Ramos Healthcare Limited

Abbotsbury EMI Rest Home

Inspection report

25 Park Road
Southport
Merseyside
PR9 9JL

Tel: 01704537117
Website: www.rhcare.co.uk

Date of inspection visit:
07 June 2017
08 June 2017

Date of publication:
17 July 2017

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

Abbotsbury EMI Rest Home is a care home providing accommodation and personal care for up to 21 people who have dementia. The detached accommodation is a large three storey building with 19 single bedrooms and one double bedroom. 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.

At the last inspection on 20 January 2015 the service was rated as 'Good'.

We undertook an early morning unannounced comprehensive inspection of the care home on 7 & 8 June 2017. This was in light of concerns raised with us about the current staffing levels at the home. By inspecting early we were able to observe the support given to people at this time and also meet with the night staff.

There was a registered manager 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.

At this inspection we looked at the staffing arrangements for the home. We found there were not enough staff on duty as people were left unsupervised for periods of time. This posed a risk to their safety. There was no dependency tool available to help monitor and analyse staffing levels in relation to the support needs.

This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality assurance systems were in place but we found these did not operate effectively enough to ensure people received a well-managed service. Not all the areas of concern we found on inspection had been picked up by the existing audits and checks for the home.

This is a breach of Regulation 17) (2)(a)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We have made a recommendation around fire safety. This is to ensure more effective monitoring of the fire doors to ensure they are working effectively. These form part of the fire safety checks by the service.

Arrangements were in place for checking the environment and equipment was safe. For example, health and safety risk assessments and audits were completed where obvious hazards were identified.

People had a plan of care and care monitoring charts were in place to help evaluate care. When reviewing

care documents we found not everyone's plan of care had been updated to reflect the current care provision. During the inspection the registered manager took prompt action to address this.

Care records showed that people's health care needs were addressed with appropriate referral and liaison with external health care professionals when needed.

We observed good communication between staff and people they supported. Staff support was given in a kind and gentle manner and staff were aware of how to respect people's rights to privacy and dignity.

People and relatives we spoke with said they were consulted about their care and we saw some examples in care planning documentation which showed evidence of this input.

Risks to people's safety were assessed. Where people had been involved in an accident/incident, for example, a fall, this was analysed for possible trends or themes to help reduce the risk of reoccurrence.

People were protected from the risk of harm because staff could identify the potential signs of abuse and knew who to report any concerns to.

Where there were restrictions in place, staff had followed the legal requirements to make sure this was done in the person's best interests. Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure decisions were made for people in the least restrictive way. DoLS is part of the MCA 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. We found the applications were continuing to be monitored by the registered manager.

Medicines were well managed and staff received medicine training to undertake this practice safely.

People's dietary needs were managed with reference to individual needs. People told us they enjoyed the meals.

Regular meetings took place for people and their relatives to attend so they could give their feedback on the service. In addition to this, a pictorial questionnaire had been given to people thus offering a further opportunity to give their opinions on the service.

Appropriate recruitment practices were in place and relevant checks had been carried out for staff prior to them working at the home.

Staff received training and support and they told us the service offered a good training programme.

There was a clear organisational management structure in place. Staff and relatives we spoke with were positive about the leadership of the home.

Activities were organised in the home and these were enjoyed by people. People took part in singing during the inspection.

People and their relatives had access to a complaints' procedure and they were aware of how raise a concern. We saw that a record was made of any complaints and these had been responded to.

The registered manager was aware of their responsibility to notify us, Care Quality Commission (CQC) of any

notifiable incidents in the home.

You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

There were not enough staff on duty as people were left unsupervised for periods of time. This posed a risk to their safety.

Measures were in place to regularly check the safety of equipment and other areas of the home.

When reviewing fire safety we recommend more effective monitoring of the fire doors as part of the fire safety checks.

Staff knew what constituted abuse and how to report any concerns.

Safe recruitment practices were in place which ensured suitable staff were employed.

