

Four Seasons (Evedale) Limited

Evedale Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 29 November 2017 and was unannounced. At our previous inspection in May 2017 we found three breaches of the Regulations. At this inspection we found improvements had been made but there continued to be a breach of two of the Regulations.

During this visit we saw improvements in providing people with support to eat and drink had been made on the first floor of the home; however the improvements for people on the ground floor were only recent and had not yet fully embedded. Therefore the service remains in breach of Regulation 14 (Nutrition).

At our last inspection visit the provider was in breach of Regulation 17 (Governance); and well-led was rated as inadequate. During this visit improvements had been made, but they had not been made for a long period of time for us to be confident they would be sustained, and further improvements were still required. Therefore the service remains in breach of Regulation 17.

At our last inspection visit the provider was in breach of Regulation 18 Registration Regulations 2009 (Notifications of other incidents). During this visit we found one incident which had not been notified to us, but this had occurred before the current manager started to work at the home. They have since sent a formal notification.

Following the last inspection we have met with the provider twice to discuss on-going concerns at the home and actions taken by the provider to improve the service. We have been in regular contact with the provider's senior management team in relation to issues which have arisen.

Evedale Care Home is a care and nursing home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Evedale Care Home accommodates up to 64 people in one adapted building. The ground floor of the building provides accommodation to older people and people with general nursing needs. The first floor provides accommodation to older people with dementia who have nursing needs. The home also provides short term stays of up to six weeks for people who have been discharged from hospital but who require further assessment to determine their future needs.

At the time of our visit there were 47 people who either lived at Evedale or who were on a short term stay at the home. This was because the provider had decided to stop admitting people for longer term care until they were satisfied the home was providing better quality care.

The home did not have a registered manager; however the new manager was in the process of applying to the Care Quality Commission to be registered. 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.

Since our last visit in May, the manager at the time of our inspection visit left the service, and two further managers have worked at the home. The most recent manager is applying to be registered with the CQC. They had been in post for five weeks at the time of our inspection visit. They had worked extremely hard in a short period of time to start improving the quality of care provided.

At our last visit there was a high number of agency staff working at the service to cover the staff absences resulting from staff leaving the service, sickness and planned leave. There continued to be high levels of agency workers but these had been booked over longer periods of time to provide continuity of care; and new staff were being recruited and inducted. Some staff who previously left the service had returned. There were enough staff on duty to meet people's needs.

There have been safeguarding concerns raised since the last inspection, but the new manager had a good understanding of safeguarding policies and procedures and has supported staff in increasing their knowledge of this. Staff understood the risks related to people's health and well-being and action had mostly been taken to reduce the likelihood of risks occurring.

Medicines were mostly managed safely. Some medicines records were not as accurate as they should be. People had the necessary equipment to support them with their care needs, and the home was clean with infection control measures being adhered to. Premises and equipment safety checks had been carried out to ensure safety, although mattresses were not always at the correct setting.

The provider had a complaints procedure, however this was not on display and there had been no formal complaints made until the later part of 2017. Where people had complained, these had been investigated.

Staff were more responsive to people's needs on the first floor dementia unit than during our previous inspection visit. However, there continued to be a lack of activities on both floors, and the budget for providing activities for each person was minimal.

Staff were kind and caring to people and permanent staff knew people well. Agency staff were also kind to people but were not as responsive as they did not know people's needs as well. People's privacy and dignity was supported.

The provider's checks on the quality of the service more accurately reflected the quality of care people received than our previous visit; and these had been completed as the provider expected.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service is mostly safe.

There were enough staff to support people, but there were a high number of agency staff used to cover staff vacancies. The provider and manager had informed the safeguarding authorities of concerns identified at the home. The premises and equipment were safe to use and clean. Medicines were mostly administered safely. Staff understood the risks related to people's care.

Requires Improvement ●

Is the service effective?

The service is mostly effective.

DoLS applications had been made as required but not all staff understood the Mental Capacity Act. People were offered a choice of meals and drinks that met their dietary needs; and improvements had been made to support people at risk of malnutrition and hydration, but these had not yet been firmly embedded into the home. People had access to healthcare when necessary. Staff training and supervision was being implemented.

