

# 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?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

This inspection was carried out on 21 June 2016 and was unannounced.

At our last comprehensive inspection of this service on 21 October 2014, we found the provider had not met all of their legal requirements and were in breach of the regulations. This was because there were not enough staff to meet people's care needs safely, and there continued to be an over reliance on bank and agency staff. Risks relating to people's care had not been fully assessed and call bells were not available to people when they needed them.

After this comprehensive inspection, the provider wrote to us to say what they would do to meet their legal requirements in relation to the breaches. We undertook a focused inspection on the 23 April 2015 to check that they had followed their plan and found they met legal requirements.

Evedale Care Home provides accommodation for up to 64 older people and people with dementia who require support with their personal care. There were 58 people living at the home at the time of our inspection. The home consists of two floors and the first floor is the Dementia Unit.

A new manager had been working at the home since December 2015 and 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.

We found there was a clear divide between the two floors of the home and the care and support provided. We found improvements had been made on the ground floor since our last inspection; however we still found areas where improvements were required on the Dementia Unit. Some staff spoke of feeling happier and more valued on the ground floor. However some relatives felt there were not enough staff to support their relations on the Dementia Unit.

The manager had already identified this and was working hard to make improvements to bring both floors into alignment with each other. The provider was also investing in making improvements to the environment on the Dementia Unit to make it more 'dementia friendly' and additional training was being provided to staff on the unit.

People and their relatives told us most staff were kind and considerate, and they felt people who lived at the home were safe. We observed, and people told us, staff members were caring but did not have time to interact with people unless they were providing personal care and we saw some people on the Dementia Unit left for periods with little interaction.

Staff treated people with kindness. Staff had a good understanding of people's needs and most supported

people with respect, most people told us staff ensured their dignity was maintained at all times.

Most staff told us they were happier working at Evedale because the number of staff on duty to support people's needs had increased and they felt the new manager was supportive and making improvements to the home.

Most people and relatives were happy with the care provided and staff were committed to providing a good standard of care, however we observed there were delays in attending to the personal care needs of some people on the Dementia Unit.

There were systems and processes in place to protect people from the risk of harm. Most staff understood their responsibility to safeguard people from harm but we saw one incident that should have been referred to the local safeguarding team had not been. Where risks associated with people's health and wellbeing had been identified, there were plans to manage those risks.

Most people were involved in decisions about their care and told us they received support in the ways they preferred. People were supported to maintain relationships with people important to them and visitors were welcomed at the home

Staff received support from the provider and new manager to enable them to provide effective care to people. However training records showed only 50% of staff had received the necessary training, this was being addressed by the provider.

Staff understood the principles of the Mental Capacity Act (MCA), and most gained people's consent before they provided personal care. People told us they were encouraged to make choices about their daily lives. There were policies and procedures in place to ensure that people who could not make decisions were protected, and we found assessments had been completed. However on the Dementia Unit some information about the decisions some people could, or could not make was not recorded consistently.

We saw people received a good choice of food and drink, and people's individual food requirements were well catered for. Most people were supported to eat and drink by staff; however on the Dementia Unit one person who required support did not consistently receive it.

Overall, people's health needs were met. We saw some appropriate referrals were made to specialist healthcare professionals where people needed support, for example with eating and drinking and skin care. However at times on the Dementia Unit, advice given was not consistently followed.

Care plans and assessments contained information that supported staff to meet people's needs. However some lacked detail and were not 'person centred' in relation to how people liked to receive their care. People and their relatives were not consistently involved in the planning of care. The manager had identified this and the provider was addressing it with further training for staff.

The provider employed activity workers to support people with their activities, hobbies and interests. Relatives had previously expressed concerns regarding the lack of activities on the Dementia Unit and the provider was addressing this.

The provider had recruited a new area manager to support the manager and the staff. They were both open and transparent about the improvements that needed to be made in the home and the provider had already taken action to address some of the issues we highlighted.

Staff felt supported by the manager and they in turn felt the provider was supportive. We found the new manager was highly motivated to make improvements in the home.

There were processes to monitor the quality and safety of the service provided and to understand the experiences of people who lived at the home. This was through regular communication with people and staff, surveys, checks on care staff to make sure they worked in line with policies and procedures and a programme of other checks and audits.

Arrangements were in place so that actions were taken following concerns raised, for the benefit of people who lived at the home. Systems were in place to drive continuous improvement at the home for the benefit of the people who lived there.

