Evendine Care Limited

Evendine House Residential Home

Inspection report

Evendine House
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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 took place on 15 and 23 March 2018. Day one of the inspection was unannounced, and day two was announced.

Evendine House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service provides accommodation and personal care for up to 20 people. At the time of this inspection, there were 18 people living at the home, a number of whom were living with dementia.

There was not a registered manager in post at the time of our inspection, but the acting manager had applied for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of our last inspection undertaken in April 2016, we rated the service as Good. At this inspection, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safeguarding service users from abuse or improper treatment, and notification of incidents.

People had not always been protected from harm or abuse. Two incidents of physical abuse had occurred at the home in January 2018, but staff who had witnessed the first incident had failed to report this to the provider, or to the Care Quality Commission and the Local Authority. This inaction placed people at risk of further harm and abuse.

The provider's safe recruitment processes had not always been adhered to, which meant there were members of staff working at the home who had not undergone complete reference checks or been subject to a formal interview.

Not all staff working at the home had received an induction when they had started. Not all staff had received training in safeguarding, which the provider addressed during the course of our inspection.

The physical environment for people was not always dementia-friendly, with a lack of signage and information about the date and time. Plans were in place to remedy this.

The provider had not always submitted statutory notifications to the Care Quality Commission, as required by law. Statutory notifications are forms the provider must complete and submit to the Care Quality Commission when notifiable incidents occur at the home.

There were enough staff to meet people's physical and emotional needs. Staff had time to spend with people, and there was a relaxed and homely atmosphere throughout the inspection.

People were protected from the risk of infection. There were individual risk assessments in place which set out how to safely meet people's needs. People's medicines were stored in accordance with the prescriber's instructions.

People enjoyed the choice and variety of food provided. People were encouraged to try different foods, and were supported to try to maintain a healthy weight. People had access to a range of healthcare professionals.

Staff knew people well, which enabled them to detect any changes to people's health and wellbeing needs, and how to communicate with them in a way which would provide reassurance and comfort.

People were able to enjoy their individual hobbies and interests, and had the opportunity to take part in internal and external social and leisure opportunities. There was a system in place for capturing and responding to complaints, comments and suggestions.

People, relatives and staff were positive about the management team. The provider and acting manager had quality assurance measures in place, which they used to monitor the quality and safety of care provided. The provider and manager had investigated the allegations of abuse as soon as they had been made aware, and had taken action to ensure people's immediate safety.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People had not been protected from harm or abuse. Where staff were aware abusive practice had occurred, this had not always been reported. The provider's safe recruitment procedures had not always been followed.

There were enough staff to safely meet people's physical and emotional needs. People were protected from the risk of infection. Staff understood people's individual care and support needs and how to keep them safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The design and adaptation of the premises were not always dementia-friendly. Not all staff had received a formal induction before starting work at the home, or received training in all key areas of care.

People were supported to maintain their health. People were encouraged to eat and drink well, and were offered choices and variety.

Is the service caring?

Requires Improvement

The service was not always caring.

A person living at the home had not always been treated with respect and their dignity had not always been maintained.

People's communication styles and needs were known and understood by staff.

People's independence was promoted, as much as possible. People and their relatives were involved in decisions about how people would be cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care provided was not always person-centred.

Staff knew people well as individuals, including their health and wellbeing needs, likes, dislikes and personal preferences. People's changing needs were communicated and acted on.

People were able to enjoy their individual hobbies and interests and were involved on decisions about any group outings or in-house activities.

Complaints, comments and feedback were captured and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The CQC had not always been informed of events at the home, as required by law.

The provider routinely monitored the quality and safety of the care provided to people, and took action where shortfalls were identified. Staff felt supported and motivated in their roles. There were plans in place to develop the service.

Evendine House Residential 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.

The inspection was prompted in part by notification of an incident following which a person using the service sustained an injury during an incident of physical restraint during personal care; there were two separate and similar incidents in total during January 2018. The information shared with CQC about the incident indicated potential concerns about the management of risk in relation to physical abuse. This inspection examined those risks.

