Four Seasons (Evedale) Limited

Evedale

Inspection report

Occupation Road,
Coventry CV2 4AB
Tel: 024 7644 8292
Website: www.fourseasons@fshc.co.uk

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 21 October between 6.45am and 7pm. It was unannounced. We went back to the home the following week to meet with the manager and regional manager who were not available on the day of our unannounced inspection.

At our last inspection in April 2014 we identified concerns with the number of agency and bank staff used and the lack of consistency in care. We also identified concerns with medication management and record management. Following this the provider sent us an action plan which told us about the improvements they intended to make. At this inspection we found there were still improvements to be made in these areas.

Evedale Care Home provides residential and nursing care to a maximum of 64 people. It provided care to older people, people with dementia, and people with mental health conditions.

Since our last visit, the registered manager resigned but had not applied to have their registration cancelled with the Care Quality Commission. The name of the manager at the front of this report is therefore not the name of the person who is currently managing the service.

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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The new manager had not applied to be registered with us at the time of our inspection.

There were not enough staff to meet people's needs. The provider was trying to fill the gaps in the rota with agency and bank staff. The use of agency and bank staff to cover staff vacancies meant people were not provided with continuity of care by people who knew them well. The 'staffing tool' used by the provider did not provide sufficient staff to meet the needs of people or take account of the size and layout of the building.

We saw staff were kind and most of them were attentive to people when they provided personal care. However, staff interaction with people was mostly when supporting people with care tasks. We saw little involvement between staff and people at any other time of the day. There were no activities and no opportunities available for people to pursue their individual interests or hobbies.

Medicines were mostly administered safely, although some areas of administration needed improvement to ensure that people received their medicine safely.

Staff had not ensured people who could use call bells had easy access to them.

Care records were not always fully completed. We could not be sure if care had been delivered to people in accordance with the person's care plan.

People's nutritional needs were met but they had varied experiences at mealtimes because some people did not receive the dedicated one to one support they required to eat and drink, and the provider had not considered how best to ensure people with dementia received a choice of food.

Permanent staff had received training required to undertake their work safely. We found they had not recently received sufficient supervision or support from management to help them work effectively.

We found safe recruitment practice and staff understood how to protect people who used the service from abuse.

We found the service met the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

The home had been through a period of management change and as a consequence staff had been through an uncertain and challenging period. The provider was aware there were concerns at the service and they were working with the new manager to improve the quality of care provided to people.

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

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?

Inadequate

The service was not safe.

People told us they did not feel safe. The number of staff on duty and the high use of agency or bank staff, did not provide sufficient staff to meet people's needs consistently.

Processes to manage risk were not always managed safely, however there were good systems for recruitment, and protecting people from potential abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People had access to health care services although staff had not always acted on the advice of healthcare professionals. The menu provided people with good nutrition but meal times were not always a positive experience and the provider had not fully considered how to provide choice to people with dementia.

Permanent staff had received training to deliver effective care but had not received regular supervision or consistent support from management in the last few months.

Deprivation of Liberty Safeguards (DoLS) had been fully implemented in the home, and people with dementia had a mental capacity assessment in line with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff were caring towards people and understood how to treat people with dignity and respect. People were not always asked about their views and preferences in day to day decisions.

People's dignity was compromised as staff were unable to attend to them in a timely way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had limited opportunity to contribute or be involved in planning for their care. Care records were not always completed which meant we could not know whether care had been carried out according to the care plan.

People were not supported to follow interests or be involved in social activities. There was limited opportunity for relatives or people to provide feedback about the care provided.

Summary of findings

The provider had investigated formal complaints according to their policy and procedures.

Is the service well-led?

Requires Improvement

The service was not always well-led

Staff had not received consistent management over a five month period. A new manager was in post but was not registered with us.

The provider had been working hard to improve the service but changes had not been fully implemented.

Evedale

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 was planned to check 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.

The inspection took place on 21 October 2014, from 6.45am to 7pm. It was unannounced. We went back to the home the following week to speak with the manager and regional manager as neither were available during the time of our unannounced inspection.

The inspection team consisted of an inspector, a specialist advisor, and an expert by experience. The specialist advisor was a nurse and a specialist in dementia care. The expert by experience was a person who had personal experience of caring for someone who had dementia.

Before the inspection we asked the provider to complete 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 improvement they plan to make. They did not complete the PIR prior to our visit however we were satisfied with the provider's explanation for the non return.

We also looked at the notifications sent to us by the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect the health, safety and welfare of people who live at Evedale Care Home. We also spoke with the local authority contract monitoring officer.

