We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

## Evedale Care Home

Occupation Road, Coventry, CV2 4AB  
Tel: 02476448292

Date of Inspection: 24 April 2014  
Date of Publication: May 2014

We inspected the following standards as part of a routine inspection. This is what we found:

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<td>✓ Met this standard</td>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>✗ Action needed</td>
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### Details about this location

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<th>Registered Provider</th>
<th>Four Seasons (Evedale) Limited</th>
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<td>Registered Manager</td>
<td>Mrs Linda Gazzard</td>
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<td>Overview of the service</td>
<td>Evedale Care Home provides nursing care and accommodation to a maximum of 64 people. The service provides care to older people, people with dementia, and people with mental health conditions. It is situated in Coventry.</td>
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| Regulated activities | Accommodation for persons who require nursing or personal care  
Diagnostic and screening procedures  
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 24 April 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and talked with commissioners of services.

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 could not talk with us.

What people told us and what we found

Two inspectors carried out this inspection on Thursday 24 April 2014, one inspector returned the following morning to complete the inspection. We visited the service from 11.30am to 8pm on the first day and from 9.30am to 12.30pm the second day. We spoke with the registered manager, the regional manager, three visiting relatives, a visiting healthcare professional, two people who used the service and nine nursing and care staff.

The evidence we collected helped us to answer five key questions; is the service safe, effective, caring, responsive and well led?

Below is a summary of what we found. The summary describes what we observed, the records we looked at and what people using the service, their relatives and the staff told us.

If you want to see the evidence that supports our summary please read the full report.

Is the service safe?

We inspected staff rotas and talked with staff. We were made aware the service had been experiencing difficulties in retaining and recruiting staff because of a local hospital's recent recruitment campaign. We saw sufficient staff had been rota'd to meet the assessed needs of people living at the home. We found there was a high level of bank staff being used and the service had to use agency staff to cover some of the shifts. Staff told us they felt there was not enough staff to meet people's needs and staff were phoning in sick.

The provider and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There was nobody living at Evedale who had a current DoLs in place.
Is the service effective?

People all had an individual care plan which set out their care needs. These provided staff with the information they needed to support people with their care. Assessments included people's needs for equipment, skin integrity and specialist dietary requirements. We saw some inconsistencies and insufficient information in some care records which could impact on the care provided.

Is the service caring?

People were supported by staff who were kind, caring and patient. We saw staff were very busy throughout the time we were inspecting the service. They did not have time to sit and talk to people unless they were supporting them to eat. However, when staff were undertaking care tasks or talking with people, they treated people with dignity and respect.

We spoke with three relatives and two people who used the service. One person told us, "Staff are busy but they will do things if you ask them." A relative told us, "We can't speak highly enough of the staff, the care is so much better here than the previous home."

Is the service responsive?

People had access to a range of health care professionals, some of which visited the home. During our inspection we observed a GP visiting a person, and a speech and language therapist visiting another. They told us, "They (staff) seem to be quite proactive in phoning us when things change." We also saw a person being taken to hospital accompanied by one of the care workers. This meant the service responded to the changing health needs of people living at Evedale.

The service was less responsive to people's social needs. There was little time available for staff to sit and talk with, or undertake social activities with people. The service employed one activity co-ordinator who worked each weekday. They were responsible for providing activities and social stimulation for the 55 people living at the service. One person living at the home told us, "It's boring here."

Is the service well-led?

The regional manager and manager told us the service had been going through a challenging period since our last visit. We saw the regional manager was supporting the manager to ensure systems designed to assure the quality of service were fully implemented. They were also supporting the manager in dealing with the challenges in recruiting and retaining staff.

Information from the analysis of accidents and incidents had been used to identify changes and improvements to minimise the risk of them happening again.

People's personal care records, medication records and other records kept in the home, had been identified by the organisation as requiring improvement. The service was working to the company's action plan in addressing the areas of concern.

