Ramos Health Care Limited

Abbotsbury EMI Rest Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This unannounced inspection of Abbotsbury EMI Rest Home took place on 20 January 2015.

Located in a residential area of Southport and near to local facilities, Abbotsbury EMI Rest Home is a residential care home providing accommodation and personal care for up to 21 people living with dementia. The detached accommodation is a large three storey building with 19 single bedrooms and one double bedroom. The double bedroom was used for single occupancy. Shared living areas include three lounges and a dining room. A call bell system is available throughout the building. Measures are in place to support access to the building for people who are wheelchair users or who have limited mobility.

A registered manager was in post. 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.

Summary of findings

Not many people were able to verbally express whether they felt safe in the way staff supported them. We observed that people were comfortable and at ease with the staff. They confidently approached and engaged with staff.

Staff understood what abuse was and the action they should take to ensure actual or potential abuse was reported.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. Staff told us there was sufficient numbers of staff on duty at all times. We observed that people's needs were met in a timely way.

Our review of a selection of care records informed us that a range of risk assessments had been undertaken depending on people's individual needs. Risk assessments and associated care plans were reviewed each month and modified to reflect people's changing needs.

People received their medication at a time when they needed it. We observed staff administering medication to people in a safe way.

The building was clean, well-lit and clutter free. Measures were in place to monitor the safety of the environment.

People were supported to maintain optimum health and could access a range of external health care professionals when they needed to. People enjoyed the food and they got plenty to eat and drink.

Staff had a good understanding of people's needs and their preferred routines. We observed positive and warm engagement between people living at the home there and staff throughout the inspection.

Staff told us they were well supported through the induction process, supervision and appraisal. They said they were up-to-date with the training they were required by the organisation to undertake for the job.

The home adhered to the principles of the Mental Capacity Act (2005). Staff had a good understanding of consent in relation to decision making by people who lack mental capacity.

The culture within the service was and open and transparent. Staff told us that management led by example. They said it was a nice place to work and the team worked well together.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it. Arrangements were in place for the registered manager to share the outcome of incidents, complaints and other investigations with the staff team.

A procedure was established for managing complaints. We found that complaints had been managed in a timely way and to the satisfaction of the complainant.

Audits or checks to monitor the quality of care provided were in place and these were used to identify developments for the service.

Summary of findings

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 safe.

Risk assessments and associated care plans were in place depending on each person's individual needs.

Staff understood what abuse meant and had received training in adult safeguarding.

We observed that medication was administered safely.

Measures were in place to regularly check the safety of the environment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Good

Is the service effective?
The service was effective.

Staff followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

People liked the food and got plenty to eat and drink.

People had access to external health care professionals and staff arranged appointments when people needed to see a professional.

Staff said they were well supported through induction, supervision, appraisal and on-going training.

Good

Is the service caring?
The service was caring.

We observed positive engagement between people living at the home and staff. Staff treated people with privacy and dignity. They had a good understanding of people's needs and preferences.

We could see from the care records that the registered manager and staff communicated effectively with families about changes to their relative's needs.

Good

Is the service responsive?
The service was responsive.

People's care plans were reviewed each month and reflected their current needs. The care was individualised and people's care requests were responded to in a timely way.

A process for managing complaints was in place. We could see from the records that complaints were responded to in a timely way and to the satisfaction of the complainant.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

Staff spoke positively about the open and transparent culture within the home. Staff said they felt supported by management and that management led by example.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Processes for routinely monitoring the quality of the service were established at the home.

Abbotsbury EMI Rest 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 was 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 unannounced inspection was undertaken by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care services.

Before our inspection we reviewed the information we held about the home. This included a Provider Information Return (PIR). A PIR 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. We also looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service to obtain their views and took into account the local authority contract monitoring reports.

During the inspection we spent time with eight people who lived at the home. We spoke with the provider, registered manager, the chef, a senior care worker and three care staff. We sought the views of a GP who was visiting the home at the time of our inspection.

We looked at the care records for four people who were living at the home, three staff recruitment files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, the dining room and lounge areas. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to them experiencing difficulties with their cognitive or communication abilities.

Good

Is the service safe?

Our findings

The majority of people living at the home had needs associated with memory loss so were not always able to verbally share with us whether they felt safe in the way they were supported by staff. For this reason we spent periods of time throughout the inspection observing how staff supported people. We noted people were comfortable and at ease with staff, whom they confidently approached and engaged with.

At the time of the inspection there were 19 people living in the home. The registered manager informed us there was a manager on duty each day and three care staff. The care team was supported by a part time activity organiser, chef and housekeeper. Two care staff worked waking night shifts. All the staff we spoke with said there were sufficient staff on duty to support people's current needs. We observed that people's needs were met in a timely way throughout the inspection.