Requires Improvement ●

Is the service caring?

The service is caring.

Staff respected people's dignity and privacy. They were kind and caring to people, and showed people respect. Visitors were welcomed into the home. The atmosphere in the home was much improved in comparison to our last visit.

Good ●

Is the service responsive?

The service is mostly responsive.

Permanent staff understood people's needs but care plans did not detail how people could receive a personalised service. The manager responded well when concerns or complaints were made but the complaints policy and procedure was not available to people. Opportunities for people to undertake activities were limited, and the budget for these was small.

Requires Improvement ●

Is the service well-led?

The service is mostly well-led.

There continued to be changes in management since our last visit, however there is now stability with management and improvements have begun to be made. The improvements had not been in place for long enough to demonstrate they could be sustained over time.

Requires Improvement 

Evedale Care 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 was planned to check whether the provider is 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 inspection took place on 29 November 2017 and was unannounced. The inspection team comprised of one inspector, a specialist nursing advisor, 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 our inspection visit we looked at statutory notifications sent to the CQC by the provider (statutory notifications provide information about important events which the provider is required to send to us by law), information received from the public via our 'share your experience' web form, and spoke with the local authority and clinical commissioning staff to find out their views of the service. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. Their views were similar to what we found during the course of our inspection visit.

During our visit we talked to nine people who lived or who were on a short term stay at the home; nine relatives/friends of people at the home; 11 staff including the activity worker, chef, a housekeeper, the administrator, care staff and nursing staff. We also spoke with the deputy manager, manager and acting regional manager. We also spoke with visiting opticians.

We spent time engaging with people and staff in the communal areas to see how staff supported people with their care needs. We 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 were not able to talk with us.

We looked at six care records, medicine records of people who lived on the ground floor, quality assurance records, complaints records, daily records and supplementary food, fluid and positional change records of those on the first floor; and health and safety records.

After our visit we spoke with the community nutritional support dietician; and requested further information

from the manager. This included their response to some of the concerns raised by the dietician.

Is the service safe?

Our findings

This key question was rated as requires improvement at our last inspection visit. We continued to require improvements in this area.

At our last inspection visit we had concerns the provider had not followed the local safeguarding policies and procedures as some incidents had not been referred for investigation. Since our last inspection the manager had identified further incidents which should have been referred to the safeguarding authorities. Once identified, these were referred retrospectively to the safeguarding team. One of these related to unidentified bruising. A relative confirmed to us they had been contacted by social services. They said, "The social workers contacted me about the bruising on dad's arms. I do not feel it was malpractice. I looked after him for five years and I know how easily he can bruise." At the time of writing, there had not been an outcome for this investigation.

During this inspection visit we also identified that a complaint raised by a relative about the behaviour of an agency staff member in September 2017, which had been managed by a previous manager and overseen by a previous regional manager had not been referred to the safeguarding authorities as it should have been. The manager confirmed this agency staff member no longer worked at the home and after our inspection visit referred this to the safeguarding team.

Despite this, the new manager and regional team had acted swiftly to ensure all the safeguarding issues they were aware of could be investigated by the external safeguarding authority. The new manager had a very good understanding of safeguarding and a passion to ensure people were safe. They had been proactive in ensuring both nursing staff and care staff understood their duties to safeguard people in their care by reporting any concerns to them. Staff confirmed they were aware of these procedures and knew what their responsibilities were.

We looked at whether the risks to people had been assessed and their safety monitored to ensure they stayed safe. At our last inspection visit we saw a person cough each time they had a drink. Staff who supported the person did not identify this as potential risk (it may have indicated the person was at risk of aspiration). The manager told us they would refer the person to the speech and language therapist (SALT) for them to assess the person. At this visit, we found the person had been assessed and the SALT team were satisfied the person was not at risk of aspiration.

We looked at written risk assessments to see if they provided staff with enough information to help them reduce the known risks people had with their care. This for example included, the risk of falling, choking, or skin damage because of too much pressure. We found people's risks had been assessed appropriately and permanent staff knew how to manage them.

