Ramos Health Care Limited  
Abbotsbury EMI Rest Home

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<th>Region:</th>
<th>North West</th>
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| Location address: | 25 Park Road  
Southport  
Merseyside  
PR9 9JL |
| Type of service: | Long term conditions services  
Community based services for people with mental health needs  
Care home service without nursing |
| Date of Publication: | July 2011 |
| Overview of the service: | Abbotsbury EMI Rest Home is a care home providing accommodation and personal care for up to 21 older people who have dementia. The detached accommodation is a large 3-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 for people who are wheelchair users or who have limited mobility. |
Our current overall judgement

Abbotsbury EMI Rest Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider and looked at records of people who use services.

What people told us

As part of the previous review we visited the home on the 5 January 2011 and spoke with nine people who live there. We also spoke with relatives who were visiting the home at the time. We sought additional views by speaking with relatives by telephone.

In relation to the care and support, the feedback we received was that the staff were kind, caring and attentive. Relatives said that their family members were happy living there and all were complimentary about the friendly attitude of the staff. Relatives said the staff make them feel welcome when they visit. One relative described the home as "extended family support".

We did not seek further views during this review.

What we found about the standards we reviewed and how well Abbotsbury EMI Rest Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

We acknowledge that the provider had taken action following our previous review by putting in place individual risk assessments and risk management plans. However the plans were not sufficiently developed to ensure all areas of risk were captured. In addition both general care plans and risk management plans did not contain sufficient information to promote a clear and consistent approach for staff.
The use of the Activities of Daily living model as a checklist for care planning was not supporting a person-centred approach. In addition complex needs were being missed, most likely because this model does not include cognition, mental health and behaviour as a core activity.

There was limited evidence to suggest that relatives or representatives were involved with care reviews.

Improvements are needed for this Outcome and we have set a compliance action.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 04:  
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement
There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
As part of the previous review we visited the home on the 5 January 2011 and spoke with nine people who live there. We also spoke with relatives who were visiting the home at the time. We sought additional views by speaking with relatives by telephone.

In relation to the care and support, the feedback we received was that the staff were kind, caring and attentive. Relatives said that their family members were happy living there and all were complimentary about the friendly attitude of the staff. Relatives said the staff make them feel welcome when they visit. One relative described the home as "extended family support".

We did not seek further views during this review.

Other evidence
We last carried out a review of Abbotsbury in January 2011 which was triggered by concerns that people living there were not always receiving safe and appropriate care. We reached a judgement that the provider was not compliant with Outcome 4: Care and welfare of people who use services. We determined that this was a major concern and we set a compliance action for the provider. We received an action plan from the provider outlining how compliance would be achieved. This was followed up by the local commissioning team in April 2011.

In May 2011 the ambulance service reported to adult safeguarding a serious issue of neglect of a person living at Abbotsbury. A safeguarding strategy meeting took place on
the 25 May 2011. One of the actions agreed at the meeting was that we would undertake a review of Outcome 4 to determine whether the people living at Abbotsbury were receiving appropriate and safe care.

We visited the home on the 1 June 2011 and looked in detail at four care records with a particular focus on assessment, care planning, risk management and review of care needs.

Each person had a separate care record file. Although the files were stored safely in the office, they were accessible to staff. The records were systematically organised with an index which made it easy to locate specific information promptly. Each file contained a personal profile about the person such their next of kin and contact details for their GP. Individualised information such as preferred foods, special dietary requirements and clothes size were also included.

We observed that each care record contained a medical history section which provided information such as diagnosis, previous health issues and medication. The medical history section also took account of current health needs in relation to matters such as vision, hearing, skin integrity, mobility and dental needs. We observed that some files contained the initial assessment of need which was completed prior to or at the point the person moved into the home.

We noted that records were on file of contact with and visits from health and social care professionals such as the GP, social worker or community nurses. We saw a good and well documented example of how the staff supported a person with toothache to access a local dentist.