## 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 was not consistently safe.

People told us they felt safe however staff were not always available on the dementia unit to observe people within communal areas. Overall staff knew what action to take to protect people if they thought a person was not safe. Medicines were mostly administered and stored safely, although some medicine protocols did not provide staff with enough detail. The provider ensured staff had been recruited safely.

**Requires Improvement** ●

### Is the service effective?

The service was not consistently effective.

Most people were supported to have a nutritious diet, however some did not receive enough support to eat and drink. Staff were aware of their responsibilities regarding the Mental Capacity Act and Deprivation of Liberty safeguards. Staff received essential training to carry out their role however not all staff training was up to date, for example dementia care training.. People were referred to other health professionals when further support was required however recommendations were not always followed by staff.

**Requires Improvement** ●

### Is the service caring?

The service was not consistently caring.

People and relatives thought staff were kind and caring. Some people did not consistently receive personal care that met their individual needs and some were not involved in the planning of their care. Individual staff members interacted with people in a caring and respectful way, but did not always have time to engage with people outside of delivering care.

**Requires Improvement** ●

### Is the service responsive?

The service was not consistently responsive.

People did not always receive care which was responsive to their needs. People's interests were supported by activity workers

**Requires Improvement** ●

however they were often involved in other tasks around the home. Complaints were recorded and responded to in a timely manner. The provider acted on feedback received from people and their relatives.

### **Is the service well-led?**

The service was not consistently well led.

The provider had recruited a new manager, area manager and managing director to support the home. All acknowledged improvements were still required on the Dementia Unit and this was being addressed. Staff felt supported by the new manager who in turn felt the provider supported them. The provider had systems in place to monitor the quality and safety of service provided and had identified some of the issues we found.

**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 21 June 2016 and was unannounced.

Three inspectors, an expert by experience and a specialist advisor conducted the inspection. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

Before the inspection we looked at the information received from our 'Share Your Experience' web forms, and notifications received from the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare. We also contacted the local authority commissioners to find out their views of the service provided; they had identified areas of concerns and were monitoring the service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information in the PIR during our inspection. We found it reflected the service we found and included plans for improvement

We talked to five people who used the service and seven relatives and friends. We spoke with 10 staff (these included nurses. We also spoke with two visiting healthcare professionals. We observed the care provided to people and reviewed nine care records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also reviewed records to demonstrate the provider monitored the quality of service (quality assurance audits), medicine records, two staff recruitment records, and complaints, incident and accident records. We also spoke with the manager and the area manager who attended the inspection. We also spoke with the new managing director following the inspection visit.



# Is the service safe?

## Our findings

People and their relatives told us they felt safe, comments made were, "I feel safe here, a lovely place. [Staff] are very good, any problems I would speak to them." And, "I feel safe, they look after me. I would speak to staff if I didn't feel safe." A relative we spoke to told us, "Oh gosh yes, most definitely safe. It's the first time I haven't had to worry about them. No concerns whatsoever."

The provider had recruitment procedures to ensure staff who worked at the home were of a suitable character to work with people who lived there. Staff told us they had Disclosure and Barring Service (DBS) checks and references in place before they started. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. Records confirmed the required checks had been made before staff started working in the home.

People were supported by staff who understood their needs and knew how to protect them from the risk of abuse. Staff attended safeguarding training and the staff we spoke with all knew the importance of reporting any safeguarding concerns to their manager. Most understood the next steps the manager would take. For example one member of staff said, "I have done safeguarding training and know what abuse is, if I was at all concerned I would refer to the nurses or managers. They would look into and refer it on...I would phone safeguarding or CQC if I thought nothing had been done."

When we looked at care records we saw an incident had occurred in December 2015, which should have been referred to the safeguarding local authority. There was no documentation to confirm this had happened. We discussed this with the manager and they told us they would investigate this further. This incident had occurred prior to the current manager coming into their new position. They told us safeguarding was a priority and staff were now questioned about their knowledge and correct safeguarding procedures at shift handover. Staff confirmed this to us and told us there was a policy they could follow which gave information on how to identify and report concerns.

We asked staff how they knew about the risks associated with people's care, and they told us, "Each person has risk assessments, I do read them but you have to make time to do this." Another told us, "If there are any changes to people's care and risk assessments they [nurses] let you know in the handover."

There was a procedure to identify and manage risks associated with people's care. People had an assessment of their care needs completed that identified any potential risks to providing their care and support. For example, one person had been risk assessed as needing thickened fluids and pureed food because of concerns they may be at risk of choking. We saw this had been given to them. This person was also at risk of skin damage and their assessment stated they needed to sit on a pressure relieving cushion, we saw this was being done.