During our inspection we observed how staff interacted with people who lived in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people who used the service and eight relatives. We spoke with six care and nursing staff.

We looked at six people's care records, records to demonstrate the registered provider monitored the quality of service provided two staff recruitment records, and complaints, incident and accident records.

Inadequate

Is the service safe?

Our findings

At our inspection on 24 April 2014 we were concerned that staffing levels and the high use of bank and agency staff to cover staff vacancies, led to inconsistent care and did not provide sufficient support to meet the dependencies of people who lived at the home. This meant the provider was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following the inspection the provider sent us an action plan detailing how they would make improvements. During this inspection we still found concerns with the number of staff available to support people, and the high use of agency and bank staff.

People and their relatives told us they did not feel safe. They felt there were not enough staff to look after people properly.

We spoke with staff working at the home. They told us they had concerns about staffing levels. One staff member told us, "At night there is ridiculously low staff. I wouldn't feel safe if I was a client at night." Another member of staff told us, "Since May we've really struggled [with staff], care staff have left and permanent staff have to work around those who do bank, due to bank staff working at the hospital." A third staff member said, "I'm feeling scared, I'm waiting for an accident to happen, we are trying our best but we are always short of hands – everyone is doing extra shifts, I am personally very exhausted."

We looked at the rota for a two week period for night and day staff. During the night three staff supported people on each floor. We saw the staff numbers were covered with a high number of agency and bank staff. We looked at the rota for day staff. We saw during the day there were mostly six members of staff on duty on each floor (including nursing staff). Again, we saw a high use of bank and agency staff. Permanent staff told us that whilst the use of agency staff meant the numbers on the rota were covered, it also meant they had additional work to do in supporting agency staff to understand how the home was run, and in helping them understand the needs of people they were caring for. This impacted on the time they had available to meet people's care needs. Staff on the ground floor told us they felt there were insufficient staff.

We looked at the dependency tool used by the provider to determine how many staff should be on duty to meet the needs of people living in the home. We found the tool did not take into account the size and layout of the building when calculating how many staff were required to meet people's needs. We found the layout and size of the building meant it took staff more time to attend to, and support people with their care needs. For example, We spent 40 minutes observing people sitting in the ground floor lounge. No member of staff was available to respond to people's needs. One person started calling out they needed to go to the toilet. We waited to see if a member of staff would arrive to support the person. They called out again and still no member of staff came. We did not want the person to continue to be in distress and so we went to find a member of staff to support the person's personal care needs. Staff were unable to hear the person because they were attending to other people in a different part of the unit.

We saw instances where the lack of staff meant staff could not always take timely practical action to relieve people's distress or discomfort. For example, at lunch time one person with a bad cold had a very runny nose. This dripped into the person's food more than once because staff were not available to help them.

We spoke with the new manager and regional manager about staffing. They were aware the staff shortages were a concern and had worked hard to recruit staff and had looked at different ways of improving the retention of staff. They told us some staff who had been recruited left soon after starting work at Evedale. Other applicants had been offered posts but had not been able to start work because the checks made by the Disclosure and Barring Service on people's police records had not been received by the home.

We were told the use of agency staff had also increased in October because staff working at the service had to take their annual leave by the end of October or lose their entitlement. The regional manager informed us the previous manager had, unbeknown to them, agreed annual leave for a significant proportion of staff in September and October and this meant their hours had to be covered by agency and bank staff. The manager told us they would be planning annual leave with staff to ensure this did not happen again.

This meant the provider was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

Staff recruitment practices at the home provided protection to people from the risk of being cared for by staff unsuitable to work with people. We looked at recruitment records and found checks had been completed to support the safety of people living at the home.

At our inspection in April 2014 we had concerns about the accuracy of the recording of medicines administered at the home. During this visit we checked 15 people's medicine administration records (MARs) and found most of the records were up to date and accurate.

We had concerns that nursing staff were not following safe practice guidance in the administration of medicines. We arrived at the home at 6.45am. We walked up the corridor of the first floor. We saw a door to one person's room was open and the person was asleep, fully dressed, in a chair by their bed. We saw a pot of medicines had been left on the table next to them. There was no nurse attending to them. Another person told us, "Medication gets left on the table in a little pot for me to take." We asked if the member of staff stayed in the room until the person took the medication, and they replied, "No." This meant there was a risk medication would not be taken or that another person would take the medicines by mistake.

One person was prescribed digoxin (a medicine used to treat heart failure and abnormal heart rhythms). It is safe practice to monitor the pulse to determine whether the pulse was too fast or too slow before administering the medicine. We found on one occasion the pulse was not checked prior to administration. The provider informed us they would undertake clinical supervision with the member of staff to remind them of their responsibilities.