The Activities of Daily Living (ADL) model is used by the home as a framework to assess each person and to formulate care plans. The model includes 12 activities which are:

• Maintaining a safe environment
• Communicating
• Breathing
• Eating and drinking
• Eliminating
• Personal cleansing and dressing
• Controlling body temperature
• Mobilising
• Working and playing
• Expressing sexuality
• Sleeping
• Dying

The Activities of Daily Living is the main component of a broader nursing model that is widely used in the UK and is particularly used by nurses in medical and surgical settings*. Whilst the Activities of Daily Living model provides a framework for directing and promoting consistency of care, the model centres on physical needs and does not specifically include cognition, memory and behaviour as a core activity.
We observed that each person had a care plan for all 12 activities even if they had no particular needs or concerns related to that activity. For example we noted that there was a care plan in place for each person in relation to controlling body temperature yet medical history or assessment did not indicate anybody had difficulties with regulation of body temperature. We discussed with the manager that using the Activities of Daily Living model as a checklist for care planning can lead to more complex needs, particularly those needs associated with mental health and behaviour, being missed. Best practice would suggest that developing care plans for people with dementia should be person-centred. With this approach care planning not only takes account of assessed needs but is determined by the person's life history, experiences, likes and dislikes and defining characteristics.

Generally we observed that care plans lacked content in that they did not always make clear how a person's need should be managed. For example one person's plan about using the toilet (eliminating) merely stated to be 'regularly toileted and changed'. There was no indication of how frequently the person should be supported to use the toilet or if/what continence aids (i.e. pads) should be used.

Our review of compliance with Outcome 4 in January 2011 concluded that risk management at the home was neither robust nor systematic. Most of the people with known risks did not have a clear and detailed risk assessment and risk management plan in place. As a result we set a compliance action for the provider. It was positive to observe that all the care records we looked at during this review included a risk assessment and risk management plan. We observed that risks outlined in recently completed assessments lacked content and did not always take account of the assessments completed by other professionals. For example an assessment by a social worker in 2009 outlined that a person had difficulty swallowing and should have a soft diet. Although the person had a care plan around eating and drinking, the risks associated with swallowing and how they should be managed were not addressed in the plan. Furthermore a risk assessment informed us that a person with unstable mobility was at times being helped by other people living in the home. However there was no care plan to address this scenario given the high risk of falls and/or injury to both the person with the unstable mobility and the other people living there.

We looked at the daily record entries from February - April 2011 and observed that at least two people had been verbally and/or physically aggressive on a number of occasions towards staff and/or other people living there. Care plans were not sufficiently developed to provide clear guidance for staff on how to manage these challenging situations.

The daily records informed us that when a person sustained an injury (i.e. skin tear) or treatable condition (i.e. skin rash) that the home had contacted the relevant health professional for advise. However a care plan, albeit a short term plan, was not developed as a result. For example we noted from the records that the district nurse was coming to the home to change a dressing on a person's leg. A brief short term care plan was not in place which would have guided staff about matters such as the frequency of dressing changes, bathing and what to do if the dressing falls off or the wound deteriorates.

The records informed us that care plans are regularly reviewed by key workers. However there was very limited evidence in place to suggest that relatives or
representatives were involved in care reviews.


**Our judgement**

We acknowledge that the provider had taken action following our previous review by putting in place individual risk assessments and risk management plans. However the plans were not sufficiently developed to ensure all areas of risk were captured. In addition both general care plans and risk management plans did not contain sufficient information to promote a clear and consistent approach for staff.

The use of the Activities of Daily living model as a checklist for care planning was not supporting a person-centred approach. In addition complex needs were being missed, most likely because this model does not include cognition, mental health and behaviour as a core activity.

There was limited evidence to suggest that relatives or representatives were involved with care reviews.

Improvements are needed for this Outcome and we have set a compliance action.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

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<th>Regulated activity</th>
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<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 04: Care and welfare of people who use services</td>
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**How the regulation is not being met:**

We acknowledge that the provider had taken action following our previous review by putting in place individual risk assessments and risk management plans. However the plans were not sufficiently developed to ensure all areas of risk were captured. In addition both general care plans and risk management plans did not contain sufficient information to promote a clear and consistent approach for staff.

The use of the Activities of Daily living model as a checklist for care planning was not supporting a person-centred approach. In addition complex needs were being missed, most likely because this model does not include cognition, mental health and behaviour as a core activity.

There was limited evidence to suggest that relatives or representatives were involved with care reviews.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

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