This inspection took place on 15 and 23 March 2018. Day one of the inspection was unannounced, and day two was announced.

Day one of this inspection was completed by two Inspectors and an expert-by-experience. An expert-by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two was conducted by one Inspector.

We reviewed information we held about the service. We looked at our own system to see if we had received any concerns or compliments about the provider. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law.

Before the inspection visits, 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 used this information to help with our planning.

We asked the Local Authority for any information they had which would aid our inspection. We used their feedback as part of our planning.

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 spoke with seven people who lived at the home, and four relatives. We spoke with the acting manager; the provider; four members of the care staff team; the cook and the activities coordinator. We looked at three care plans, which contained healthcare information; mental capacity assessments; risk assessments and communication care plans. We also looked at three staff pre-employment checks; the provider's quality assurance records; medication administration records; the provider's recruitment policy; the provider's statutory notification file; the provider's home improvement plan; and comments, complaints and feedback received.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection, we became aware of two separate safeguarding incidents which had occurred at the home in January 2018. These incidents involved the physical restraint of a person living at the home, which had resulted in injury. A total of five staff were involved in both incidents; some staff were involved in the physical restraint, whilst others had witnessed this. Two senior members of staff were involved in both incidents.

Although this restraint amounted to physical abuse, staff involved in the first incident did not report this internally or externally as a safeguarding concern. Furthermore, during our inspection, other members of staff told us they had been aware the incident had occurred as a member of staff involved had discussed it openly with the staff team. These staff also had a duty to report this alleged abuse, even if they had not directly witnessed it themselves. All staff must be aware of their individual responsibilities to prevent, identify and report abuse. By failing to report this matter, this placed the person, and other people, at risk of further harm and abuse.

After the second incident, a member of staff reported this to the provider and to the Care Quality Commission. The provider carried out an internal investigation as soon as they were notified by staff, which is when they first became aware this was the second time inappropriate physical restraint had been used. The provider told us they took immediate action to ensure the safety of people living at the home, and were satisfied the risk was not ongoing. The provider also ensured they alerted all the relevant authorities, including the police, the Disclosure and Barring Service, and the Local Authority.

The actions the provider took to keep people safe included the dismissal of one senior staff member. We also saw that staff involved in the incidents had received a supervision meeting with the acting manager, in which they were formally told their actions had amounted to abuse and that they had contravened the provider's policies on safeguarding, whistle-blowing and physical restraint. However, from reading these meeting minutes, we found that only the second incident had been formally addressed with staff. The provider acknowledged the incidents had been treated as one, although different staff were involved and the injuries sustained by the person had been different on each occasion. The provider told us they would revisit this and ensure the first incident was also addressed.

Staff must receive safeguarding training to enable them to recognise types of abuse and the way they can report concerns. At the time of our inspection, not all staff had received safeguarding training, nor had additional safeguarding training been arranged for staff who had been involved in the restraint and continued to work at the home, one of whom remained in a senior role. We raised this with the provider, who told us action would be taken to ensure all staff had received training, or refresher training, in this key area. On the second day of our inspection, the acting manager had arranged face-to-face safeguarding training for all staff by an external body.

We spoke with the provider about their decision to retain the services of two staff who had been involved in, or witnessed, the abuse and had failed to report this. The provider's disciplinary procedure states that a