Medicines including controlled medicines were stored safely in line with manufacturer's guidance and the administration and recording of controlled medicines was safe. We saw detailed protocols were in place for people who received 'as required' medicines. This meant all staff would understand why people were prescribed the medicines and promote consistency in administration.

Identified risks had been assessed for individuals and management plans developed to minimise the risks and protect people from harm. We saw risk assessments relating to issues such as medical conditions, nutrition and hydration, and skin integrity. Not all risk assessments had been updated, and staff had not always updated the risk assessment tool to determine the dependency needs of people. This meant we could not be sure the provider had an up to date understanding of the risks and dependency of all people living at the home.

The regional manager had reviewed accidents, incidents and records of people who were at risk. Their review in September 2014 found the falls people had experienced had not been analysed to see whether there were trends or patterns in falls and to act on any individual fall risks. They had also identified gaps in care records and inconsistencies in risk assessments.

We were concerned people were put at risk because call bells were not always in reach of people, either in the communal areas or in people's bedrooms. During our 40 minute observation we saw none of the five people sitting in the room were independently mobile. None were positioned in the room where they had access to a call bell to inform staff if they needed support or help. One relative told us their relation did not have a call bell in reach in their bedroom since the bedroom furniture had been moved around.

This meant the provider was in breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One of the lifts and the bath on the top floor were out of order and had been for over two months. We found some of the rooms had door handles hanging loose. After the inspection, we discussed this with the provider. They confirmed the door handles were no longer loose, and explained why the bath and lift had been out of action for so long. We were satisfied the provider was working to rectify both issues in a timely way.

We asked staff how they ensured people who lived at the home were safe from abusive behaviour or actions that could cause harm. All staff we spoke with had a clear understanding of what constituted abuse and what actions they should take. One person told us, "I would report it, I would stop it happening." The manager confirmed all permanent staff had received training in identifying and reporting abuse.

Requires Improvement

Is the service effective?

Our findings

We looked at how food and drink was provided to people. We saw there was a good choice of meals and snacks available to people. However, we were concerned the home did not fully support all people with dementia or poor memory, in making choices for their meals. We were informed on the dementia unit, people were supported to make their choices through the use of picture card menus and could make their choices on the same day. People who lived on the ground floor made their choices the day before to aid forward planning. For example, we were told people could order a cooked breakfast the day before and we saw cooked breakfasts plated up ready to give to the people who had requested it.

We observed breakfast being served in the ground floor dining room. We saw some people in the dining room had poor memory or dementia. We saw there was a choice of cereal, but the cereals were not out on display and most people were observed eating porridge. This meant people who could not recall what a cooked breakfast was, or had forgotten the range of cereals, were limited in their choice. We also saw staff struggled to understand the needs of a person who did not have English as their first language. We saw there were no pictures to help communicate with the person, written words in the person's own language, and staff did not know any words in that person's language to help them support the person.

Staff did not always provide effective support to people who required assistance to eat their meals. We saw on the ground floorstaff did not always have the time to sit with one person from the start to finish of their meal. Instead we saw them start to support one person, and then move to another person, and come back to the person they started helping.

One person told us they should be having physiotherapy to help them walk again but this had not happened. We saw the physiotherapist had left photographic and written instructions for exercises to aid the person's recovery from an operation. We asked a member of staff if staff had been supporting the person to do the exercises. The staff member told us they had not. We looked in the person's care records and we could find no record of other staff supporting the person to undertake the exercises.

This meant the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) 2010.

Other care records showed us people were referred to appropriate health and social care professionals and staff had followed advice given. These included the person's GP, tissue viability nurses, the speech and language team (SALT) and psychiatric services. For example, we saw where the speech and language team had changed the diet of a person to a pureed diet because of their risk of swallowing, this had been carried out.

Permanent staff had received training to support them in ensuring people's health and safety was met. This included moving and handling training (to safely support people who required equipment such as hoists to move them), infection control, and safeguarding adults. We saw systems in place to alert the provider if staff had not updated their required training to ensure this was met. Much of the training was e-learning. We saw staff put their training into practice. For example, we saw the safe moving of people, and staff used aprons and gloves effectively when undertaking personal care to reduce the potential for infection spreading. The regional and manager told us training was planned to improve staff's knowledge and understanding of dementia care needs.

Staff had been through a period of management instability and not all had received regular supervision to support them in their work. One staff member told us, "We were having regular supervision but I haven't had one this year". Another told us, I've had supervision with the nurse, every six months we get supervision." We saw a management audit which showed the provider had identified staff were not receiving the number of supervision sessions the provider expected and were putting plans in place to address this.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff responsible for assessing people's capacity to consent to their care, demonstrated an awareness of the Deprivation of Liberty Safeguards (DoLS). This is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. There were no people subject to any formal authorisations to deprive their liberty at the time of this inspection.