You can see our judgements on the front page of this report.
What we have told the provider to do

We have asked the provider to send us a report by 06 June 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Consent to care and treatment  ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We looked at care files to see if there were clear procedures for gaining consent from people for any of their health and social care needs. We saw an assessment had been undertaken with each person to determine their mental capacity to make informed decisions. The records informed staff of the level of a person’s mental capacity. For example some records informed the person did not have capacity to make major decisions but they could make day to day decisions and choices.

The records informed staff how a person might communicate their needs if they were unable to do so verbally. For example, one person’s records stated, “X will let you know with a smile if x likes something. They will close their eyes if they don’t want to engage.”

The provider might find it useful to note that we spoke with one relative who was concerned a member of staff had not respected their relation’s visual cues for refusing food and had continued to support the person to eat. They told us they had only recently seen this happen and had not spoken with the manager. We informed the manager of this during our visit. This meant not all staff acknowledged when consent was not given.

We saw where major decisions were taken for people who lacked capacity they were taken in the person's best interest. Decisions were taken with the relevant family members and professionals involved in the person's care. This meant the service was complying with the Mental Capacity Act.

We noted there had been advanced planning for end of life care. Where appropriate, discussions had been held with the person or their family to determine whether it would be in the person’s best interests to be resuscitated, should the situation arise. The correct forms had been completed (DNAR).

During our visit we saw staff encouraged people to make their own decisions about day to day living. For example, people were asked what they wanted for their meals, what drinks they wanted, and where they wanted to sit and when they wanted to go to bed.
Care and welfare of people who use services  Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Evedale Nursing Home provides nursing support to people with dementia on the first floor and more general nursing support to people on the ground floor. We looked at the care and welfare of people living on both floors.

We asked whether any person living at Evedale was currently on a Deprivation of Liberty Safeguard (DoLs). This is where a person is assessed by the local authority to determine whether their liberty requires restricting to keep them safe. We were told no one was currently on a DoLs safeguard. The provider might find it useful to discuss the recent ruling by the Supreme Court with their DoLs team. The changes might mean some people who were not previously subject to DoLs safeguards may now be required to have one.

We were told the service had an activities worker who provided one to one and group activities at the home. They were on sick leave at the time of our visit. We were informed the activity worker was usually available each week day. They were responsible for planning one to one and group activities for all of the 55 people who lived at the home. This meant they had a large group of people to support. It also meant there was nobody to provide this support when they were on holiday or on sick leave.

On the ground floor we observed people having their lunch. We noted 1940's music was playing whilst people ate. We saw the tables were laid out with tablecloths, cutlery, flowers, glasses, napkins and salt and pepper. We saw two people being assisted to eat their meal. Each person had one member of staff support them. We saw staff take their time with people and supported the person to eat at the person's pace. We noted that people were in the dining room for a long time. We saw seven people were taken to the dining room at 12.30pm. At 2pm there were still six people in the dining room and no staff present. One person was saying, "I want to go to bed and watch the TV."

Later we undertook a SOFI (short observational framework for inspection) in the ground floor lounge. There were four people sitting in the lounge. We noted staff were busy elsewhere and during our observational time (20 mins) walked in the lounge just to check on people sitting there. We saw staff speak only to one of the people and there was no activities, music or TV to stimulate people or for them to engage with. After a while a member of staff turned the TV on during one of their checks of the room. Later, we spoke
with one person living in the home who had entered a lounge we were in. They told us they were bored and there was nothing to do in the home.

On the first floor dementia unit we saw staff were patient and supportive with people who had behaviours which could challenge others. We observed staff being very busy supporting people with personal care as well as supporting people with their behaviours. We saw staff talking with people whilst undertaking care tasks but we did not see staff had time to sit with people to talk with them or to undertake activities.

We observed people on the first floor having their tea. Again we saw tables were nicely laid out and people who required support received one to one attention. However, because of the behaviours of some of the people, we saw staff at times had to stop what they were doing. This was so they could help another person and then come back to complete their support. This meant not all those requiring support to eat had an un-interrupted tea time experience.