However, we observed one person in the Dementia Unit who was sat out of bed, but had their head resting on their bedside table. This person had a recorded injury of a bruised shoulder and chest earlier in the

month. Their notes said they 'sometimes' lean over the bed table. On the day of our visit we saw them continually leaning over the table and there was no risk assessment in place to inform staff how to reduce any risks of further injury. We also observed at lunch this person leaning over their lunch and at one time their face was in their meal. We intervened and alerted staff who came to assist. We informed the manager about this and they assured us this would be addressed immediately.

We asked people and relatives if they felt there were enough staff to provide care and support. We had mixed views from relatives on the Dementia Unit about staffing, one told us, "The staff are very good but there are not enough of them." They went on to say they did not feel there were sufficient staff to observe the communal areas. Also their relation used to slip off their seat onto the floor and they were concerned how long it might take for a member of staff to see this. However another relative we spoke to told us, "I am so happy [person] is here and I think there are enough staff to care for him."

During our visit we observed one person was trying to get a slipper off another person in one of the lounges. There were no staff in the room to see and respond to the situation and the relative had to call out to a passing member of staff to alert them. We also observed another person walking around who looked as if they were about to fall, and we intervened to support them and informed a member of staff.

On the ground floor people also had mixed views. One commented, "I don't think there is enough staff. They are understaffed." However they went on to say, "When I do ring my bell, they come in a few minutes." Another person told us, "I think so [enough staff], I have to wait half an hour sometimes." Relatives we spoke to commented, "Sometimes [in the past] they seemed short staffed before the new manager came. They used to use agency staff a lot, but they don't now. She seems to be trying to make things better." Another told us, "[Person] is always nice and clean when I come. I come every day, there's always enough staff."

On the day of our visit there were sufficient staff to meet people's assessed care and treatment needs on the ground floor. However, on the Dementia Unit we observed staff were constantly busy and we did not see them have the opportunity to sit and speak with people or to support them with their emotional needs. A member of staff told us they had chance to sit with people but this was, "When we give supper, we have time to sit and talk or watch TV together."

We asked staff if there were sufficient numbers to provide the care and support people required, comments included, "There is sufficient staff when we have five carers, very occasionally we have six and that's great. We could do with six at peak times in the morning between 8am and 11am as there are a lot of people to help wash and get up." Some staff told us they would like to see more staff especially at night time; however others commented that staffing had improved. One told us, "This has improved since the last time you [CQC] were here. We have five now and that is much better than the four we used to have."

We were told by the manager that they had increased the staffing on each floor to five care workers and two nurses during the day. They commented, "According to our dependency tool we are overstaffed, but I want the best for people, I won't have unsafe levels to care for people." We found staffing levels were as the manager had told us. The home was no longer using agency staff and the provider had recruited several new care staff and nurses.

We asked people if they received their medicines when they required them, one told us, "I do. Four times a day and it seems on time, I am never in pain luckily." A relative we spoke to commented, "[Person] gets his medicine on time every day, I check the book."

We looked at how medicines were managed by the service on both floors. Overall we found medicines were

stored and administered safely. We observed the administration of medicines for eight people in their rooms. The nurse knocked the door before entering and introduced herself and enquired as to the person's well-being. We saw people were appropriately supported to sit up before taking their medicines and explanations given before the medicines were administered.

We checked several medicine administration records and found these were completed correctly. Some drugs require careful storage and monitoring due to their strength and their stock levels need to be checked daily. We found two dates where this had not been carried out and discussed this with the nurse in charge who told us they would address this with the other staff.

Some people had medicines prescribed on an 'as required' basis (PRN), for example, pain relief drugs. On the Dementia Unit we saw two PRN protocols (guidelines) that did not contain sufficient information. For example, one person was prescribed pain relief; the protocol stated that if the person was in pain they should be given their medicine. However, it did not record where they might be experiencing pain or how they might show they were in pain and needed their medicine. Their records did not show how their pain levels were being monitored or assessed. This is important as some people living with dementia are not able to tell staff if they are in pain.

Another person had a protocol in place for a medicine used to treat people living with dementia who may become upset. However, this did not inform staff of the maximum dose that could be safely given to the person, this was brought to the attention of the manager who asked the nurse to address this immediately. They had already identified further detail was required for the protocols and had already addressed this with the nurses shortly before our visit. The manager told us they would review the protocols again with the nursing staff to ensure changes were made immediately.

On the ground floor we saw PRN protocols were in place and we found these were clear and comprehensive. In addition where people were taking medicines that were infrequently used or required additional monitoring from staff, guidance was attached to the protocol. This meant that the nursing staff had information available to identify any concerns about the medicine and its effect on people.