However, the manager contacted us prior to our inspection visit, because a person's skin had become damaged. This was as a consequence of staff not acting on identified risks quickly enough. Once this had been identified the manager acted quickly and provided staff with further training to help them understand

the importance of making sure identified risks were acted on quickly. The family of this person were visiting on the day of our inspection. They told us, "They have cared for our sister in bed for the last 10 years. She is now in end of life care and this is the first bed sore she's ever had."

Those people at risk of skin damage were provided with mattresses that had air rotating within the mattress. These mattresses had different settings according to the weight of the person. We did not find this had been assessed to make sure the mattresses were on the correct setting for the person's weight. This could potentially increase the person's risk of skin damage.

We also found the daily records staff completed to demonstrate they had undertaken actions related to risks were not always completed. For example, where risks of skin damage (pressure ulcers) were identified, care plans outlined how often the position of the person should be changed to minimise the risk of too much pressure being placed on an area of skin. One person should have had their position changed every two hours, but the record indicated there had been a period of six hours, and a period of nine hours between positional changes.

The premises were secure, and records demonstrated there were regular checks for fire, gas, electric, and water safety, and to make sure the equipment used was mechanically safe. People had individual evacuation plans to help fire and rescue services evacuate the premises if the need ever arose. We saw sufficient equipment was available to support people with their needs. Since our last visit, a number of people had been provided with specialist chairs to help them sit more comfortably and be provided with care more safely.

At our last inspection visit we were concerned about the high number of agency staff used at the home. Agency staff are staff employed by another organisation which provides suitably skilled and experienced staff to care and nursing homes when they are short staffed. We found during this visit there continued to be a high number of agency staff to manage the continuing high number of staff vacancies. To reduce the concerns about people not receiving continuity of care from staff they knew well, the manager had block booked agency staff so they could become familiar to those they cared for.

In May 2017 we were concerned there were not enough staff to meet people's needs. Since our last inspection the provider had limited the number of new people coming to live and receive treatment at the home. This was because they had identified the quality of service needed to be improved and wanted to ensure people who lived at the home were safe.

The home could provide care for a maximum of 64 people but was instead providing support to 47 people at the time of our visit. We saw enough care and nursing staff on duty on both floors to provide people with the support they required. Staff confirmed to us they now had enough time to meet their responsibilities.

At our last inspection visit we had some concerns about the administration and management of medicines. Since our inspection visit we have been informed by the provider of medicine errors at the home. During this visit we looked at the medicine records of all people who lived on the ground floor. The records were consistent with the medicines given to people. Where people had refused, this had been noted by staff although they had not noted the reason why the person had refused them. Where people had been prescribed medicines 'as required', there were records informing staff of the reason why they might be required (for example if the person experienced pain), to help staff provide consistency in offering this medicine to people.

Some people used transdermal patches (medicines applied directly to the skin via a patch). To ensure these are applied safely it is good practice to record the date, time, and where about on the body the patch is applied, and that the previous patch has been removed. These records did not consistently provide all this

information, which meant there was a risk that people might not have their patches applied correctly or at the right time.

We saw one of the nurses administer medicines to people. She respected people's dignity during this process and worked with patience. A person's relatives told us the person got their medicines on time and the staff had worked with the GP to try to simplify their medicines. Meetings had been held with the relatives at the home to try and sort the person's medicines out to better suit them.

We looked at how people were protected by the prevention and control of infection. At our previous visit we had concerns about the cleanliness of the home. During this visit we found the standards of cleanliness had improved. We spoke with one of the housekeepers who had been transferred from another of the provider's homes to improve the cleanliness at Evedale Care Home. They told us the cleanliness "was bad" when they came in July 2017 but they were happy with the cleanliness in the home now. They told us the new manager had supported them in purchasing equipment they needed to help keep the home clean.

The manager told us of steps they had taken to remove odours from the home, particularly the odours people smelled when they came through the front door. During our visit we found all areas of the home smelled fresh. The manager was also looking at having the personal protective equipment such as gloves and aprons available in the corridors for staff so they did not need to be stored in people's rooms. They were looking at storage facilities which staff could access easily but would be safe when people with dementia walked through the corridors.