We saw examples of staff supporting people with dignity and respect. A person with dementia asked the member of staff for 'squares' after their dinner. The member of staff understood the person meant tissues and replied, "Is it tissues you mean sir?" and handed the person tissues to wipe their hands. It was what the person wanted.

We saw a person who spent much of the time shuffling through the corridors on their hands and bottom. A member of staff asked if they would like a rest and sit in a chair. The person indicated they would like this. The staff member and two others supported the person to be hoisted safely into a wheelchair. All the time they were explaining to the person what they were doing so the person felt safe.

We saw staff celebrate a person's birthday. They went into the person's room and surprised them by singing happy birthday with candles lit on the birthday cake. The cake had a fried egg in fondant icing on the top. This was because the person's favourite food was fried eggs.

We noted there was an unpleasant odour coming from the corridors, particularly from the first floor. This had been identified during our previous visit in October 2013 and we were informed the carpets were being replaced with a different type of flooring. We were informed this would eliminate the odour. We saw on the day of our visit a person from a flooring company measuring the floor space to provide a quote to the provider. We were told this was a priority.

We looked at the care records of six people. We saw each person had an initial assessment of need and care plans for the different care and support required. For example, care records contained care plans for tissue viability (skin care), personal care, nutrition, medication, mental capacity, communication and mobility.

The records also contained risk assessments to support staff in determining the care and treatment required. For example, the service used a risk assessment tool to determine what risk the person had of developing pressure ulcers. They also used the MUST (Malnutrition Universal Screening Tool) to determine people who might be at risk in relation to nutrition or hydration. We saw inconsistencies and insufficient information in some people's care plans, risk assessments and daily records. This meant we could not be sure staff had clear information about the care needs of all people.

We saw people had access to health care professionals when they required them. For
example, care records showed involvement of social workers, the GP, speech therapists, occupational health therapists and dieticians. During our visit we saw a GP checking on the needs of one person living at the home and a speech and language therapist checking on the needs of another. We spoke with the speech and language therapist who told us they had visited the service three times to support the same individual. They told us staff, "Seem to have quite good insight into the problem."

We talked with three visiting relatives. One told us, "The care has been excellent, X has got to know the staff well." Another told us, "I can't speak about the quality of care in glowing enough terms." A third person said, "I think it is good (the care), it seems a bit more homely here."
Management of medicines

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not always protected against the risks associated with medicines because medicine records were not being effectively managed.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the administration of medication on both the ground and first floor of the home. We saw the majority of medicines administered to people were in blister packs set up by the pharmacy (a blister pack is a card of pills backed with foil. For each dose time, there is a pre-filled collection of medications to administer). We saw some medicines were not in blister packs.

We checked the record of medicines administered at 8am. We noted there were some errors in recording. For example, on the first floor one person's morning dose of Sertraline was not in the blister pack which would indicate it had been given. The record did not have a signature to confirm this was the case. Another person's Memantine medicine had not been given, but there was no record to inform why this was the case. We spoke with the nurse who had administered the medicines that morning. They told us they had administered the Sertraline but had been called away to deal with something else and had not signed for it. They also told us the Memantine had not been given because the person was asleep. They had gone back to the person when they woke up and had given them their medicines then. This meant people were receiving their medicines but the nurse had not followed policies and procedures in recording the administration of medicines.

We looked to see if the number of medicines available tallied with the quantities recorded as being available to people. On the first floor we checked the records of seven people. We found inaccuracies in the tally for three people's medicines. For example the record for one person's Co-codamol suggested they should have 139 tablets left. There were only 116 remaining. The nurse supporting us with this part of the inspection was asked to check our calculations for each of the people where we found inconsistencies. They agreed with our findings. This meant we could not be sure what had happened to the medicines not accounted for.

On the ground floor we looked at two people's medicines and found inaccuracies in the tally for one person's medicines. For example, according to the records there should have been eight Tiotropium in stock but there were nine. Tiotropium is used to prevent
wheezing, shortness of breath and chest tightness in people who have difficulty breathing. We could not be sure that the person received this medication.