Processes were in place to ensure the safe management of medicines.

Risks to people's health were monitored.

Is the service effective?

Good

The service was effective.

Staff told us they were supported through induction, appraisal and the home's training programme.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

People living at the home got plenty to eat and drink and their nutritional needs were monitored.

People had access to external health professionals to oversee their health and social care needs.

Is the service caring?

Good

The service was caring.

We observed positive engagement between people living at the home and staff.

Staff were warm, kind and respectful in their approach.

Staff had a good understanding of people's needs and preferences.

Is the service responsive?

Good

The service was responsive.

People had a plan of care that reflected people's care, treatment and support.

There were social activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

People and their relatives had input into the running of the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems and processes were in place to monitor the service. We found on this inspection that the existing auditing system was not robust as this had not picked up on the deficits we identified during the inspection.

The service had a manager who was registered with the (CQC) Care Quality Commission.

People, relative and staff spoke positively regarding the overall management and leadership of the home.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home and the rating from the last inspection was displayed within the home for people to view.

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 was an unannounced inspection which took place over two days on 7 & 8 June 2017. The inspection team consisted of two adult social care inspectors 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.

Prior to the inspection we collated information we had about the service and contacted the social service contracting team to seek feedback about the home.

The provider had 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 any improvements they plan to make.

We used all of this information to plan how the inspection should be conducted.

During the inspection we were able to meet and speak with seven of the people who were staying at the home. We spoke with five family members, three on the inspection and two by phone. We spoke with four care staff working at Abbotsbury EMI Care Home as well as the registered manager and a representative for the provider (owner). We were also able to speak with three health professionals who were visiting the home.

We looked at the care records for four of the people living at Abbotsbury EMI Care Home, as well as medication records, four staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the lounges/conservatory.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we had received information that there were insufficient numbers of staff to provide care to people at Abbotsbury EMI Care Home and therefore people living at the home were waiting too long to receive attention. We informed the registered manager and provider of the concerns and they sent us information about the current staffing arrangements. This included information around the staffing numbers for days and nights, support and 'on call' arrangements by the registered manager.

Through our discussions with staff and our observations we found that there was not enough staff to safely observe support people at different times.

There were 19 people living at the home at the time of our inspection. When we arrived at 6.30am there were two experienced staff members (carers) on duty. Night staff worked from 8pm to 8am. A new member of the care team who was new in post was shadowing the carers as part of their induction though they were not counted in the staffing numbers. The home was usually staffed with two carers at night.

The registered manager arrived early to support the inspection. The day staff arrived at 8am and the staff team was made up of a senior carer, two carers, a stand-in cook and a domestic staff member. The numbers of staff were consistent with the staffing rota and in accordance with the information provided by the registered manager. The registered manager informed us there were two night carer vacancies and staff had been recruited. They were waiting for confirmation of the necessary police checks and induction.

During the inspection we used a short observational framework for inspection tool (SOFI) for 50 minutes to observe the engagement of people using the service and the quality of staff interactions. When we arrived we found 10 people were already up, dressed and sitting in the lounges. Seven people were sitting in one lounge and three in the other lounge. We observed that the seven people on a number of occasions were left unsupervised for up to 10 minutes, whilst three people in another lounge were unsupervised apart from when they were later brought their breakfast. Two staff were required to assist two people with personal care on two occasions, leaving both lounges totally unsupervised, on one occasions for approximately ten minutes and five minutes on another occasion. Four people appeared to be asleep and no one had been served a drink or breakfast prior to our arrival. A staff member brought through a breakfast trolley to the lounge at 7am. Breakfast was not given out until 7.10am as the carer was needed to assist a person with their personal care.

During our early morning observations an inspector needed to intervene on two occasions and stop an interaction in the lounge between two people which could have placed both people at risk (the people concerned did not come to any harm). We requested carer support for the people involved. On another occasion a person came into the lounge and took toast served to two other people which they ate. This was not witnessed by the staff as they were not present in the lounge.