Nursing staff had their competency to administer medicines checked to ensure people received their medicines safely. The nurses we spoke with told us they had attended medicines management and administration training provided by the company when they started working at the service and they attended regular training updates.

Incidents and accidents were monitored by the provider to reduce the likelihood of them happening again. The manager told us there had been concerns regarding the number of people falling at the home, especially on the Dementia Unit and they had addressed this and reduced the incidence. They had achieved this by analysing all recorded falls to see what had contributed to them occurring and staff had received additional training on preventing falls. In addition they had increased staffing numbers to provide closer monitoring of people.

On the Dementia Unit we saw a number of mattresses and chairs with rips and tears. We discussed this with the manager and they told us new chairs and mattresses were on order. They acknowledged that improvements needed to be made to the unit and the provider had begun to redecorate and improve the environment for people. In addition, the garden was heavily overgrown, and not fit for the use of people living at Evedale. The manager told us plans were in place to address this shortly after our visit. We saw new linen and towels had been delivered on the day of our visit.

## Is the service effective?

### Our findings

During our time on the Dementia Unit, we walked past a person who was in their bedroom with their door open. We saw them eating their breakfast alone. They had porridge, scrambled eggs and spaghetti hoops. Their cutlery had fallen off onto their lap and they ate their spaghetti hoops with their hands. Their porridge remained untouched. Later we saw the same person, with their meal in front of them. They had eaten at least half of their meal, but had fallen asleep before they had a drink, or had eaten their pudding. Again, their cutlery had fallen into their lap and their head had fallen into their meal. Their face, clothing and pillow was covered in food. We called staff over to help clean the person, at which point their meal was taken away from them. Through our observation, we became concerned about the person's care and how they were supported to eat and drink.

We looked in their care plan and saw the dietician had reviewed this person as they had been losing weight. They had requested high calorie drink supplements and smoothies to be given to the person, we did not see either during our visit. We observed in the person's care records that staff had been instructed to encourage and support the person to eat and drink. At no time did we see this happening. Later in the visit, we looked at the care chart which recorded how much the person had to eat and drink that day, and it did not reflect what we saw. For example, the chart recorded that the person had eaten their porridge, and had refused their pudding and drink. However, we saw they had not eaten their porridge. This posed a risk that the person was not receiving enough support to maintain their health and well-being. We fed this back to the manager and they told us this would be addressed with staff on the floor to ensure support was provided to the person to have food and drink.

We saw drinks were available to people living at the home however on the Dementia Unit we saw staff did not always have time to sit and assist people with theirs. We observed some drinks appeared untouched and hot drinks had been left to go cold.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

People had a choice of meals, and alternatives to the main meal options were offered. The menu choices of the day were displayed on the notice board for people to see. People gave us positive feedback about the quality of food provided. They said, "There is a menu in the dining room and they ask you what option you want. The meals are good, I don't eat large amounts so I don't like my plate piled high, but they do give you a small portion if you ask for one and they will offer you more if you want it." Another said, "The food is really good, it always looks and smells so appetising. Unfortunately I have to have a pureed diet...they present it well, but it doesn't taste the same as proper food."

Staff had a good understanding of other people's specific dietary needs and we saw on the ground floor they supported the small number of people who required additional encouragement during meal times, at their own pace. One member of staff told us, "Several people need assistance to eat, there are enough staff to do this. There is a list in the dining room that tells you if people need pureed food or thickened fluids."

There is also one in the kitchen and the cook sends meals out already pureed."

People's dietary choices or needs were catered for at the home. We spoke with the Chef who told us they were provided with information about people's individual dietary needs and preferences.

We saw that people were weighed regularly and where people had been assessed as requiring extra calories, referrals to the dietician had been made. Fortified food was provided, such as full fat food products and regular snacks were given. A relative told us, "[Person] eats everything. I've seen them get a choice for breakfast and lunch. If they don't like it they can have something else." We saw people had access to regular drinks during the day and snacks were provided.

We asked people if they felt staff were well trained to care and support them. Some people were unable to eat or drink and had a percutaneous endoscopic gastroscopy (PEG) tube in place. A PEG is a way of introducing food, fluids and medicines directly into the stomach for people who are unable to swallow. One person told us, "I have a PEG, I can do most of it myself but the nurses make sure it's working properly... The nurses know what they are doing." Another person who needed specialist equipment to move told us, "I have to use a rotunda (a device to assist people to move) as I can't stand by myself since I had my stroke. Staff know how to use this perfectly well."