We saw there were protocols in place for the administration of medicines on an 'as required' basis (known as PRN). We saw there were protocols for people having Paracetamol 'as required' but not for a person who had been prescribed a medicine to treat anxiety. This meant staff did not have information about when and why the person should be offered the medicine.

We looked at the storage, administration and recording of controlled medicines. We saw they were stored securely and in line with legislation for storing controlled medication. We saw records which demonstrated two members of staff witnessed and signed for the administration of controlled medication. We saw the number of controlled medicines available tallied with the recorded information. This meant the administration of controlled medicines was safe.

We looked at the storage of medicines. Medicines were stored securely in a medicines room on both the ground and first floor. The first floor medicines room had air conditioning and medicines were not at risk of being in an overly heated environment. Records showed the ground floor medicine room regularly reached the maximum acceptable temperature. We were told when the room got hot, the trolley was taken up to the first floor air conditioned medicines room. This meant the effectiveness of medicines was not compromised.

We were told there was a protocol in the home that nurses should not be disturbed when administering medicines. We were told nurses had a red tabard to wear which indicated they were not to be disturbed. We saw one nurse undertaking a medicine round who was not wearing this tabard. We had also been made aware that one nurse had temporarily stopped doing their medicine round to deal with other issues. This meant the protocol was not consistently being followed.

We looked to see whether there were systems in place to check the competency and skills of staff administering medicines. Only nurses had permission to administer medicines to people who lived at the home. We saw the service checked the nurses' competency in administering medicines once a year. We saw the deadline for the competency checks of three of the nurses was imminent.
Staffing

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Prior to our visit we were informed by Four Seasons (Evedale) Ltd (the provider) they had a new system for identifying the number of staff required in relation to the assessed dependency levels of people who lived at the home. On the day of our visit, there were 55 people living at Evedale. Under the service's dependency tool this meant there should be six staff on duty on each floor in the morning, including two nurses (from 8am to 2pm), five in the afternoon, including two nurses (2pm to 8pm), and three at night, including one nurse (8pm to 8am). We saw the numbers were met.

The manager and visiting regional manager told us the service had been experiencing difficulties in retaining and recruiting nursing staff. They told us the local hospital's recent recruitment campaign meant they lost some of their qualified nurses, or their nurses moved to being bank nurses for the company. We were told this had also impacted on the service's ability to recruit to vacant posts. This meant there had been difficulties in covering the rota with permanent staff.

The majority of the nurses who worked at Evedale were bank staff whose primary employment was elsewhere. This meant they were restricted in the amount of hours they could work for the service. The manager and regional manager told us they had been able to ensure the number of staff required to cover the rota was met each day. This was made up of bank staff and at times agency staff. We looked at rotas for the two week period of 7 April through to 20 April 2014. Rotas confirmed the home was staffed according to the dependency tool but there was a lack of continuity of staff both in the day time and at night.

Most permanent staff we spoke with were not contracted for fixed days each week. Their contracts were for a set number of hours. They therefore needed to see the rota in advance to find out what shifts they would be working. Staff told us the rotas were often delayed in coming to them. This meant sometimes they had made plans for the days they had been scheduled to work and then had to change them. One member of staff told us they thought this might also be a reason for staff phoning in sick.
We spoke with nine care and nursing staff. They told us they felt rushed in doing their work and there was insufficient staff to meet the levels of dependency in the home. They also felt there were no incentives for staff to stay. Whilst management told us they ensured the home was not short staffed (according to assessed dependency), all staff we spoke with felt there was not enough staff to meet people's needs.

One member of staff told us, "It's terrible, it's difficult for them to get and keep staff here, there is no extra pay for NVQ2 or 3, there's no extra pay for nights and no outside training available." They also said, "Morale is appalling."

Another told us, "We need to have five care workers and this morning was four".

A third said, "It's very busy, we are struggling with staff...we are begging for people to work extra but they are all shattered...some agency staff won't come because they say it's too hard...people don't have specific days of working...it makes it difficult to sort out a rota, covering nights is the hardest we have exhausted bank staff."