We talked with the night staff about the staffing levels. Staff told us about the early morning routine. Staff told us that the two members of staff worked together to support people who needed two staff members

when getting up and dressed and then usually one staff member would prepare the breakfasts whilst the other staff member supported the more able people to the lounge. Staff told us that this particular night had been busy as people had been disturbed by the high winds hence a number of people were up early. This routine however raised concerns, for if two staff members are supporting people to get up early morning then there would no staff presence in the lounge at this time. Staff informed us that people were given a cup of tea and breakfast when they got up and were sitting in the lounge. We did not observe this during our inspection.

The registered manager told us the night staff were responsible for undertaking a number of cleaning duties and food preparation (peeling potatoes). They confirmed that staff would always attend to people's needs first however in light of our findings we were concerned about the extra duties, including laundry duties, which staff were expected to undertake as the home did not employ a laundry assistant. We observed this during our inspection.

The registered manager informed us that approximately five people needed two staff to support them with their mobility and three people needed full assistance from staff. There was no dependency tool available to help monitor and analyse staffing levels in relation to the support needs of people so that these dependencies could be taken into account. A current personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the home and consideration needs to be given to the effectiveness of these evacuation plans taking into account the staffing arrangements and people's dependencies. In respect of staffing numbers the registered manager informed us that the number of staff on nights had never changed and always been set at two carers.

For the majority of the day we did see staff in both lounges and responding quickly to people's needs. However on two occasions the inspection team did need to call for staff assistance. This was for one person who was shouting as they needed assistance to the toilet and for another person who was walking with their frame and was unsure of how to return to their chair (the staff did respond promptly as soon as they could.)

This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On the second day of the inspection the provider's representative provided more hand held devices in the lounge for people to use to call for assistance and we saw people using these with effect. The registered manager appreciated that not everyone was able to use these and that staffing arrangements would need to be reviewed in light of our findings. Following the inspection the registered manager informed us additional staff were being recruited to assist with monitoring people's care and support needs.

We found an 'on call' system was in place should staff require senior management support out of hours and in an emergency.

The PIR recorded details about fire prevention and we looked at fire safety during the inspection. On the first day of the inspection we found a lounge fire door with a self-closing device propped open with a chair. This was rectified immediately by the registered manager as retaining fire doors in an open position means they cannot close automatically, which placed people at risk in the event of fire. We were shown a fire safety report from the fire service dated April 2017 and some suggested actions to improve fire safety; the service had a target date for June 2017 for this work to be completed. The fire report recorded suggested actions around inspecting fire doors to ensure they closed to their rebates. We saw weekly checks of the fire doors and other fire safety measures, however, on inspection a small number were found not to shut to their rebates. The required work was undertaken during the inspection and the provider's representative was

able to provide assurance at this time that all the fire doors were working effectively.

We recommend the service reviews the monitoring arrangements for fire safety. This is in respect of the fire doors to ensure they are working effectively.

People and relatives told us they had no concerns around not feeling safe. A person said, "The staff are here for me."

We found arrangements were in place for checking the environment to ensure it was safe and well maintained. For example, health and safety audits were completed where obvious hazards were identified. Any maintenance repairs were reported electronically and the area needing repair made as safe as possible. Maintenance / safety certificates, for example, gas safety and Legionella, hot water checks, were up to date. Records showed fire alarms were tested weekly and emergency lighting on a monthly basis. The service had a fire risk assessment which was subject to regular review. Overall there was good attention to ensuring safety in the home and on-going maintenance and refurbishment.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. We found that safe recruitment procedures were followed.

Prior to the inspection an analysis of the number of notifications we received about incidents that occurred in the home was reported as high; this included the number of referrals made to safeguard people's welfare. The care records we looked at showed risk assessments were completed to guide staff how to mitigate risks related to people's individual health and social care needs. We saw risk assessments in areas such as falls, catheter care, mobility, nutrition and smoking. These recorded control measures to mitigate risks taking into account people's rights to independence. The registered manager told us that the incidence of falls was far less at this time as people were more settled. Sensor mats were available in people's rooms and this helped to alert staff should a person get out of bed.

