when they visited. Further developments were planned for the new year, including dementia friendly decorations around the home and reviewing staffing levels on the night shift were monitored.

We saw that the provider had ensured information about the service's inspection rating was displayed as required by the law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance system operated by the provider was ineffective at identifying the concerns raised by our inspection.