We looked at the personnel records for two recently recruited members of staff. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff. We spoke with a member of staff who had started working there on the day of the inspection. They told us they were offered a start date after references and relevant checks had been obtained.

The four care records we looked at showed that a range of risk assessments had been completed depending on people's individual needs. These included a falls assessment, swallowing assessment and a mental health assessment. Care plans based on the risk assessments were developed if appropriate. Risk assessments and associated care plans were consistently reviewed on a monthly basis and revised depending on people's changing needs. Staff we spoke with had a clear understanding of each person's risk. They provided examples of how they had managed risks and we noted this was in accordance with people's risk management plans.

A process was established for recording accidents and incidents. If people presented with behaviour that challenged then a different process was used to support staff in identifying patterns to the behaviour.

Medication was held in a secure trolley attached to the wall in the one of the lounges. Medication that needed to be refrigerated was stored in a dedicated fridge in the kitchen. Care staff monitored the fridge temperatures to ensure they were within a safe range. We spoke with a member of staff who confirmed that medication training, including refresher training was provided for the staff with responsibility for administering medication. We looked at the medication policy and noted that it did not quite capture all the elements of the national guidance on the management of medicines in care homes. The registered manager agreed to review the policy in accordance with national guidance.

We observed staff administering medication throughout the morning. Medication was given at a time when each person needed it and we could see that staff waited for people to get up before giving them their medication. We looked at the medication administration records (MAR) and they were appropriately completed. A plan was in place for the medication people took only when they needed it (often referred to as PRN medication). The management of medicines was audited monthly and we noted the last audit took place in December 2014.

One of the people living at the home was receiving medication covertly. This means medication is disguised in food or drink so the person is not aware they are receiving medication. This approach was taken as the person was refusing important medication for their health. We could see from the person's care records this had been discussed with the person's GP who had formally agreed to administration of the person's medication covertly in their best interests. Although staff were clear how the medication was given covertly, a care plan had not been developed to describe how staff should administer the medication in food and what they should do if the person did not wish to eat the food which contained the medication. The registered manager said they would ensure a care plan was developed.

We spoke with staff about adult safeguarding. They told us a safeguarding policy was in place and they had access to it if needed. Staff confirmed they were up-to-date with adult safeguarding training. We checked the training records and it identified that all staff had received adult safeguarding training in the last three years. The home's policy defined that safeguarding training was annual and a few of the staff had not received refresher training in the last 12 months.

Good

Is the service safe?

The training matrix indicated this was being arranged. We observed staff supporting people in a kind and considerate way throughout the day. Staff were constantly checking on people and they regularly monitored the lounges.

Arrangements were in place for a range of annual risk assessments to be undertaken in relation to the environment, equipment and processes within the home. Records informed us that these were last undertaken in November 2014. The registered manager also conducted a health and safety audit each month and we had access to the records confirming these audits took place. Plans were in place to deal with emergencies such as a passenger lift failure, a flood or an electric failure. The fire system was regularly checked. We noted from the care records that each of the people living at the home had a personal emergency evacuation plan (often referred to as a PEEP) in place.

A maintenance person was employed and the registered manager advised us that urgent maintenance requests were seen to promptly. On the day of the inspection we observed the maintenance person arrived to check a person's radiator in their bedroom not long after the registered manager reported it.

We had a look around the home including some bedrooms and observed that the environment was clean and clutter free. People's personal toiletries were stored high up on wardrobes if it was considered that the person may be at risk from having access to them when on their own. A call-bell system was in place in the bedrooms. A regulating system had been installed to ensure the temperature of the home was stable. Pressure mats to alert staff if people were up were available for the people who needed them at night time, particularly the people who were at risk to falling.

We did note some concerns with the environment and equipment and highlighted these to either the provider or the registered manager who agreed to address them promptly. For example, the window at the top of the main stairs did not seem stable and a wall mounted television in a person's bedroom was unstable.

Good

Is the service effective?

Our findings

Due to needs associated with memory loss not all the people living at the home were able to verbally share with us whether they were supported to achieve good health care. One of the people we spoke with said to us, "I have fairly good health and if I am ill they [staff] look after me."

During the inspection the home was visited by a GP who told us the staff made appropriate contact with the surgery and in a timely way for people who were unwell. The GP was satisfied that staff responded promptly to people's changing health care needs and followed through with instructions on how to manage individual health needs.