Staff told us they completed an induction when they started working in the home and had training to refresh their skills. The provider was planning to enrol staff on the Care Certificate which provides care staff with the fundamental skills they need to provide quality care. One told us, "I have sufficient skills to meet people's needs. We are trained to use a hoist and do theory on the computer."

However, another told us, "I think there should be some further training about dementia, we have people here living with dementia and the training I had was a long time ago and things have changed."

The manager told us some staff had not received all training the provider considered essential to meet people's health and social care needs. The first floor was a specific dementia care unit and one member of staff had received no dementia care training, even though they had been at the home for six months. Another member of staff had worked at the home for a year, had undertaken an online course and told us they would like more training. Observations showed staff had a basic understanding of engagement with people who had dementia. They understood behaviour and how to manage behaviour, but the focus was on keeping people safe. Staff did not appear to know how to support people who lived with dementia to have a better quality of life.

The manager had also identified that further training was required and was committed to enhancing staffs' skills and knowledge. They told us the provider was looking to implement the 'Dementia Care Framework' at the home in the near future, the aim of this is to train staff to provide personalised care for those people living with dementia. In addition, the manager was identifying other providers of dementia care that had been rated as outstanding by ourselves, and intended for staff to visit these homes to gain further insight and knowledge.

Staff received regular individual supervision (one to one meetings with their line manager), one member of staff told us, "We have supervision with the nurses, I think it's every three months. I've had a few and it has been better recently. [Lead nurse] is very good and will check your knowledge by asking questions in the handover."

Staff team meetings were also held regularly. We looked at staff meeting notes. The meeting agenda

focused both on staff issues, and how best the staff could support people who lived at the home. We saw the manager had discussed the importance of speaking with people's relatives when they visited, as this gave staff the opportunity to gather important information about the people they were caring for.

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. 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.

The management team understood the relevant requirements of the Mental Capacity Act (MCA) 2005. We saw that mental capacity assessments had been undertaken and these determined whether people could make informed decisions about various aspects of their lives. Care plans contained information as to whether people had capacity to make certain decisions, and if not, what decisions they needed support with or should be made on their behalf in their 'best interests'. However, we saw in one person's care plan in the Dementia Unit they were considered as not having capacity to make simple or complex decisions. In another section the plan stated they were able to communicate their needs verbally about non-complex decisions. This meant there was inconsistent information about the person and whether or not they could make decisions about how they received their care. This posed a risk they would not be supported correctly with decision making.

Staff had an understanding of the principles of the Act and how this affected their practice. Staff understood the importance of obtaining people's consent prior to providing care and support. A staff member told us that they would always ask people for their consent prior to undertaking care tasks. They told us, "It's about people's ability to make decisions, most people on the ground floor have some capacity and can make everyday choices and decisions."

Another told us, "We have had e-learning training about this. Nurses do the initial assessments and let us know about the person's capacity. Quite a few people here are unable to make certain decisions, staff support them to do this on a daily basis and most have family who support with other decisions."

We asked people if staff asked their consent before providing their care and we had mixed views. One commented, "They just come in, they don't knock and do what's needed, they don't ask first."

However, another person told us, "They ask my consent, always." However, on several occasions we observed that staff did not knock and seek consent before entering people's rooms.

We looked at whether people received health and social care when required. One person told us, "There is a doctor who comes round. They do my feet. The optician came not long ago." A relative told us a doctor visited one person and also the chiropodist and a dentist. Appropriate and timely referrals had been made to health professionals, for example when people were unwell or when staff had identified that people were losing weight.

From care records on the ground floor we saw that staff followed instructions given to them by health professionals to make sure people received the necessary support to manage their health and well-being. However, dietician advice for the person on the Dementia Unit had not been consistently followed.

We spoke with a health professional who visited people at the home. They told us, "It was a good referral that I received with relevant information. The staff listen to my suggestions and are eager to learn." They

went on to tell us they felt welcomed by the staff and were always asked to record their visits and recommendations in the person's care records so staff were able to refer to these.



## Is the service caring?

### Our findings

We asked people and their relatives if they thought staff were caring. One person told us, "Yes they do care for me. I whinge and moan a bit. They have never left me in distress; they are caring, it's their job." Another told us, "I do yes. They are alright."

All the relatives we spoke with told us they found staff to be caring, comments included, "They seem to care, they are very nice." And, "I have walked in and found them stroking [Person's] arm and talking to them. I observe all the time and they are so good."

A healthcare professional who visited the home said to us, "All staff are really nice and friendly and I think the care is good."