Requires Improvement

Is the service effective?

The manager was aware of a recent high court ruling which meant the criteria for applying for a DoLS had changed. They told us they had sent some applications to the supervisory body (the local authority) for their consideration.

We found staff followed the principles of the Mental Capacity Act 2005 (MCA) and were acting in the person's best interest. The MCA protects people who lack capacity to make certain decisions because of illness or disability. We saw where people did not have full mental capacity, assessments had been made to inform of the person's decision making abilities and how and why these may vary. We saw a 'best interest' meeting had taken place for a person without full mental capacity to determine whether they should have medicines given in disguise (covertly) as they sometimes refused their medicines.

Requires Improvement

Is the service caring?

Our findings

We saw many permanent staff had a good understanding of people's needs and preferences. Staff used different ways of enhancing communication by using touch, and by ensuring they were at eye level with people who were seated or in bed. However, on the day of our inspection there were new staff and agency staff on duty who were still learning about people's needs and communication with people was often brief.

When staff undertook care tasks they were seen to be caring and kind. For example, we saw a person pour their drink into their pudding. A care worker spotted this quickly and replaced the person's drink and pudding and told them, "not to worry about it." A relative told us, "Staff are very good, they do look after [person]...person] is not always patient, these guys are always patient." Another relative said their relation had lived at Evedale for over a year. They told us, "Staff are great, they've got the patience of a saint."

Staff told us they wanted to be able to spend more time with people. They said they wanted more meaningful interaction with people. One member of staff told us, "We don't get time to talk with people unless we're doing personal care. It would be nice to not have a routine. If residents are stuck in their room, it becomes a routine of only speaking to them when the tea-trolley comes." Another member of staff told us, "I would love to spend some quality time on a one to one basis with residents."

We did not see staff always seek the consent of people during day to day tasks. For example, a person was brought into the ground floor lounge in a wheelchair by a new member of staff. The staff member did not ask them where they wanted to be positioned in the room. Later, the person had to leave the lounge for personal care. An experienced member of staff helped deliver the personal care and returned the person to the lounge. When they returned, the person was not given the choice of where they wanted to be positioned in the room. Instead they were placed against a wall at the far end of the lounge, away from other people. We asked the person if they had been given a choice of whether to come back into the lounge, and they very clearly told us, "No".

We did not see people always being involved in day to day decisions about their social care needs. For example, five people had been placed in the large ground floor lounge at 10.30am and were there until 1pm when lunch was served. We saw them sitting in front of the TV screen. They had lunch in the dining room and were then placed back in the lounge for the afternoon where they were mostly left to sit in front of the TV screen again. None of the people appeared interested in the programmes showing, and we did not see people being asked if they wanted to be in the room or if they wanted to watch the TV.

Some people were being cared for in bed with their bedroom doors ajar. We observed one person's bedding had become dislodged and this exposed their legs and lower half of their body to people passing in the corridor including visitors. A visiting psychiatrist told us they had just left the room of a person who, "Was half undressed with no dignity, lying at a 45 degree angle with their legs hanging over the bed." This meant staff had not attended to the person's needs to support their privacy and dignity.

Records seen did not demonstrate that people were involved or contributed to assessing the quality of care provided. People who had capacity were not involved in the reviews of their care.

There had been a relatives meeting in July 2014 to inform people of the new manager and one had been arranged for 30 October 2014 to discuss staffing, recruitment and activities.

Requires Improvement

Is the service responsive?

Our findings

Due to the staffing levels, we saw very little social interaction and stimulation for people who lived at Evedale. People who were cared for in bed were socially isolated and depended on relatives or friends for company, and interaction with staff for the brief periods of time they were providing care support. One person told us it was easier for them to stay in their room all the time and for the most part in their bed. They said it was, "Lonely," but they were pleased that a bird feeder was placed outside their window so they could watch the birds. Another person told us they could not remember ever having been asked whether they wanted to get up out of bed to visit other parts of the home or to be encouraged to interact with others.

There was not a programme of activities for people, and there had been nothing available since August 2014 to support people with their own hobbies and interests. One relative told us, "Nothing like this had been encouraged since the departure of the Activities Coordinator in August." A relative told us, "[Person] had seen physical activity going on in the unit upstairs, but [person] had never seen anything of this nature taking place downstairs. People just seemed to sit and watch TV or sleep down here." We found other staff had not been able to support people's hobbies or interests because of the other staffing challenges.