From our conversations with staff it was clear they had a good knowledge of each person's health care needs. People's care records informed us they had regular input from health care professionals if they needed it, including the dentist, optician and chiropodist. A form was in place to record all consultations with health or social care professionals. We could see that some people received specialist health care input if they needed it. This included input from the local community mental health team and the speech and language therapy service.

We spoke with a member of staff who had just started working at the home. They were on induction on the day of the inspection and were supernummary to the staff numbers. We observed and heard a senior member of staff talking through with the new member of staff the arrangements for administering the medication. This included explaining what certain medications were for and people's preferences with how they took their medication.

Staff told us they were up-to-date with their annual appraisal and said they received supervision when it was needed. The registered manager confirmed that appraisals were up-to-date. We looked at the training matrix (monitoring record) that outlined the training staff were required to complete by the provider. This showed training was being monitored. Where there were gaps in training we could see that training had been arranged.

We spent time in the dining room with people when they were having their lunch. The food was wholesome and people seemed to enjoy their meals. There were plenty of staff to support people with their meal if they needed it. The menu for the day was displayed on a notice board in the foyer. We spoke with the chef and noted he had a good understanding of people's dietary preferences. He told us that if someone did not like the choice available then an alternative meal could be arranged. Drinks were available to people at regular intervals throughout the day. A person said to us, "It is never a problem [to the staff] if I need a drink."

We noted from the care records we looked at that people's weight was monitored on a regular basis to check for any fluctuation. We could see that people were referred to a dietician or speech and language therapist if there were concerns about their nutritional intake.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. The four care records we looked at contained mental capacity assessments. Each listed the decisions people were able to make, such as what to choose to eat or what to wear each day. They also listed the decisions people needed to be supported with making in their best interests, such as decisions about finances.

The registered manager confirmed that applications in relation to Deprivation of Liberty Safeguards (DoLS) had been submitted to the Local Authority for each of the people living at the home. The registered manager advised us this was carried out in response to the requirements of the Local Authority for people living in care homes. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The registered manager had not received feedback on the status of the DoLS applications.

The registered manager and deputy manager had completed training in the Mental Capacity Act (2005). Although the staff team had not had this training they had a good understanding of consent in relation to decision making by people who lack mental capacity. Care plans were worded in such a way as to promote people to make their own decisions where possible. Throughout the day we observed and heard staff encouraging and prompting people with decision making regarding their care needs in a positive way. The training monitoring record showed that mental capacity training was in the process of being arranged for the wider staff team.

Good

Is the service effective?

We had a look around the building to see how well it had been adapted to support the needs of people living with dementia. There were three spacious lounges and a dining room on the ground floor which were all used by people living at the home, and provided plenty of space for people to walk about.

There was a toilet off the lounge used by most of the people living at the home. We noted that there was an unpleasant odour in the lounge from frequent use of the toilet. We highlighted this to the registered manager who advised us that measures were in place to minimise odours and said they would look into this further with the provider.

The patterned carpets had been replaced with plain carpets. Colour contrasting had had not been used effectively to promote people's independence. For example, the colours between walls, corridor handrails and doors were not contrasting so that they stood out for people to find their way about more easily. Equally, bedroom doors were not painted in different colour so as to assist people in locating their bedroom. Not all signage was large enough or in a pictorial format to assist people with finding the room they may be looking for. We discussed this with the registered manager who agreed to look into it with the provider.

One of the people living at the home did not think there were enough toilet facilities. The person said they would prefer to have a toilet in their bedroom. We passed this feedback to the registered manager.

People living at the home were unable to access the garden independently. The registered manager advised us that in the good weather staff supported people to access the garden. We were shown pictures of people using the garden in the summer to play bowls and staff told us about other activities held in the garden during the summer.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff supporting people in a caring, respectful and dignified way. We heard staff explaining to people what was happening prior to providing care or support. Any personal care activities were carried out in private. Staff we spoke with demonstrated a warm and genuine regard for the people living at the home.

Each of the care staff was a keyworker for a small group of people. They explained the role involved making sure people had enough clothing and toiletries, and that their needs were being met. Staff had a good knowledge of people's backgrounds. They told us knowing about people's personal history helped with engaging people in conversations and exploring different activities they might like to do.

Detailed information about people's personal histories was in all of the care records we looked at. A document titled 'My life story' provided information about the person's relationships, working life, hobbies and preferences in order for staff unfamiliar with the person to get to know them. We could see that some families had been involved with developing the 'My life story'.

The care records informed us that people were involved in the monthly reviews of their care. The registered manager confirmed she discussed people's care with them and/or their representative on a regular basis.

The registered manager confirmed just one person did not have family member to represent them but they had independent representation regarding their finances and care needs. People told us they could have visitors whenever they wished.