We observed staff on the ground floor supporting people during our visit and they were observed to be friendly and caring towards people. Staff knew people well; they addressed them by their preferred names and spoke to people about their family members and individual interests. Staff were respectful to people, knelt down to speak to those who were seated and took their time to listen to them.

However, on the Dementia Unit we observed that staff had little time to engage with people and we saw little interaction between staff and people outside of providing care and support. During our visit we conducted an observation within the lounge area. We observed an Occupational Therapist engaging with two people. However, we observed one person who had no interaction other than being moved from their wheelchair by staff. The person had no further communication with anyone in the 40 minutes we observed. During the last 15 minutes they fell asleep and this was after their chair was turned to face a TV which they had previously shown no interest in watching. We also observed they were sat very close to the screen.

We observed good communication between most people who lived at the home and the staff supporting them. It was clear that staff had built up good relationships with people, had a good understanding of their needs and any preferences they had in relation to the way their care and support was provided. We overheard friendly banter between people and staff. One relative we spoke to told us, "They spend hours talking about the war with him."

On the ground floor we observed two people being assisted with their midday meal. One person was reluctant to eat and the care staff assisting them patiently and encouraged them using humour; they told them, "This is the best mashed potatoes in Coventry, there's a queue of people wanting the recipe!" We saw the person laughed and began to eat all of their food and appeared to enjoy the meal.

On the day of our visit, several people who lived at the home were cared for in bed. Care staff ensured people's privacy was protected when providing personal care and closed bedroom doors. However, we observed some occasions when staff did not knock on the person's door to gain permission to go in. We found one person on the Dementia Unit had removed their bed clothing and was exposing their body, their bedroom door was open, and we covered them to protect their dignity. We also observed another person



whose trousers appeared to be falling down and they appeared upset by this. We alerted staff who then took the person to their room and corrected the problem. The person seemed much happier following this.

Most people we spoke with told us their dignity and privacy was respected by staff. They told us, "They [staff] help me to wash the parts I can't reach and put cream on my back and lower legs for me. I can reach the rest myself. They are very respectful when they do this and there is no embarrassment when I am undressed." And, "I think they are respectful..." A relative said to us, "They give them a shower but it's difficult now, so they have a bed bath. They are quite discreet, they are not embarrassed."

We asked staff how they ensured people's dignity was maintained. One staff member told us, "I make sure I close the doors and curtains if needed and ask anyone else in the room to leave while personal care is being given to maintain privacy and dignity."

Some people we spoke with confirmed they were involved in making decisions about their care and had been involved in planning their care. They told us they were supported to maintain their independence and the support they received was flexible to their needs.

One person told us, "I've had lots of chats about my care." Another told us, "I didn't like it at first as I was so used to being independent, but I had to accept I needed help till I recover from my stroke. I like it now, I've got to know the staff and nurses and they are all lovely." Relatives we asked told us where people were unable to discuss their care needs they had been consulted. They told us, "They do definitely discuss (care)." Another relative commented, "They discuss my relation's care with me, I am never left out of the loop."

The manager told us it was important to sit and talk with people and their families to gain as much information as possible. They told us, "If your heart is not in it, that's not good, you must want to care. You have to find out about people and relate to them." They went on to say, "In my life I have learnt to appreciate the elderly and their value."

People were encouraged to maintain relationships important to them and visitors were welcomed at the home. A relative told us, "You can come when you like here." One relative on the Dementia Unit told us they felt cared for by staff, they commented, "They know me by name." During the day we observed several visitors spent time at the home with people. One relative told us they were upset that a long standing member of the staff who had been supporting their relation had been moved to work on the ground floor. No explanation had been given why and they were unhappy about this, they told us the member of staff, "Went above and beyond the call of duty." The manager told us some staff had been moved and they felt it was important to involve staff in working on both floors of the home.

We saw there was a choice of sitting areas throughout the home so that people could meet with their friends and families privately if they wished and confidential information and care records were kept securely to maintain people's privacy.

## Is the service responsive?

### Our findings

We asked people and their relatives if they thought staff knew them well and supported them to maintain their health and well-being. One person we spoke with told us, "They know everything about me; they are here all the time." They went on to say that staff were familiar with what their likes and dislikes were. A relative told us, "With [person's] dementia it's difficult, but they know what they like, for example they like their tea hot."

Each person had a care and support plan with information personal to them. Some care plans included information in relation to maintaining the person's health, their daily routines and preferences. However, on the dementia unit the care plans we looked at did not fully explore people's views and wishes. They focused on the risks to people and how staff should support people to be safe. There was minimal information to guide staff on how to support people with their emotional and social care needs. Information about how their diagnosis of dementia impacted on their lives and the support they needed as a result of this was not included. The lack of information meant staff could not support people in having as much choice and control as possible.