Housekeeping staff, and care and nursing staff all understood measures to take to reduce the risks of infection. For example, they put soiled linen into red laundry bags separate from non-soiled linen; and used disposable gloves and aprons to reduce the risks of possible infection from being transferred via skin or clothing. Staff ensured they washed their hands before and after personal care was provided.

People who required equipment such as slide sheets and slings (to help staff move them) had individual ones. This helped prevent any cross infection because there was no sharing of equipment, and each person had at least one spare so that one could be used whilst another was washed.

We looked at whether the provider learned from mistakes and made improvements when things went wrong. We found the current senior management team and manager were open and candid about mistakes made. At an organisational level we found where things had gone wrong, practice was shared and improvements made. For example, a complaint had been made by a relative about a person's mattress deflating. When this was investigated they found the mattress had deflated because the electric cables became trapped in the moving mechanism of the bed. This information had been shared with the provider's other care homes because they recognised this could easily happen elsewhere unless staff were informed about the risk.

Is the service effective?

Our findings

At our previous inspection in May 2017 we rated this key question as 'Requires Improvement' and there was a continued breach of Regulation 14 of the Health and Social Care Act Regulated Activity Regulations 2014, Meeting Nutritional and Hydration needs. At this inspection we found improvements had been made, but some improvements were very recent and had not yet been embedded into practice. This meant the provider continued to be in breach of this regulation.

At our previous inspection we found people waited lengthy periods of time before their meals were served, and some people who required individual support with their meals, did not get the support they required to ensure their nutritional needs were met. During this visit the meal time process for breakfast and lunchtime was more effective. People received their meals in a timely way, and we saw people who required support being given that support. We found on the dementia floor, most of the staff on duty were agency workers. This meant they did not know people's needs as well as permanent staff and relied on them to tell them what to do. Despite this, the lunchtime ran relatively smoothly and people received their meals as expected.

During our visit, where doors were open, we looked in people's bedrooms to see whether drinks were available to them and in reach. Most people had a drink by their bedside and most were in reach. One relative shared concerns with us that their relation did not get enough to drink; whilst another told us staff ensured their relation had 'plenty to drink.' A care worker told us they felt people got the food and drink they needed most of the time, but said they could not always be sure of this because agency staff did not always record when they had given people what they needed.

We also saw people who needed extra nutrients and calories in the form of milkshakes and puddings receive these. For example, we saw a care worker bring a thickened strawberry milkshake for a person. The person was asked how they would like to drink this, and the person said they would like to take it from a spoon. The care worker took time to make sure the person received the whole milkshake, and chatted with the person throughout the process.

We looked at the food and fluid records of people on the first floor identified as being at high risk of dehydration and/or malnutrition. The records we looked at showed people had received the foods and fluids required, and this included the additional supplements. However, we found where agency staff had completed the record the information was not always in the correct place and could cause confusion as to whether a person had received the expected nutrients.

One person had a percutaneous endoscopic gastrostomy tube (PEG). This is a tube which feeds foods and medicines into the stomach and is used when people are unable to swallow. We saw clear instructions about how to look after the PEG and how staff should use it to support people's nutritional needs. A relative of this person told us they got their medication and line feeds regularly and on time.

We asked people what they thought of the food available. One person said, "The food is very good. I love the porridge." Another told us there wasn't much choice but "I enjoy what I get."

We contacted the community nutrition support dietician who regularly visited the home. They shared with us some concerns they had since our last inspection about people who were at high risk of malnutrition and dehydration not receiving the food and fluids they needed. This was more so in relation to people who were supported to eat on the ground floor.

People had been referred to a dietician if they had been losing weight; and to the speech and language team if there were concerns a person had swallowing difficulties. However, the dietician informed us that whilst referrals were appropriate, staff were not always following the recommendations for improving people's dietary intake so they did not get to the stage of requiring a referral to them. They also had concerns that people did not receive the extra snacks and booster shakes and mousses to support an increase in calories and nutrients to help people gain weight.