Accidents and incidents were recorded and analysed to identify any trends or patterns to help reduce risks and keep people safe.

For a person who had suffered some episodes of aggression there was no chart in place to record and monitor these incidents. The registered manager informed us that had been no episodes of this nature since April 2017 and the person was settled at this time. This we observed, however, the registered manager agreed to place a chart on file, for recording such incidents, which was in accordance with an external professional's support plan.

We reviewed the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock checks and other medicine records for people living in the home.

Staff were administering medicines in the home and we both discussed with and saw evidence staff were trained in the safe administration of medicines and the registered manager checked competencies on a regular basis. Staff interviewed had a good knowledge of people's medicines and we saw these were reviewed on a regular basis by health professionals.

We observed part of a medicine round and observed the staff member administering medicines safely to

people. Staff took time with each person to ensure they had taken their medicine and to provide reassurance. People told us they were able to request pain killers if needed and got them promptly.

Medicines were stored in a locked trolley which was kept in a lounge. The service did not have a clinical room for the storage of medicines. The medicine fridge was kept in the kitchen and the temperature of the fridge was checked and recorded. The temperature of the fridge was within safe range; if medicines are not stored at the correct temperature, it can affect how they work.

The registered manager informed us that no one was prescribed a controlled medication at this time. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

MARs we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had and the charts had been completed fully. We looked at a number of MARs and saw that staff had signed the MAR charts to say they had administered the medicines. We saw that for medicines that needed to be given at a specific time, the staff ensured this was administered at the stated time. This was an important part of the person's treatment thus ensuring the efficacy of the medication. We saw that medicines were given safely as prescribed.

Quantities of medicines received into the home must be checked to provide an accurate stock check. We found quantities of medicines received had been checked and recorded. We checked the stock balance of a number of medicines and they were accurate.

We saw evidence of PRN (as required) protocols and records in place. PRN medicines are those which are only administered when needed for example for pain relief. Guidance regarding administration of people's medicines recorded within people's care plans; this included the administration of PRN medicines. When reviewing a number of MARs we saw that some people were prescribed a painkiller such as, paracetamol. We saw staff had recorded the actual times they were administered to ensure accurate records were kept when administered. This ensures the correct length of time is left between the doses.

The application of topical preparations (creams) were recorded on the MARs and cream charts were being introduced by the registered manager for the care staff to sign. Body maps were completed to identify the area of the body the cream was to be applied to.

For a person who was receiving their medicines covertly, staff were following the home's procedure for the medicines to be given via this route in the person's best interest. Covert administration for medicines means giving people medicines without the person's consent or knowledge in their 'best interest'. The decision to administer the medicines covertly was recorded and a risk assessment was in place to support this practice.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to the registered manager. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available. The registered manager had identified some safeguarding issues and had reported these effectively with good liaison with the safeguarding authority.

When we looked round the home we found it to be clean though there was a malodour in one of the lounges. This was raised with the registered manager and they informed us that carpets were regularly deep cleaned. A date was being arranged for this deep cleaning this month.

Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. We found one cleaning product in the hairdressing salon and some toiletries in a bathroom; these were removed; all other cleaning products and toiletries were safely stored.

Good

Is the service effective?

Our findings

We asked people to tell us what they thought about support they received. People said they were happy with the care and they could see their doctor at any time. People and their relatives confirmed the staff were good at caring for people with dementia.

Care record we looked at showed people received support to maintain their health and they could see a doctor when they wanted. People's care documents contained information about people's medical conditions, health care and medicines. We saw people had access to health care professionals, including GP, dentist, social worker, dietician, speech and language therapy team (SALT) and community psychiatric nurses (CPN).