It was confirmed by staff and the manager that the 'activity worker' had left their post in August 2014 and no-one had replaced them. We were told by the manager a new activity worker would be starting soon. This one person would have the responsibility to support and encourage a programme of activities and individual interests for up to 60 people. We were unsure this would be sufficient to meet the needs of all people in the home.

We looked at a sample of daily charts and 'My Journals'. These were the provider's system to ensure there was evidence staff were carrying out the care detailed in the care plans. We saw gaps in the records of three people. For example, one person's journal had not been completed since 2 October 2014 This meant we could not be sure that care had been carried out according to the care plan.

The home was open for visitors throughout the day and night. We saw people come to the home and ring the doorbell a number of times for staff to hear them and let them in. On a few occasions we had to find staff so people could get into the building. A relative told us this had been a problem for a while. The regional manager told us they were in the process of getting quotes to have a new door entry system which meant staff would be able to respond more effectively to the doorbell.

A relative told us the manager had been responsive to an informal request to move their relation from the first floor of the home to the ground floor. The relation had found the first floor too noisy and had felt intimidated by others. They felt happier downstairs but said, "The room is not a place she can spend very much time as it is so dark due to the large bush outside the window…it's not right that someone should have to stay in a room that is so dark and hardly gets any sun. It is depressing." The provider told us they were aware of this and had arranged for a tree surgeon to attend to the bushes.

We saw there had been complaints made to the home and the provider had responded to the formal complaints in line with their complaints policy and procedures. Where the investigation had identified learning points for staff, these had been acted on. We were aware two of the complainants were not satisfied with the outcome of the investigation. They had been provided with information about how to escalate the complaint and request a review of how the complaint had been investigated.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection the home has had a period of management instability. The registered manager left in early June 2014 and the provider put in place interim management arrangements until a new manager was recruited and started in the first week of August 2014. Staff told us this had proved difficult because the different managers had different styles. They told us this had led to some staff losing motivation and focus. At the time of our inspection the new manager had not applied to the Care Quality Commission to be the registered manager.

The manager and regional manager were not present at the inspection on 21 October 2014. We went back to the home on 30 October 2014 to continue our inspection with them present.

The new manager understood their responsibilities and was aware there were areas of concern that required action. They were being supported by the regional manager. The regional manager told us the provider had already identified the home as a 'focus' home that required additional support and attention by the company. The provider had looked at ways they could improve recruitment of nursing staff to their homes. They had also looked at how they could retain staff through improving pay and rewards and had started to introduce new pay and reward systems. They had also changed the annual leave approval system. This was because they had found too many staff had their annual leave approved for September and October leading to an increase in cover required by agency and bank staff.

Whilst we saw insufficient staff, the permanent staff on duty had a good understanding of their roles and responsibilities. We saw the heads of each unit supported staff well to undertake their tasks; this included giving clear instruction to agency staff.

Staff had mixed feelings about the management of the home. Some felt the new manager was approachable and accessible, they said, "She's more supportive, before it was always somebody's fault…she's very approachable and supportive." Others told us they felt able to talk to the new manager but felt it was, "Too early to say whether she will deal with things." One staff member told us they, "Didn't feel supported at all, and the manager just talks about the budget."

We looked at the checks the provider carried out to ensure the safety and wellbeing of people. We talked to the manager and regional manager about the dependency tool used to determine the staffing numbers in the home. The regional manager told us they recognised the tool did not account for other factors such as the size of the building. The provider told us they had already recognised the need for more staff and they would be providing additional staff cover for the ground floor of the home, once recruitment checks had been completed.

We saw the provider had monthly checks in place to monitor the quality of care and the health and safety of people. We saw some of the issues we had identified as concerns had already been identified by the provider and action had been requested. For example, concerns about record keeping had been identified and staff had been instructed to improve this. A lack of communication between staff and people in the lounge had been noted. The response to this was to arrange training for 'Residents Experience.' We saw there had been a quality check on medication management which had raised concerns. The provider had asked the manager to take action to address these. This had been done.

The regional manager and manager told us of an initiative the organisation was going to introduce in November 2014. They informed us the home would be part of the company's 'Providing Excellence and Enriching Residents Lives (PEARL) scheme. They told us this was an accreditation scheme which had high benchmarks for the quality of care and dementia support given to people. This meant the provider was putting systems in place to improve dementia care in the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider did not ensure there were sufficient numbers of suitably qualified staff to meet the needs of people living at Evedale Care Home. There continued to be too many bank and agency staff employed who did not know the needs of people who lived at the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider did not plan and deliver care which supported people's individual needs.**