A fourth member of staff told us, "There's not enough (staff) because of the nature of the residents...we need to spend more time with them." They told us it was hard, "Trying to feed and do personal care, plus mid-morning drinks and supplements, you are on the go all the time...sometimes certain residents can be demanding."

A fifth member of staff said, "There's not enough staff...some staff phone in sick...last few months it has been really bad...they interview new staff, they either don't turn up or stay for just one shift." They went on to talk about rotas and told us, "For those not on set days the rotas are a nightmare...they come out too slowly and for a week at a time." They told us, "As a staff group we never get asked opinions about the home, I can't remember the last meeting we had...we've not had a meeting for well over a year."

A sixth member of staff said, "We are short staffed all the time. Some of the residents want you to sit with them for five minutes but we don't have the time to. It's not fair on them...some people (staff) don't want to come in because they know it is going to be short. Sometimes we have one nurse and three carers."

A seventh member of staff said, "Even agency staff don't want to work here because it is too difficult...there are three staff at night, one nurse and two carers, I don't feel that is enough for the dependency of residents...we need one more care worker, we've been asking for this for years...sometimes we only get the rota three to four days before we start the new rota, it can cause issues, we don't feel listened to...the main problem is feeding people, it takes a long time."

We observed staff supporting people on both floors of the service. We saw staff were very busy and had little time to sit and talk with people unless they were supporting them to eat. We noted the corridors were long. It was not always easy for staff to quickly attend to a person’s needs if they were at one end of the building and the person was at the other end. We saw since our last visit nursing staff were now deployed at meal times to support the care workers in helping people eat their meals. This had eased the staffing issues at these busy times but one nurse told us it meant 4.5 hours a day were spent undertaking care work and not nursing tasks.

We spoke with three relatives about their relations' experience living at the home. One
A person told us, “The staff are all lovely, they really are, across the board there’s care and affection.” They went on to say, “They could do with a couple more staff at times for personal care.” Another relative was complimentary about the staff who worked at the home but said to us, “I sometimes worry about the monitoring of patients that are bed-bound as they are totally unable to defend themselves.” They told us their relative who was bed-bound had the door to their bedroom shut to stop other people from coming in. They said if the person had capacity they would want the door open because they used to like seeing life go by. They felt the door was shut because there were not enough staff available to monitor the movements of others.

Our observations, combined with the views of staff and relatives meant the staff dependency tool did not provide for sufficient staffing during peak times of the day and evening to meet people’s fluctuating dependencies.

The regional manager told us they were aware of the concerns staff had about sickness, rotas and recruitment to post. They were aware that staff morale was very low. They told us they were arranging individual meetings with staff which would include representatives from the company’s human resources department to discuss staff concerns and look at how they could improve morale.

The regional manager showed us their most recent quality monitoring visit notes which demonstrated the organisation was aware and working towards improving sickness rates, and rota planning. They were also looking as a company at what incentives they could offer to people employed by the company to encourage recruitment and retention of staff.
Assessing and monitoring the quality of service provision  

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

On the day of our visit, the regional manager for the service was visiting Evedale to undertake their monthly quality audit of the home. We saw the regional manager was working closely with the manager to monitor the quality of service provision. We saw there was regular quality monitoring visits. The visits had identified areas of concern and actions the manager and staff needed to take to address concerns. We saw the regional manager was supporting the manager to ensure the required actions were being addressed.

The majority of the issues we identified during this visit had previously been identified by the regional manager and work was being taken to address them. For example, ensuring rotas were provided to staff well in advance of their shifts.

We saw there were systems in place to identify, assess and manage risks relating to the health, welfare and safety of people living in the home. We saw risk assessments had not always been updated but senior management were working with staff to improve implementation. For example, we saw evidence of audits for the prevention of choking, medication, pressure ulcer care, bed rail assessments and nutrition. Where audits identified errors or omissions, actions were taken to address these.