Staff were aware of the importance of recording and monitoring people's health and welfare. We looked at a sample of these care monitoring records. Some people who lived in the home had their food and fluid intake recorded to help to demonstrate their diet, when, for example, they had lost weight. We found that most people's records were completed regularly. However, the records for one person, who should have had their food and fluid intake recorded, were not completed each day. Records showed gaps in recording for nine consecutive days in May and no record since 2 June 2017. We checked the person's weight chart which recorded their weight each month. We saw that they had put on weight between May and June 2017, which helped to demonstrate a good nutritional intake. They person concerned told us they were eating well and we saw this during the inspection. The registered manager put a fluid and diet chart in place but agreed to discuss this further with the health professional who was overseeing their care.

For a person who needed two hourly pressure relief their care monitoring chart recorded this care provision. The monitoring charts helped to provide an effective evaluation of care and discussions with the staff confirmed their knowledge around monitoring people's care and to ensure their optimum health and well-being.

During the inspection a person living at the home required emergency medical treatment. The staff provided this support in a professional and timely manner. They sought immediate advice and support from the emergency services; staff provided a great deal of reassurance and comfort to the person concerned.

During the inspection we spoke with three visiting healthcare professionals. They told us the staff were responsive to people's needs and were 'good at contacting them if they had any concerns'. They said they found the staff knowledgeable regarding people's current needs and they were happy that any recommendations they had made for people living in the home were followed by the staff caring for them. A visiting health professional told us how a person's mental and physical state had improved since coming to live at the home. They said the implementation of one to one support had been well managed by the staff and proven to enhance this recovery.

The PIR told us about the staff training and on inspection we saw records that showed staff received support and training in a number of areas. This included subjects considered mandatory by the provider such as, fire

safety, health and safety, safeguarding of vulnerable adults, infection control, moving and handling and deprivation of liberty safeguards (DoLS). Domestic and catering staff had completed mandatory subjects such as, food hygiene and nutrition and diet. Senior care staff had completed safe handling of medicines training in 2017.

New staff completed an induction when they began working in the home. This included four shadow shifts with experienced care staff and the completion of a 12 week induction course. The registered manager informed us that two new staff who had recently started work in the home would be completing the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers without any previous experience work towards and have their practice assessed and signed off by a senior member of staff.

All staff who worked at Abbotsbury EMI Care Home had achieved an accredited health and social care qualification made up of units such as, NVQ (National Vocational Qualification) at level two or three or Diploma under the QCF (Qualifications and Credit Framework). This was confirmed by records we saw.

We saw that staff had received regular supervision throughout the year and also an appraisal. Staff received supervision with a senior carer, deputy or registered manager at least every three months. The registered manager informed us that they preferred supervision to be held more often, usually once every eight weeks. Supervisions are regular meetings between an employee and their manager to discuss any issues that may affect the staff member; this may include a discussion of on- going training needs. Staff we spoke with told us they enjoyed their job and received good support from their colleagues and the registered manager. One staff member said, "We attend staff meetings, have training and have regular supervision meetings, it's very organised."

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager maintained records to show when applications had been made to deprive people of their liberty, when they were authorised and when they were due to expire. The registered manager had a good understanding of DoLS and was aware who this applied to within the home. We found evidence of good practice for best interest decision making, involving families and representatives, in areas such as medication and living in the home. Mental capacity assessments were undertaken for specific decisions, such as provision of care and medication to demonstrate that care and medication would be given by staff 'in people's best interests'. This included the administration of covert medication.

We saw examples of DNACPR (do not attempt cardio pulmonary resuscitation) decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with the relevant people.

We observed lunch being served both to people in the lounges and dining room and to people in their rooms. People sat either in the chair they were already in, with individual tables being used to facilitate this, or at the dining tables in the conservatory. Some people had a plate guard to help them eat independently.

People were not offered a napkin or condiments with their meal and there were no plate covers to help keep the food warm. We advised the registered manager of our observations.

