Anville Court Care Limited

Anville Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Anville Court Care Home is a nursing home providing personal and nursing care to up to 50 people. At the time of the inspection 43 people were using the service. The service provides support to people over 65 including those with physical disabilities and people living with dementia.
The home is a purpose-built building and accommodation is provided over 2 floors both of which have adapted facilities.

People's experience of using this service and what we found
Management of safety at the home was inconsistent and improvements were required to ensure people's safety.

Governance systems needed improvement to ensure the provider was able to identify and make improvements to the service where appropriate

People could not be assured that information about them when held by the provider would be secure as a record of a complaint had been deleted from the providers system before it had been dealt with.

People's care plans did not always contain clear guidance for staff and required improvement to ensure people received the support they required.

Staff managed people's medicines safely, in line with national guidance. People were supported by staff who had been assessed as safe to work with vulnerable adults. People were kept safe from the risk of infection and COVID-19.

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.

The manager and staff were clear about their responsibilities. The service worked in partnership with a variety of community professionals to ensure people received any specialist support they needed.

Management sought people's views about the service and acted upon them.

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 good (published 19 May 2018).

Why we inspected

The inspection was prompted in part due to concerns received about the care and welfare of people living at the home As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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.

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 provider's governance and oversight of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

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

Is the service well-led?

Requires Improvement

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

Anville Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted 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
This inspection was carried out by two inspectors on the first day and one inspector on the second day.

Service and service type
Anville Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Anville Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.
At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced. Inspection activity started on 12 September 2022 and ended on 4 October 2022. We visited the service on 13 and 21 September 2022.

What we did before inspection
We reviewed information we had received about the service since the provider's last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven people that used the service and six family members of people who used the service. We also spoke with 12 members of staff including the nominated individual, registered manager, deputy manager, nurses, care assistants, activity workers and domestic staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed staff providing support to people in the communal areas of the service. We reviewed a range of records. This included four people's care records and medicines administration records. Quality monitoring systems and a variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Management of safety at the home was inconsistent and improvements were required.
- During the inspection we found a damaged window in an unoccupied first floor bedroom. The damage had rendered the restrictor ineffective resulting in the window hanging from the frame. Although the room was unoccupied, the door was unlocked, and people could access it and were at an increased risk of falls from height. We shared concerns with maintenance staff who immediately made the window safe until permanent repairs could be arranged.
- Records of checks of safety systems showed a gap of several weeks where no checks had been carried out. We were told that the person responsible for carrying them out was absent from work during that period. We shared the concerns with the deputy manager and nominated individual who recognised the need for somebody to deputise when this happened and told us they would make sure another member of staff was competent to carry out these checks.
- Health checks such as blood pressure checks were not being carried out consistently and this placed people at increased risk of ill health. Guidance for staff in care plans was vague and referred to checks being made regularly or frequently rather than specific guidance. We shared these concerns with management of the service who agreed that this needed reviewing and clear instructions for staff provided.
- Information for staff around people's needs when being assisted to move using a hoist was inconsistent. Some care plans contained detailed instructions for staff, but others lacked essential information such as which sling to use. Although we saw no harm caused by this, it placed people at an increased risk of harm through misuse of hoists and slings.
- Checks of equipment, water hygiene and of gas, electrical and fire safety systems and equipment had been carried out by registered contractors as required by law.

Learning lessons when things go wrong

- The provider was not always learning lessons when things go wrong. We saw that accidents and incident were investigated to find ways of preventing re-occurrences. However, we were made aware that a person's complaint had been voided on the provider's electronic care system which had not be investigated. This meant that the provider missed an opportunity to learn lessons and avoid potential re-occurrences.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found an open bin for handtowels in a bathroom which should have had a foot operated lid. We also found that pull cords in bathrooms did not have plastic covers fitted to allow effective cleaning. We shared these concerns with management at the home and they had addressed these

issues by the second day of the inspection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● 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.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were supported to have visitors in line with the governments most recently guidance on visiting in care homes.

Staffing and recruitment
● We received mixed feedback from people and their families about staffing levels at the home. Everyone we spoke to were complimentary about the carers at the home, but some felt that the carers were rushed, and more staff were needed.
● We shared these concerns with management at the home who showed us that they constantly monitor staffing levels at the home using a dependency tool. On both days of inspection, we saw people had access to staff when they needed them.
● We looked at staff rotas at the home that showed us the staff levels were consistent with what we saw.
● The registered manager had undertaken appropriate pre employment checks on new staff, such as DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff had undergone a thorough induction to the service. One member of staff told us, "I had a good induction to the service and was able to shadow staff."

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely
● Medicines were received, stored, administered and disposed of safely.
● Regular checks were made of the temperature where the medicines were stored, including medicines that required refrigeration.
● Medication administration records (MAR) were fully completed by staff when they administered people's medicines.
● Medicines were labelled correctly when staff started a new supply. This meant that the provider could be

assured that the medicine would be safe and effective if administered.

● People were consulted as to how they wished their medicines to be administered and clear protocols were in place for staff to follow. This included medicines that were prescribed to be administered "as required".

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Governance systems and quality checks required improvements as they had failed to identify concerns found during the inspection.
- Management oversight and audits had failed to ensure a damaged window in a first-floor window was either made safe or access to the bedroom restricted until repaired. This placed people at an increased risk of harm.
- Management audits had not identified information in people's care plans lacked precise instructions. For example, a care plan we looked at stated "check at regular intervals". Whilst we found no harm had been caused as a result of this, this could result in people not getting the support they need.
- Management audits had failed to ensure that care plans contained consistent information about peoples handling needs. Some care plans contained relevant information for carers about which hoist and sling was required, others we saw lacked this information. This could result in the wrong equipment being used and placing people at risk of harm.
- The registered manager and provider had failed to identify that a record of a complaint had been voided on their electronic care plan system. This meant that the complaint was not investigated and handled in accordance with their complaints policy. This meant the opportunity to make improvements or changes was missed.

Effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager understood their regulatory responsibilities and ensured incidents were notified to the commission and ratings from the previous inspection were displayed prominently in the home.

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

- People's equality characteristics were identified prior to them moving to the service and we saw that these were considered when providing care and support. One person told us how they were provided with meals from their cultural background.

● The provider sent out surveys for people and relatives to express how they felt about the service and make suggestions around any changes that might improve the service. Feedback from the surveys was positive.
● One relative told us, "The carers are amazing, they know [name]really well and always let them know if football is on tv, which is important for them."
● Staff told us they had the opportunity to discuss any concerns at staff meetings and performance reviews, but they could approach the registered manager at any time.

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
● The registered manager understood their responsibilities to be open, honest and to apologise if things went wrong.

Working in partnership with others
● The provider worked in partnership with other professionals, including the district nursing service, physiotherapy, occupational therapy and local GP's. This meant people received specialist support when required.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The providers governance systems had failed to identify improvements required to the environment, care plans and records and security of information held by the service.