We discussed their concerns with the manager. The manager told us staff now knew who needed additional support and measures had been taken to ensure staff acted on the recommendations made by the dietician service. This was very recent and had not been fully embedded into the practice of the home.

Staff mostly knew the needs of people. For example, they knew who needed a pureed diet and support with eating. They also knew if there were other specific needs. However, a relative told us that whilst their relation mostly received a 'diabetic' diet, sometimes staff did not provide this for them.

We saw notices around the home advising visitors to check with staff before offering people food in case they were on restrictive diets. This was to ensure safety; so for example, a relative did not offer a person who had problems with swallowing and was on a soft food diet, a biscuit or something they might choke on.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found where people had been deprived of their liberty, applications had been made to the local authority to legally authorise them. One relative told us, "We have been through the DoLS procedure on a yearly basis" (this is because a DoLS usually expires after one year). Where people lacked capacity, most of the people's care plans informed us they had been assessed to determine when people might be able to make decisions, and what decisions had to be taken in their best interests. For example, one person required medicines to be given 'in disguise'. This person refused medicines when offered to them, and it was considered in their best interest that they continue to receive them. In order to do this they had to be put into food and disguised. The appropriate healthcare professionals were involved in this decision. However we found two care records where assessments had not been completed, which meant it was not clear what their capacity was, and how staff could support them.

The manager had 500 hours of agency staff cover and had been recruiting new nursing and care staff to permanent positions. This meant there were staff in the home who were yet to complete all the training

required by the organisation. The manager made sure that agency staff had the skills and competency to work with people in the home, and had asked some agency staff not to return to the home when they had become aware their work performance was not of the standard they required.

For permanent staff, the manager was in the process of improving the training provided. For example, a lot of the provider training was through e-learning. The manager had started a process of testing staff knowledge after their e-learning to check they fully understood the learning provided. The results of the tests would then be discussed at individual supervision sessions with staff to make sure they had a clear understanding of the subject tested.

Through speaking with staff we found their knowledge of DoLS and the MCA 2005 was limited. The manager agreed with this and said they had already decided this would be one of the first areas staff would receive further training on to support them in their knowledge. They later sent the CQC information to demonstrate what questions staff would be asked.

The provider and manager were supporting staff to increase their knowledge and skills. Care staff were encouraged to train as a CHAP (Care Home Assistant Practitioner). This was a senior position which required additional training and enabled care workers to take on some of the clinical responsibilities usually assigned to nursing staff.

One of the nurses we spoke with was newly qualified and new to working at the home. They had been on a two week company induction period and had worked in the home for four weeks prior to being included in staff numbers on the rota. They were being supported and supervised by more experienced nursing staff. Another member of nursing staff who had worked at the home for a number of years told us they were going to be undertaking training to verify deaths and to refresh their skills in venepuncture (taking blood). Care workers were encouraged to take national vocational qualifications to support them in their work.

The manager and nursing staff told us they worked constructively with other professionals who supported people in the home. A relative told us, "I have met the GP and the advanced nurse practitioner. They have been involved with mum's swallowing problem and sickness after food." However, another relative was less sure they could rely on staff to liaise with other healthcare professionals. They told us, "I phone the doctor myself if there's a problem. I've learned to deal with the problems myself." A relative was at the home waiting for a professional to attend a review meeting about their relation's medication. The opticians were at the home on the day of our visit undertaking eye checks and tests on people who lived there. They told us they were pleasantly surprised by the changes they had seen during their visit that day.

Is the service caring?

Our findings

At our previous inspection in May 2017 we rated this key question as 'Requires Improvement.' On the day of our inspection we found both agency and permanent staff treated people with kindness, dignity and respect.

At our last visit we did not see staff engage much with people because they were too busy with personal care tasks to have time to do so. This time, there were less people in the home and staff had time to give people the care they needed and wanted.

We asked relatives and people what they thought of the care provided. Most of their views were positive. One person said, "The nurses here are good. They know what I need doing." Another broke into an emphatic smile and nodded their head when asked if they thought the care workers did a good job. They responded, "Very." A third person kissed a care worker's hand when they came into the room with a drink because they were pleased to see them.