People told us they liked the meals though not everyone said they got to see the menu. The menu for each day was written on a white board in the hallway and the menu recorded one option. We found that whilst there was only one option offered, people did ask and were given an alternative if they preferred. The registered manager confirmed that there were two meal options available and these were recorded on the main menu sheets.

People were given a hot main meal and a dessert at lunchtime, and soup and sandwiches with a dessert in the evening for tea. On the first day of our inspection the meals were being provided by non-catering staff as a chef had recently left. The registered manager informed us that there was a fulltime cook in post. We spoke with a carer who was knowledgeable regarding special diets people required and they told us of recent updates relating to changes in people's dietary needs. The carer was supporting the staff in the kitchen. A record of dietary requirements and preferences was on display in the kitchen. Staff offered people drinks and snacks regularly throughout the day. A person said, "I can have a 'cuppa' whenever I want."

The home was well lit and warm. The home had been adapted to support people with limited mobility and people had access to equipment to help their independence. Bathrooms contained equipment to assist people to bathe safely, including an easy access bath, and for a person who required the use of a hoist and special cushion to ensure their comfort and safety, this had been sought. There was a ramp up to the main entrance of the home. A passenger lift gave access to much of the home with a chair lift in one area. Doorways were wide to enable people using wheelchairs or walking aids to mobilise easily throughout the home and there was suitable access to the enclosed garden and patio area at the side of the building.

The home had a large number of wheelchairs and a hoist stored in a third lounge on the ground floor. The room was used as a 'quiet' room and also to conduct meetings. The registered manager informed us there was a lack of storage space in the home and therefore this room had to be used to store equipment. We saw the hairdressing salon was also used being used for storage and the registered manager said this would be cleared.

We looked around the home to see if the environment was suitable for people living with dementia. Some contrasting colours were evident and pictorial signs to help orientation, as well as a clutter free environment. People's bedrooms were identified by their photograph and the name they wished to be called by. A new menu board had recently been purchased to display pictures of the daily menu; this was going to be displayed this month. We saw staff photographs were displayed to help people to know who they were being supported by.

We discussed with the registered manager ways of developing the home further in respect of promoting a dementia friendly environment. This included the use of the garden which at the time of the inspection although enclosed was not secure. Plans to improve the grounds were discussed with the provider's representative.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring and staff treated them with dignity and compassion. People said, "They are very nice indeed", "Yes, they are very good", "I have every confidence in them (staff)", "Yes, the staff are polite." People went on to say the staff listened to them though we received a mixed response when we asked if staff had time to sit and chat.

The SOFI we undertook helped to confirm that when staff assisted people, their interactions were positive and good communication existed between staff and the people they supported. Our observations showed people living at the home were relaxed and at ease in the company of the staff. Relationships were warm and friendly. When staff attended to people's needs their approach was kind, patient, gentle and friendly. We observed staff supporting people with moving around, accessing the toilets, administering medicines and in some cases helping people with meals and drinks. Over lunch we observed no one was rushed though there was minimal interaction by the staff with the people they were supporting. For a person who changed their mind and wanted something else to eat, the staff were respectful of this decision and offered alternatives. People told us that when they needed support with daily tasks and person care, staff did respond in a timely manner. People said, "Oh yes, they do their best every time" and "I see them first and then call them."

The PIR told that Abbotsbury EMI Care Home was a dignity champion though there was no one particular staff assigned for this role. This was something the registered manager was looking to address. Staff told us how they promoted good standards of dignity in the workplace and we saw staff knocking on people's doors before entering, or saying hello/calling the person's name when their door was open, before going in. People's bedroom door could be locked and people were offered a key if they so wished to maintain their privacy. During the inspection the radio was on in both lounges and the volume was up loud. We did not see any staff ask people if they wanted the radio on.

The staff we spoke with were able to talk about people as individuals and knew their preferred choices regarding routine and what was important to them. Staff we spoke with told us they encouraged people to make choices, such as choosing what clothes to wear each day, what to have to eat and drink, what activities to get involved with. A staff member said, "This is their home, their needs come first."

