

Four Seasons (Evedale) Limited

Evedale Care Home

Inspection report

Occupation Road, Coventry, CV2 4AB
Tel: 02476 448292
Website: www.fshc.co.uk

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Ratings

Overall rating for this service

Requires improvement 

Is the service safe?

Requires improvement 

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 October 2014, at which breaches of legal requirements were found. This was because there were not enough staff to meet people's care needs safely, and there was an over reliance on bank and agency staff. This meant there was a lack of continuity of care. Risks relating to people's care had not been fully assessed and call bells were not available to people when they needed them.

As a result of the breaches of the legal requirements and the impact these had on people who lived at Evedale Care Home we rated the key question of 'Safe' as 'Inadequate'.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook a focused inspection on the 23 April 2015 to check that they had followed their plan and to confirm that they now met legal requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Evedale Care Home' on our website at www.cqc.org.uk.

Evedale Care Home provides accommodation for up to 64 older people and people with dementia who require support with their personal care. There were 49 people living at the home at the time of the focused inspection.

A new manager had been working at the home for three weeks. She was applying to be registered with us. 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 and associated Regulations about how the service is run.

At this inspection on the 23 April 2015, we found that the provider had followed their plan which they had told us would be completed by the end of March 2015 and legal requirements had been met.

People and their relatives told us staff were kind and considerate, and they felt people who lived at the home were safe. Staff told us they were much happier working at Evedale Care Home, because the number of staff on duty to support people's needs had increased. There was

Summary of findings

now minimal use of agency and bank staff and people were now being supported by a consistent staff group who understood the risks of the people they provided care for.

Risks to people were being documented more effectively, and people had access to call bells, or were being more closely monitored to ensure the risks to them were minimised.

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?

We found that action had been taken to improve the safety of the service.

This meant that the provider was now meeting legal requirements.

While improvements had been made and we have revised the rating to 'Requires Improvements'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

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 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.

We undertook a focused inspection of Evedale Care Home on 23 April 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 21 October 2014 had been made. We inspected the service

against one of the five questions we ask about services: is the service safe. This is because the service was not meeting legal requirements in relation to that question. The inspection was undertaken by one inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with two people who lived there, five visitors, the manager, the deputy manager, two nurses and three care staff. We also looked at two care records, staff handover records, the staff rota and the record of falls and actions taken.

Is the service safe?

Our findings

At our comprehensive inspection on 21 October 2014 we found the provider did not ensure there were sufficient numbers of suitably qualified staff to meet the needs of people living at Evedale Care Home. This had also been identified at our inspection in April 2014. We found there continued to be too many bank and agency staff employed who did not know the needs of people who lived at the home.

This was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.

At our focused inspection on 23 April 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 22.

The provider told us they had provided more staff to support people who lived at the home than their 'staff dependency tool' had calculated. This is a system which assessed the number of staff required in relation to the levels of assessed dependency of people who lived in the home. They told us this was to take into account the size and shape of the building. We saw the rota and spoke with staff; both confirmed there were more staff on the rota to meet people's needs.

The provider told us they aimed to recruit 10% above the staffing level to help cover sickness, annual leave and reduce the use of agency and bank staff. We saw by looking at the rota, and talking with the manager and staff there had been a vast decrease in the use of agency and bank staff. This was because most of the vacant posts had been filled, and where gaps in the rota remained, these were filled by staff who had agreed to work overtime for extra re-numeration. The provider had not yet achieved the recruitment of 10% above the staffing level; however people were being supported by a staff group who were familiar to them and provided continuity of care.

We asked people and their relatives their thoughts on the care people received and whether people were safe. One relative told us, "The care is very good." Another said, "Staff are very kind." A third relative told us, "[person] is very safe here, the home is very caring, no-one knows when you are coming and we always find it very nice, we've just done a

surprise visit and someone was feeding [person]." We saw one person, who was from a black and ethnic minority group was supported by staff who could speak their language.

We found staff morale had improved since our last visit. One member of staff told us of their experience of the changes, "Staffing was really bad, but management has concentrated on staff and improving care. Things are better. We were always complaining about shortages of staff but that never happens anymore." Another member of staff, who was new to the home when we undertook our inspection in October said, "When I started I wanted to quit. It was always agency staff; it was difficult for people, difficult and stressful. Now everything is getting better, it is really nice." All staff told us the big difference having more staff on the rota had made in terms of their ability to care well for people. One staff member said, "It is much better now we have more staff. There is enough time to meet people's needs."

One relative told us that whilst they were very pleased with the care provided during the day, they had concerns about the level of staffing at night. This was because their relative had fallen. We looked at some of the records kept, for example; the rota, the record of falls and incident book and we also looked at the notes of the staff handover meetings between night staff and day staff. We saw nothing in the records to indicate there were any concerns in relation to the night time staffing levels. The manager also told us they felt there were sufficient staff on duty at night to meet people's needs.

We also found at our comprehensive inspection that the provider did not plan and deliver care to people which supported their individual needs. This was because the risks in relation to people's care had not always been fully considered and documented, and falls people had experienced had not been analysed to see whether there were trends or patterns for staff to act on and reduce the risks. During the visit we found call bells were not always in reach of people either in their bedrooms or in the communal areas.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.

Is the service safe?

At our focused inspection on 23 April 2015, we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 9.

We found care records were being reviewed to ensure the people's care needs, and changes to their care and nursing needs, were recorded and acted on. Where the manager found gaps in the records, these were noted on the person's file, and the named worker was asked to ensure the identified gaps in information were completed. The manager had met with staff to discuss the importance of documentation. We saw from the care records we looked at there were still some inconsistencies in reporting however the information about people had improved.

Falls and incidents were being analysed to check whether there were any trends which needed to be addressed. We found that staff had a better understanding of people's needs, and were working more effectively as a team. For example, we saw people were given effective support at lunchtime in eating their meal.

There were systems to ensure people had call bells within their reach to use. When staff undertook their checks on people in their rooms, these now included ensuring call bells were in reach and this was documented on the person's record. When people were sitting in the communal areas and were not able to use call bells, they ensured there was a record kept of how often staff went into the room to check on people to ensure they were well. At our last visit we saw people crying out because they needed support and there was neither a call bell close to them, or staff near them to hear. During this visit we heard call bells being answered promptly and saw sufficient staff in close proximity available to meet people's needs.

At our last visit, we saw staff, people and relatives who told us they were unhappy. During this visit we saw a happier staff group who told us they felt management had listened to their needs and who were supportive of them. People and their relatives were more complimentary about the care they and their relations were provided.