Relatives thought the quality of care was improving. One told us there were more care workers employed by the home now and less agency staff; another said, "The carers seem really good, [person] has built a particularly good relationship with a Polish guy." A third told us that most of the care workers were great but a few did not know how to relate to people. During our visit we found this to be the case. Most care workers had a good knowledge of how to care for people. Those who did not, were agency staff who were caring, but did not always know the person to be able to respond or relate to them as well as permanent staff. A relative also told us staff could be "So lovely and re-assuring." We again saw this on the day of our visit.

We asked one of the housekeepers what they thought of the care provided. They told us they spoke with people as they went from room to room, and people usually told them what they felt. They said people were a lot happier with the care now than previously, and their own perspective was the staff were more approachable and happy. They felt people were now getting a better quality of life.

At our last visit we had particular concerns about how staff interacted with people on the first floor dementia unit. This was because staff routinely left people alone in the communal lounge, and when they did go into the lounge it was to quickly carry out a task and leave again. This time we saw most people were supported to use a larger and more homely communal lounge.

We found there was always one member of staff there to support people. The member of staff who was there during the time we visited engaged well with each person sat in the lounge. They made sure each person was comfortable and tried to engage them in reminiscence discussions. At one point, a person was supported to come into the lounge. Both care workers agreed the person did not 'look themselves' and asked a nurse to check the person over to make sure they were well. The nurse took the person to their room to do some checks to ensure the person was well.

During meal times all of the inspection team saw staff provide support at a pace which suited the person.

They were patient and respectful of people's needs. They also provided encouragement to people. For example, one person was eating their meal in their bedroom. Each time staff walked past they gave encouragement for the person to eat a little more.

Staff understood how to respect people's privacy and dignity. Personal care was provided behind closed doors, and staff understood the importance of privacy. The majority of bedroom doors of people who were cared for in bed were left open. Where people wanted their bedroom door shut, we saw a note on the door making it clear to staff this was the person's choice. We saw the door of one person's room remained shut during the course of our inspection visit.

Previously staff had made us aware they did not feel valued or cared for by the management or the provider. In the time between the last and this inspection, we had been told that staff were exhausted by the changes in management and their morale was low. However, during our inspection visit most staff told us they were beginning to feel more supported and cared for by the new manager and the provider. If staff had felt demoralised they did not let it show. We saw staff being helpful and cheery to people in their approach.

During our inspection we saw visitors were welcomed into the home. They were able to stay the length of time they wished to. We saw one visitor bringing some soup for their relation. The manager asked why they had brought the soup rather than their relation have soup made in the home. The relative told the manager the soup was spicy and bought from a shop which made food products to support their relative's culture. The manager asked for the name of the shop so the home could get this for the person and support them with their cultural needs. They later informed us they had made contact with the shop and they were going to be using them in the New Year to support the person with their dietary wants.

We saw relatives who had just been informed their relation was now on an end of life care pathway. They were with the manager who had been discussing the GP visit and what this now meant in terms of the care provided to the person. The manager gave the relatives their personal telephone number if they needed to speak with them out of hours about the care being provided.

Is the service responsive?

Our findings

This key question was rated as requires improvement at our last inspection visit in May 2017. The provider continued to require improvements in this area.

At our last inspection visit in May 2017 we saw a member of staff was unresponsive to a person who needed support. During this visit we saw staff tried to respond to people's needs. Permanent staff had a good knowledge of people and were quick to act if support was required. Agency staff needed direction from permanent staff and whilst they did their best, they were not as responsive.

At our last inspection we had concerns that people in the dementia unit had little engagement with staff. During this visit we saw more engagement with staff, and the environment had improved. People were using a larger and more homely lounge which had better views out of the windows; and the other smaller lounges and corridors had some activities available for people to engage with such as books for reminiscence, and pictures people could look at. We saw two people enjoyed purposeful activity with two dolls which were available to them. However, their care records did not inform staff they enjoyed being with the dolls, and we did not see other equipment such as a pram or cot which they could use to further their enjoyment (doll therapy is recognised as being helpful to some people who live with dementia). On the ground floor there were limited activities available.