Due to the nature of the service people at the home were not always able to be involved with planning their care though staff told us how they spent time with people and their families to get to know their care needs. We observed staff seeking consent from people before undertaking an activity or task with them. An example of this was obtaining a person's consent before helping them to the bathroom or their bedroom.

Care plans we viewed contained evidence of people and /or their families being involved in the care planning process; this was evident through signed consent forms and records of discussion with people and families. We discussed with the registered manager better recording around consent within the care documents to evidence people and/or relative inclusion as part of the care review when changes to the plan of care were needed.

During the two days of the inspection we observed relatives visiting the home at various times. The staff told us there were no real restrictions on visiting though if people wished to retire early then relatives were informed. We saw that positive relationships were encouraged with relatives. A relative told us, "The staff are excellent, really good, no concerns at all."

For those who did not have any family or friends to represent them, contact details for a local advocacy service were available at the home. One person was actively receiving support from an advocate at this time. One person told us as they had no visitors so the staff took them out once a week.

We discussed the provision of end of life care with the registered manager and were shown documents for future care planning. These wishes were clearly recorded and kept under review in accordance with people's wishes.

Good

Is the service responsive?

Our findings

We asked people how staff knew what they liked/disliked and if they could make choices about how to spend their day. People told us they could make choices and were involved in day to day decisions. A person said, "I like to sit in this lounge and like the singing." With regards to social activities and relative told us the staff always asked if their relative would like to join in but it was their decision and they were 'not forced'.

We saw staff knew people well. For example, for a person who had a particular way of wearing their foot wear, staff were aware and followed their instruction. For another person, staff had a good knowledge around when to offer support with personal care in accordance with how the person was feeling on the day.

We looked at how people's care was planned and recorded. We saw that a pre assessment of care which was completed with the involvement of the person where possible, relatives and relevant health professionals. This information helped to formulate a plan of care. A care plan provides direction on the type of care an individual may need following people's needs assessment. The care plans we saw recorded information which included areas such as, personal care, medication, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and medical conditions. Care plans were specific to the individual and there was reference to social background and life story to get to know people's social care needs in more detail. Details around this were recorded in the PIR. The PIR told us that 'we (the home) have a ''Life Story'' document that we ask the families to have input in as well if the resident is unable to tell us about themselves so we can get to know them better and how we can reassure them if anxious'. These records, along with staff's daily written evaluation/notes meant care files contained important information about the person as an individual and their particular health and care needs.

When reviewing care documents we found not everyone's plan of care had been fully updated to reflect the current care provision. For one person their plan of care lacked detail about the need for pressure relief during the day (this was recorded for night time); for another person their plan of care lacked detail information on how best to provide staff support and the triggers involved when dealing with a behaviour that may challenge and have the potential to place them and others at risk. Detailed risk assessments were in place to support these needs and during the inspection the registered manager took prompt action to review and update the documents concerned. The registered manager completed a plan of care to support a person who was receiving covert medication to support an existing risk assessment and protocol for this practice. Following the inspection it came to light that the original covert plan of care was with the person's MAR. Staff interviewed were able to confirm the care needs of these people and we saw this care and support being delivered safely and effectively during our inspection. Other care plans we saw were completed in good detail.

Relatives said the staff communicated with them in a timely way about any changes to their relative's health care needs. A relative said, "I always get a phone call if they (staff) are worried."

We asked what sorts of things the home provided to keep people interested, active or involved. The home had four external activities organisers who visited the home each week and six hours allocated for a member

of the care team to oversee social events. We met with an activities organiser who visited the home twice a week. They were enthusiastic about their role and told us how much people enjoyed singing along. There was plenty of laughter and chatter between people and the staff and this was particularly evident during the music session which a number of people took part in during the afternoon. People were able to take part in games, chair exercises and beauty sessions. They were also able to attend social events held in neighbouring care homes.