Care plans also did not tell us about how people liked their personal hygiene needs met. Two care plans indicated that people needed two care workers to assist them with personal care. Neither said how they liked to be supported, for example if they preferred a bath or a shower, and how often they should have one. We looked at the daily records for one person to see when they had been assisted with a bath. We could not see any specific information about this as the records simply said 'personal care' had been given. We looked in the communication book and this identified that the person last received a bath on 25 May. We could not be certain if this was the actual date of the person's last bath or that records were not kept up to date. The manager told us they would discuss this with staff.

There was some information about people's preferences recorded in their care plans. For example the care plan of one person on the Dementia Unit identified that they liked to be in bed by 10pm and up again at 8am. They also enjoyed listening to music and we saw they were sat in the lounge listening to music during the day. We saw this person's family had been involved in discussions about how the person liked to receive their care and what they would need assistance with to maintain their health and well-being.

Improvements needed in relation to care records had already been identified by the new manager as part of the provider's auditing system and they had started to address this before our visit. We saw minutes of a meeting held with nursing staff in May 2016 and the lack of information recorded, along with family involvement in the planning of care, was discussed. The new manager identified staff that required additional training in how to complete care records correctly and they informed staff that following this training they expected to see an improvement in the quality of the care plan information. The provider was in the process of organising training for the nursing staff.

We asked care workers if they found time to read people's care plans and they told us, "We don't get time to read these. Plans are reviewed by the nurses monthly and we are told about any changes like moving and

handling, or if their independence has changed. We also get this information repeated in the handover." And, "No, we don't have time to read these. Nurses tell us about any changes and we find out about people's preferences by talking to them, or the nurse tells us."

Staff told us they had a shift handover where they would be informed of any changes to people and the care and support they required. They spoke positively about this, comments made were, "We have good information about people, not just they are okay, but if they have eaten and slept well. For example this morning we were told [name] didn't sleep at all last night so we know why they are tired and less responsive today."

However one staff member told us, "Communication downstairs is fantastic compared to upstairs." "Handovers are very thorough, we discuss people's conditions and any specific tasks required that shift."

The new manager told us they had extended the handover period as they did not feel sufficient time was taken to update staff on any changes that had taken place. They had informed the nursing staff that handovers to care staff needed to be more informative especially on the Dementia Unit as relevant information was not always being passed on. They told us they expected nurses to utilise handover time effectively by discussing areas of concerns with staff, and setting goals and standards that staff should be working towards. Nurses were also encouraged to identify areas where they felt care staff required further development, for example how to deliver person centred care and how staff could promote this during their day to day work.

The provider employed two activity coordinators to support people with their preferred hobbies and interests. The new manager told us relatives had expressed concerns about the lack of activities available for people especially on the Dementia Unit and this was being addressed. A new activity co-ordinator had just started working at the home. They told us to increase their knowledge they had been carrying out independent research on how best to support people with dementia and we saw they had a real desire to make people's lives more fulfilling. They were in the process of trying to find out about more about people's individual likes and dislikes, so they could organise appropriate activities for them.

They also told us that part of their responsibilities was to accompany people to hospital visits. This meant that any planned activity sessions would have to be cancelled. In addition to their role, they supported care staff with assisting people to eat their meals which was not part of their responsibilities and this impacted on the time to carry out activities with people.

People and their relatives told us they would have no concerns if they needed to make a complaint. People told us, "I wouldn't think twice about complaining, I would speak to the person in charge." Another told us, I would talk to the manager if I had any concerns, she is very nice."

Relatives we asked told us, "I would go to the manager, she is a lovely girl." One told us they had made a complaint and it was resolved to their satisfaction, "I was told how to make a complaint. I would go to the manager first. The only complaint I made was about cutting [person's] meat, it was resolved."

The manager told us they were keen to obtain feedback from people and their relatives and we saw the provider's complaints procedure was on display in the main foyer. The opportunity to remind people how to make a complaint was discussed at the residents and relatives meetings. In addition as part of the providers auditing process there was a 'tablet computer' available in the main foyer where visitors could register a complaint and make a request to see the manager to discuss any concerns. The manager also told us "I tell people 'come in to my office', I want people and their families to have a say, especially on the Dementia Unit."

Complaints received were recorded in a complaints log and had been investigated and responded to in a timely way. There were no trends or patterns identified with complaints received.