We discussed the toilet located in the lounge with some of the people living at the home to see if its location could compromise their dignity and privacy. People said they did not mind the toilet in lounge and some people said they liked that it was close by in case they needed it quickly. We observed staff supporting people to discreetly use the toilet. However, the toilet could be seen from the main hallway. The registered manager said staff were regularly reminded of privacy and dignity matters in relation to the location of toilet.

Good

Is the service responsive?

Our findings

Throughout the inspection we observed staff responding to people's needs and requests in a timely way. Care plans were detailed and were focused around people's current needs. We could see that care plans had been revised to reflect any changes to people's needs.

We observed staff supporting people to mobilise. Sometimes this was a slow process but people were not rushed. The register manager confirmed that moving and handling equipment was not used by any of the people living at the home. Two people had wheelchairs but when they were indoors staff encouraged them to be independent by mobilising with staff support.

People's preferences and preferred routines were documented in the care records. Each of the care records we looked at included the person's daily routine. People's needs at night and preferred times for getting up and going to bed were outlined in the records. Staff told us there was no pressure to get people up in the morning and that people went to bed when it suited them.

A programme of recreational activities was displayed on a notice board in the main hallway. An activity coordinator was employed 17 hours per week and they organised activities within the home or supported people to go out in the community. People told us they did chair exercises, bingo and had music at the home. The registered manager told us that over the summer people went out three days each week. These included trips to the local park and trips further away, such as Blackpool.

External entertainers came to the home on a regular basis and provided activities, such as chair exercises, quizzes, floor games and music sessions. People told us they enjoyed these activities. Some people said they did not join in but liked to watch.

A complaints procedure was available. A small number of complaints had been received in the last year from families. We could see from the paperwork that these had been dealt with in a timely way and were resolved to the satisfaction of the complainant. People told us they liked the registered manager and said they would tell the manager if they were concerned about anything.

Good

Is the service well-led?

Our findings

We asked the staff their views of working at the home. They told us it was a good place to work as the staff team worked well together and supported each other. A member of staff said, 'I love it here. It's friendly and the atmosphere is good." Another member of staff told us, "There is a really friendly atmosphere and it is a nice place to work." From our conversations with staff it was clear they felt supported by management and that management led by example.

Staff told us an open and transparent culture was promoted within the home. They said they were aware of the whistle blowing process and would not hesitate to report any concerns or poor practice. They were confident the registered manager would be supportive and protective of them if they raised concerns.

We asked the registered manager their views of achievements within the service. The registered manager felt the home provided good person-centred care and leadership. The registered manager said the home had a good reputation now and rarely had a vacancy. Sometimes there was a waiting list for people to move in. We also heard how the home was proud that staff did a 10 mile walk in the summer and raised over a thousand pounds for the Alzheimer's Society.

We asked the registered manager about any planned initiatives for the service. We were informed that four trips out to places of interest would take place throughout 2015 for people living at the home. In addition, the registered manager planned to implement a 'Carer of the month' award. The service was also looking to facilitate more staff team events.

'Residents and relatives meetings' were held each month. Where appropriate these were chaired by one of the people living at the home. We looked at the meeting minutes from November and December 2014 and it was clear that the views of people were sought about the service. For example, the minutes informed us that the food, activities and people's satisfaction with their bedroom was discussed. Any comments people made were quoted in the minutes. The meetings had started to incorporate a mini satisfaction survey. This had a scoring system which was confusing. We discussed it with the registered manager who agreed to relook at the approach to the survey.

A combination of full staff meetings and senior staff meetings were held on a regular basis. We looked at meeting minutes from September and November 2014. The minutes were detailed and we could see that matters such as preventing falls, staff presence in the lounge areas and medication were discussed. The minutes also demonstrated that the expectations of staff, such as use of mobile phones in work and communication were discussed. The minutes informed us staff were provided with the outcomes of any concerns investigated.

We enquired about the quality assurance system in place to monitor performance and to drive continuous improvement. The provider informed us they visited the home at least once a week and undertook spot-checks at night. An annual meeting was held with the registered manager to set out the business plan for the forthcoming year. The provider confirmed this meeting had recently been held.

Risk assessments and care plans were subject to a review each month. The keyworkers completed their monthly review of the care. The registered manager also reviewed the care plans and made a record of their findings. Audits and checks were carried out by the registered manager or senior on a regular basis, including a monthly medication audit (last completed in December 2014). A range of checks were in place in relation to the environment and cleaning.

We looked at the incident reporting system and could see that the registered manager reviewed each incident and recorded actions for staff if required. The incidents were analysed to check for any emerging themes and patterns.