We saw management took seriously its responsibilities in ensuring staff were performing satisfactorily in their work. Where performance was an issue, we noted performance plans were put in place to help support the member of staff in understanding their roles and responsibilities. We noted where concerns had been raised about staff competency, the provider had put monitoring systems in place.

We saw incidents and accidents at Evedale had been monitored and analysed to see whether any patterns were identified. For example, a falls analysis had been conducted and it was noted there were more falls around tea times. A decision was taken to bring those more at risk of falls into the dining room first and ensure a member of staff was with them at all times. This meant management was being pro-active in trying to minimize the risk of people falling.

The service had a complaints policy and procedure. We saw audit information which
showed the service had not been recording all complaints received during 2014. Regional management knew this because they were aware of complaints from staff and families that had not been logged. This meant management wanted to ensure there was openness and transparency with the complaints received and in demonstrating how these were dealt with.
Records

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment because records were not always accurate.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the care records of four people who lived at Evedale. We saw care records contained care plans and risk assessments for each area of assessed need. We found inconsistencies and insufficient information in the records checked. This meant staff could not rely on them to give an accurate picture of people's health and social care needs.

For one person we found the falls risk assessment was last reviewed in October 2013. This meant we could not be sure whether their risk of falling was the same or had changed over the six month period. We saw information showing the person required a slide sheet to be repositioned in bed. Staff told us the person could re-position themselves. This meant the care plan gave inaccurate information to staff. We saw bedrails had been put in place and the risks for bedrails had been assessed monthly. We saw gaps in bedrail reviews between September 2013 and March 2014.

The records indicated the person's hand was gradually closing. This meant there were hygiene issues which needed to be assessed. The notes from the hospital stated the person should use a splint. We found no information in the care records specific to hand hygiene and no evidence of a splint. This meant we could not be sure whether staff were aware of how to clean the person's hand or of the need for the person to have a splint.

The person had epilepsy. We did not see a care plan linked to their epilepsy. This meant staff would not know if there were signs and symptoms which determined the onset of a seizure. We could not be confident staff would know what to do to support the person should they have a seizure.

The TPR and BP chart (temperature, pulse and respiratory rate, and blood pressure) for the person had not been updated since December 2013. These observations are important for the early detection of any deterioration in a person's condition. This meant staff did not have information which might help with the early detection of any deterioration in the person's health.
The person was assessed as being at high risk of skin breakdown. The care plan informed staff to monitor skin and to check and report any redness or breakdown to the nurse and to do a body map. These were in place but there was no information in the care plan about the equipment required to prevent them from developing pressure sores such as the type of mattress and cushions to use.

The second person's care records did not give us clear information about their catheter care. The records for September 2012 stated the person had a long term catheter in dwelling (this is used to drain the bladder of urine). An indwelling catheter drains urine by attaching to a drainage bag. A nurse told us the catheter had been removed three weeks prior to our inspection. We asked to see a copy of the catheter change record prior to the catheter being removed. We were then told it had been removed in September 2013 when the person was discharged from hospital.

We looked at their records on the date of discharge. One record indicated there was no catheter on discharge. The daily notes for the same date told of the 'urinary catheter draining well.' We asked the service to look at their archived information to see if anything confirmed the catheter was no longer to be used. A week after the visit they had not found any information to confirm this. This meant we could not be sure whether the appropriate healthcare advice had been given to remove the catheter.

This person also required PEG feeding (percutaneous endoscopic gastronomy). This is where the person has foods and fluids through a tube which goes into their stomach because they are at risk of choking. We could see no information in the records about their mouth care. This meant we could not be sure the person's oral hygiene was being maintained.

On the first floor, we looked at the care records of two people who were at risk of pressure ulcers and could not move themselves. Records for both people showed there were inconsistencies. This was in relation to staff observation charts and charts relating to these people being repositioned in bed.

For one person the care plan stated they should be repositioned three hourly (how many times the person's position is changed to reduce the chances of skin breakdown). We looked at the charts in the person's room to find out how often they were being re-positioned. We saw the practice for re-positioning was more than this. Whilst this further reduced the risks of skin breakdown, it meant the person was not having as much rest during the night as they would have if the care plan was adhered to.