## Is the service well-led?

### Our findings

Since our last inspection in April 2015 the service had undergone a change in management. There was now a new manager in post and they had been at the home since December 2015. There was also a new area manager in position and the provider had appointed a new managing director to the area.

The new manager told us that in the last 18 months the staff had seen three different managers at the home and this had been a challenging period for them. Staff we spoke to confirmed this, one told us, "It's been difficult to adjust to different managers, they all have their different ways of working. We have also had a lot of new staff to support."

However, everyone we spoke to at the home spoke positively about the new manager. People told us, "I've met (manager) several times. Very nice, brilliant. I've never asked to see her, no need." And, "It's okay here, the staff are fine and the new manager is lovely, best one they have had. I see her every day and she speaks to everyone."

Relatives commented to us, "The new manager is very good. She always comes up and talks to me. Whenever I've wanted to speak to her she is available. She is always around the home." Another told us, "[Person] is very approachable, her door is always open. We just had a relative's meeting and we asked for more activities and they have responded to that."

We found the manager was highly committed to making improvements at the home for people, their relatives and staff. They told us, "I want to retain our staff and develop and empower them. I want them to enjoy what they do. We have to be more person centred in our care and I want to hear the voices of people who live here and their families."

We asked staff if they felt supported by the manager and they told us, "New manager is really good, visible in the home and approachable. She has made some change to the service like increased staffing and the atmosphere seems better." And, "The manager is approachable and supportive. I feel I could report to her if I had any concerns and my line manager wasn't available."

The manager told us they identified that improvements were required on the Dementia Unit and the provider was investing in upgrading the environment to make it more dementia friendly. For example, to personalise people's rooms and assist them to identify their bedrooms, doors painted different colours were being explored. They went on to say it was a priority to settle new staff on to the unit so they could begin to develop relationships with people and their families. They told us, "We have to build trusting relationships. We have to listen to families and follow up concerns, we need to ask, 'what can we do to improve'."

Staff told us they felt there was a divide between the two areas of the home. Some told us they felt less valued on the Dementia Unit. Comments made were, "Upstairs is different down here they speak to you with a different manner and seem to have a different attitude, we are treated like a member of a team." Another told us, "I love working downstairs, its much less stressful then upstairs. I don't think you are

appreciated upstairs."

The manager acknowledged some staff were unhappy and they were trying hard to address staff morale on the Dementia Unit. They told us, "We can do this together, they need to build that trust in me. We will listen to each other and learn as a team."

The provider carried out audits to monitor the quality of the service provided. There was a timetable indicating audits that needed to be carried out by the manager on a weekly and monthly basis. These included audits in relation to medicines, falls and skin care. Random checks of care plans were conducted and staff, people who lived at the home, relatives and visiting healthcare professionals were spoken with to see if they had any concerns. We asked the manager what happened at weekends and they told us the checks were still conducted by the staff on duty. The area manager told us they monitored this to ensure these checks were being carried out. We saw audits were being undertaken and had identified some of the concerns we found.

The manager told us they carried out daily walkabouts and 'spot checks' of the home and this included at night time. They told us, "I do spot checks at night because I want to see what is going on, for example are there enough staff to keep people safe. It's also an opportunity to speak with the night staff."

We asked people whether communication was good and if they felt informed. One told us, "I haven't got a clue about residents meetings." However, we saw minutes from the last residents and relatives meeting which was held in May 2016. Relatives had been informed about the 'tablet' computer available for them to provide feedback and the manager was encouraging people to give their opinions on the service to drive improvements within the home. Relatives had concerns regarding the poor state of the gardens at the home which we observed were overgrown and not easily accessible. The manager had informed people at the meeting that this was being addressed. During the week of our visit, assistance was being provided by another maintenance worker from one of the provider's nearby homes to cut the grass. The lack of activities had also been discussed and addressed by the manager.

We saw feedback displayed for people and their relatives of satisfaction surveys carried out between January to May 2016. We saw the overall satisfaction rating of people living at the home was 91% and relatives 91%. Healthcare professionals had also been surveyed and they had responded positively at 94%. We asked the new manager how many people the surveys would have included and they told us approximately 40. Staff satisfaction was recorded at 75%.

The manager told us they were keen to improve communication and share information with people and relatives and planned to hold regular group meetings. We asked how they listened to the experience of people who were unable to attend the meetings particularly people who remained in their rooms. They told us as part of their 'quality of life' audit staff would visit people to discuss if they had any concerns or issues.

The manager had made significant improvements to the home in the short period of time they had been in post. However improvements had yet to become imbedded into 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 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  14 (1) (2) (4) (a) (d) People did not always adequately receive food and fluids to sustain life and good health.