People had access to a complaints' procedure and this was available and displayed for people living in the home. A system was in place to record and monitor in line with the provider's policy. We viewed a recent complaint about the home which we had notified the registered manager of. The complaint had been investigated fully and the complaint response was on file; a copy of which had also been sent to us. People said they could speak to staff if they had any concerns with one relative saying, "No problems. They (staff) are very communicative."

People were unsure about how they could give feedback about the home though we saw that in April 2017 pictorial questionnaires had been given out. The questionnaires helped to ascertain people's current mood. We viewed a number which provided positive responses. The PIR told us that feedback from people had resulted in the bathroom being upgraded and we saw people now had the use of a specialist bath.

Requires Improvement

Is the service well-led?

Our findings

We looked at the governance arrangements to monitor standards and drive forward improvements. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with an effective and safe service.

We found arrangements for monitoring standards were not always robust to ensure the service was run in the best interest of people who lived there. The existing auditing system which included a number of audits completed by the registered manager and the director's audits had not picked up on the deficits we identified or were pending completion. For example, ensuring people safety in respect of having enough staff on duty and assessing these levels based on people's dependencies and ensuring effective fire prevention monitoring. We were concerned as we found a number of fire doors did not shut to their rebate and this work was therefore completed when we brought this to the attention of the service. Care plan reviews had not picked up on all the shortfalls we identified when reviewing care documents. We were informed there were no outstanding actions from the director's audit when reviewing this document. We saw the director's monthly audit had not been completed each month.

The registered manager showed us an audit from April 2017 and the previous audit was completed in February 2017. There were no other audits on file.

This is a breach of Regulation 17(1) (2)(a)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a clear management structure for the service at provider level and within the home. The registered manager was supported by a deputy and senior carers.

We found the registered manager had a positive ethos of care in the home. The registered manager was open and reflected positively on the feedback we gave as we went through the inspection. The provider's representatives took swift action to rectify the fire doors and staff took part in a fire drill during the inspection to reinforce fire safety procedures.

The PIR said, 'we promote open and effective communication to those who use our service to ensure that the care is person centred, open and empowering.' On inspection staff and relatives were complimentary regarding the registered manager's leadership qualities. People and relatives we spoke said the manager was very nice and helpful and that there was a good staff team. Their comments included, "Yes, very friendly, helpful, and approachable" and "She is a really friendly and nice person, very cheerful." With regards to the overall management a relative told us, "Yes, I just think it's a wonderful place for my (family member) to be in, the care is exceptional, and "Very good communication." A staff member said, "The manager is brilliant, you can go to (manager) with anything, (manager) has made so many good changes."

We discussed with the registered manager the overall management and development of the service and also the home's vision, values and culture. The registered manager told us about how they strived to

develop the service using 'best practice' and research based guidance for people who have dementia. For example the registered manager attended a local 'dementia care' forum and any learning was shared with the staff. The registered manager informed us that a staff member was being appointed the role of infection control lead to monitor standards of cleanliness. A new infection control audit has recently been introduced and this was completed during the inspection as we raised a concern around a malodour on entering the home. The need for a more regular deep clean of the carpets was discussed during the feedback and the provider's representative took swift address to address this.

We viewed other audits of the home and this included medicines and maintenance checks. These were current and no concerns had been identified.

The service had systems for getting feedback from people living at the home and their relatives as well as staff. Surveys and meetings were held. Resident and relatives' meetings were held every two months and staff meetings, plus a separate senior meeting, every three months. Relatives told us they were able to attend the meetings and minutes were available. Staff said the meetings provided opportunities to discuss the home and future events.

The registered manager was aware of their responsibility to notify us, CQC, of any notifiable incidents in the home.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Abbotsbury EMI Care Home was displayed for people to see.

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 We found arrangements for monitoring standards were not always robust to ensure the service was run in the best interest of people who lived there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not ensure people were always supported by sufficient numbers of staff. This posed a risk to their safety.