We were informed there should be two activity workers to support the activities in the home. One had recently returned to the home after a period of absence; and another was on maternity leave. One person had been recruited to take on one of the roles during the member of staff's absence but had decided not to commence work at Evedale.

We saw people on the ground floor had limited opportunities to take part in activities. The activity worker told us they could not see all the people who lived in the home each day. One person told us, "I'm not aware of any activities on offer." A relative told us, "The activities lady tries to do a daily programme three to four times per week. She shows videos, books or painting. She's trying to get in therapy dogs." One member of staff remarked to us, "A radio in reception doesn't constitute stimulation."

The manager told us they were looking to improve the activities in the home. They told us the activity co-ordinator had, on returning to the home, undertaken remembrance activities with people, such as making poppies and a remembrance display. They told us they hoped to get 'pat' dogs back into the home, and a hairdresser was once again visiting.

The activity co-ordinator was not aware of the monthly amount they had available to spend on activity resources. We asked the acting regional manager how much money the organisation spent on activities per person in the home. The budget for activities did not provide a lot of scope for the activity worker to provide meaningful activities and to bring external activities into the home.

We saw some people on the ground floor sat in the communal lounge. They were there to watch a film. The

reception on the television meant it was impossible to watch the film without the images becoming blurry. One of the people watching the film told us the television reception was often like this and people had complained but nothing was done about it.

We looked at the complaints record to see if this had been identified. The manager said it had not been addressed as a formal complaint as it was not to do with care. We informed the manager that all complaints needed to be addressed through the complaint procedure. They said they would address this as a complaint and immediately look at how this could be improved.

The complaint record indicated there had been no complaints made in 2016/2017. We were surprised by this because we had been aware there had been on-going concerns at the home. We asked where the information was to tell people how to make a complaint as we did not see any displayed. The manager acknowledged they had not noticed this, and other staff told us the complaint information had been taken down prior to the manager starting work at the service, to enable the decorators to re-decorate the hallway. The manager told us this would be rectified immediately.

People and their relatives were asked if they felt able to complain. One relative told us, "I would complain if I needed to but they always seem to do their best." Another told us some of their relation's jewellery had gone missing and they had complained to the provider. The provider had reported this to the police who did not pursue an investigation. They said the provider conducted their own internal investigation and whilst they did not find out what happened to the jewellery, they were pleased with the way it was managed. They told us they had been offered some financial compensation for the loss.

We looked at whether care provided was personalised. The care plans provided information to meet people's basic health and safety needs and gave some information about people's likes and dislikes. But they didn't go into detail about how staff could provide a personalised service to people in line with their preferences.

Whilst people were involved in determining what they wanted to do each day, we could not see by looking at their care records that they were involved in the monthly reviews of their care. The manager told us this was an area they were looking to improve. We also looked at some supplementary charts which should have told us if people had received the personal care they required (for example, teeth cleaning, and washes). These had not been completed and the people were not able to tell us themselves (because they lived with dementia) if this had been done.

We looked at equality and diversity in the home. The provider had recently updated its policy on equality, diversity and human rights. This included a process prior to admission where people would be asked information about their age, disability, gender, religion, beliefs and sexual orientation to ensure their needs could be met. It also included checking how a person could be communicated with effectively such as having appropriate translations or the use of communication aids to support people.

During our visit, we saw one person had been using a communication board until recently because their needs had changed. Another person who was recently admitted spoke a different language to English and preferred different foods. Some of the staff at the home spoke the same language; and the person required a pureed diet. The person loved a type of food and so to help them know they were receiving the food, staff showed them the food uncooked, at the same time as showing it as a pureed dish so they would know it was the same..

Is the service well-led?

Our findings

At our last inspection in May 2017 we rated this key question as 'Inadequate'. This was because continual changes to management at a local and regional level had not supported the home to improve.