The moving and handling care plan of the second person informed the person should be repositioned every two hours. The skin integrity care plan for this person stated they should be re-positioned every three hours. This meant there was an inconsistency in the care plans. We looked at the records held in the person's room. For example on 16 April, the person was positioned on their back for four hours and on 17 April, they were on their back for almost five hours. This meant they were more at risk of skin becoming sore and breaking down.

We looked at the catheter care of this person. The catheter should have been replaced within a 12 week period. We saw the service replaced the catheter early when it was blocked or there were issues with it. However we noted it was last changed on 23 March 2014 when it should have been changed on 12 March 2014 at the latest. We looked to see whether there had been any prompts to remind staff the change was required and we could not see this. The nurse on duty checked for us and told us there had been no
information recorded in the diary to remind staff of this. We asked the nurse to also check whether a prompt for the current catheter change had been put in the diary, as there was nothing in the care record to inform of the date for the next change. This was checked and again there was no record to prompt staff of the change date. This meant the catheter might have been in use for longer than it should have been. This was rectified during our visit.

We saw the organisation had been auditing records to ensure they were fit for purpose. The organisation had asked staff to improve their management of records.

People's care records were locked in cabinets in an office accessible to staff. We saw the office was locked when not in use. Medicine records were kept locked in a separate medicines room. Records relating to staff and which provided information about the running of the home were kept securely in the manager's office. This meant records were kept securely and could be located promptly when requested.
This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Management of medicines</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Regulation 13</td>
</tr>
<tr>
<td></td>
<td>The recording of medication was not always accurate to make sure people received the correct doses of medicines and medicines were safely managed.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Regulated activities</th>
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<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Staffing</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Regulation 22</td>
</tr>
<tr>
<td></td>
<td>The service does not have sufficient permanent qualified staff whose primary responsibility is to Evedale Nursing home to ensure consistency in care. The deployment of staff during the day and evening does not always meet people's fluctuating dependencies.</td>
</tr>
</tbody>
</table>
This section is primarily information for the provider

<table>
<thead>
<tr>
<th>Accommodation for persons who require nursing or personal care</th>
<th>Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 20 (1) (a)</td>
</tr>
<tr>
<td></td>
<td>Not all care records provided accurate, consistent and up to date information to ensure people's needs were met appropriately and safely.</td>
</tr>
</tbody>
</table>

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 06 June 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
About CQC inspections

We are the regulator of health and social care in England.

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

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✅ Met this standard
This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed
This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken
If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

<table>
<thead>
<tr>
<th>Respecting and involving people who use services - Outcome 1 (Regulation 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to care and treatment - Outcome 2 (Regulation 18)</td>
</tr>
<tr>
<td>Care and welfare of people who use services - Outcome 4 (Regulation 9)</td>
</tr>
<tr>
<td>Meeting Nutritional Needs - Outcome 5 (Regulation 14)</td>
</tr>
<tr>
<td>Cooperating with other providers - Outcome 6 (Regulation 24)</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)</td>
</tr>
<tr>
<td>Cleanliness and infection control - Outcome 8 (Regulation 12)</td>
</tr>
<tr>
<td>Management of medicines - Outcome 9 (Regulation 13)</td>
</tr>
<tr>
<td>Safety and suitability of premises - Outcome 10 (Regulation 15)</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)</td>
</tr>
<tr>
<td>Requirements relating to workers - Outcome 12 (Regulation 21)</td>
</tr>
<tr>
<td>Staffing - Outcome 13 (Regulation 22)</td>
</tr>
<tr>
<td>Supporting Staff - Outcome 14 (Regulation 23)</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)</td>
</tr>
<tr>
<td>Complaints - Outcome 17 (Regulation 19)</td>
</tr>
<tr>
<td>Records - Outcome 21 (Regulation 20)</td>
</tr>
</tbody>
</table>

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.