Since our last inspection the home had once again had changes of managers both in the home and at regional level. The person who was managing the home at the time of our last visit left the service, and another interim manager was recruited. This manager did not stay the length of time they were contracted for. At this inspection, the manager had been at the home for five weeks. The regional management team who were present at our last inspection visit had also been replaced. The new regional manager also left the service prior to our inspection visit.

During this inspection we found the home continued to require improvements. This was because whilst there had been improvements since our last visit, these had only recently happened and there continued to be improvements required. Staff were improving their response to people's nutritional needs but further improvements were required; staffing levels were better, but the high use of agency staff meant that continuity of care continued to be an issue even though agency staff were now block booked to reduce this impact. Activities and engagement for people who lived with dementia had improved, but overall the activities for people in the home remained limited. Care records were now mostly being completed but there remained gaps in completion of supplementary charts, some medicine records, and care records were not personalised. Staff training was improving and staff access to supervision had been identified but this continued to need embedding. And information about making complaints had not been readily available to people.

This meant there continued to be a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance.

Since our last inspection the CQC had met with the managing director for the home along with commissioners of the service. This was to have an open and transparent dialogue about the improvements to be made and any continuing concerns. The CQC had also been contacted by senior management when issues were identified within the home, and to inform of the steps being made to improve.

Whilst the current manager had only been in post for approximately five weeks they had worked hard to improve the service. They had applied to the DBS for their CQC clearance ahead of applying to register as manager of Evedale Care Home.

We had been informed prior to our visit that staff morale was low and staff were exhausted with the changes. We were also aware that more staff had left the service with another change of manager and management style. During our visit staff told us the manager expected high standards and was working with them to achieve this.

A senior member of staff told us, "I am personally grateful for [manager] to be here. She is so willing to do

changes here. She has a very dry sense of humour. Some people might take it the wrong way, but I think she is great." She went on to say, "I now feel I can sleep at night." This theme was consistent with other staff. One member of staff said the manager was "A go getter, she is not standing for any nonsense." Another said, "If I have any concerns I go to [Manager] She's straight and that's how I like it."

All staff we spoke with had respect for the manager and acknowledged what they had achieved in the short space of time they had worked at the home. One staff member said, "There are a lot of good things happening. We've lost a few staff but the ones we've got are committed and really good with the residents." "We've got new nurses, they're newly qualified and they'll learn our ways and not have bad habits." The manager had met with the different staff groups to discuss how they were going to move the home forward and to discuss the improvements they felt were required. For example, they had identified in October 2017 there were issues regarding infection control, and staff taking smoking breaks without having these agreed with the nurse in charge.

The staff view of the manager was echoed by many of the relatives we spoke with. One said, "I don't see much of the new manager. It looks as if she can crack the whip." Another said, "The home has had a lot of issues. The manager is trying to get on top of things. We've seen her on the war path in the last five weeks." A third told us, "After two weeks of the new manager, the gardens were spruced up." And we also heard, "The manager seems alright; pleasant and caring."

During our inspection visit we saw the manager had an open door policy. We saw relatives were in the office talking with the manager about their relation. We also found they had a good understanding of the people who lived in the home. We spoke with one relation who had been supported by the manager of the home to write a letter to the person's GP because of concerns about how a change in medication had affected the person badly.

The manager felt supported by the regional team. They told us they had been received support from another manager from the provider's group of homes and this had helped. Regional management had also provided support.

The provider had checks to monitor the quality of the service. These included the auditing of accidents and incidents, complaints, and medicines in the home. Whilst we found some discrepancies within the audits, for example with complaints, unlike on our last visit, these mostly accurately reflected how well the home was functioning and the quality of service.

The provider had a responsibility to inform the public of the CQC's most recent rating of the service. The rating of the home's performance had been displayed in the reception area of the home and the provider had published the most recent rating of Evedale Care Home on its website.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Diagnostic and screening procedures	People at risk of malnutrition or dehydration did not always adequately receive support to eat and drink.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Systems and processes were not fully embedded at the time of our visit to be fully assured the quality and safety of the service could be sustained.
Treatment of disease, disorder or injury	