failure to report abuse, or being part of abuse, amounts to gross misconduct. However, no formal disciplinary action had been taken, following the provider's assessment of the matter. Whilst we were reassured the staff member recognised the mistakes they had made, we could see no evidence of any risk assessments about their suitability to continue to work at the home, or competency assessments to demonstrate how the provider had assured themselves the staff member did not pose an ongoing risk. The provider and acting manager told us competency assessments would be carried out, and any concerns about any staff member's practice would be addressed as a matter of urgency.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Not all staff we spoke with had undergone a structured interview before they had started work at the home. One member of staff told us, "I had a bit of an informal chat with (former manager) and it was a case of when can you start?" Out of a sample of three staff pre-employment checks we looked at, there was not any evidence of interview notes, or record of how the applicant had met the provider's criteria for the role. We spoke with the provider, who confirmed this was contrary to their safe recruitment procedures. We also found the provider's recruitment policy had not always been followed in terms of reference checks. For example, one member of staff's second reference had only been received six months' after their start date at the home. Another member of staff only had one reference on their file, instead of the two references required as per the provider's recruitment policy. We brought this to the attention of the provider, who told us they would look into the matter further. Before they could start work at the home, staff had been subject to checks by the Disclosure and Barring Service ("DBS"). The DBS helps prevent unsuitable people from working in care, and is used by providers to help them to make safer recruitment decisions.

We looked at whether people received their medicines safely, and as prescribed. Prior to our inspection, the provider had notified us of an incident in which staff had failed to follow the provider's on-call and medication policy. A member of kitchen staff had been directed by a health professional to administer, by way of injection, a particular medicine to a person living at the home; the member of staff in question had not received medication training as it was not part of their daily role. The senior member of staff on duty that day permitted the kitchen staff member to inject this medicine to the person, with directions over the telephone from the health professional who had requested this. Whilst no harm was caused to the person concerned, this placed them at risk of receiving medicine incorrectly and in an unsafe manner. We spoke with the acting manager, who told us action had been taken internally and externally to ensure such unsafe practice did not happen again. They told us staff had failed in this instance to follow correct procedures to ensure people's safety.

We looked at how people's medicines were stored and administered. Where medicines needed cold storage, temperatures were monitored and recorded to ensure their safe storage. Where people needed 'as required' medicines, there were individual protocols in place which set out for staff when to consider administering the medicines, and the process they should follow. We carried out a random stock take of medicines, and the balances held married with the amounts recorded on the running balance section of people's medication administration records. We saw that when staff administered people's medicines, they explained what the medicine was and ensured the person had taken it safely.

Individual risk assessments were in place for key areas of people's care, which set out for staff how to safely meet people's needs. These were in place for areas such as mobility, skin health and people's ability to administer their own medicines, as well as around people's emotional and mental health needs. Staff we spoke with were knowledgeable about people's care needs and the measures in place to keep them safe. However, we found that staff did not always know about the risk posed to people by allergies. For example,

one person had an allergy to a particular type of dressing. We saw an incident form from December 2017 about a minor injury the person had sustained. The incident form recorded the member of staff who completed the form had offered the person the dressing they were allergic to, which the person had refused. We spoke with a range of staff about their awareness and understanding of people's allergies. Whilst the kitchen staff were aware of people's individual food allergies, not all care staff were aware of other items people were allergic to. One member of staff we spoke with told us, "I don't recall seeing any information about allergies, or anyone telling me this." One member of staff told us, "[Person's name] is allergic to [wound dressing], but only the district nurses are allowed to apply those," However, this was the same person a member of staff had offered this dressing to. We raised this with the acting manager, who told us they would revisit people's known allergies with staff and discuss how to keep people safe from allergic reactions.

People told us there were enough staff to attend to their physical and emotional needs. One person we spoke with told us, "They (staff) are always ready to help, always ready to make people laugh. I think that is brilliant. There is never an argument; everybody helps each other out all the time. It's laughter all the way; I am very happy here." Another person we spoke with told us, "It's homely. Everybody (the staff) is so polite and helpful." We saw throughout the inspection people did not have to wait long for staff assistance, such as with mobilising or with eating and drinking. Staff we spoke with told us they had enough time to spend with people outside of personal care tasks, such as spending time with people having a chat and a drink. We saw that staff were not rushed in their interactions with people, and the atmosphere in the home was calm and upbeat. Agency staff were not used by the provider in order to ensure people were only cared for by familiar staff. All shifts were covered by the existing staff team, management and bank staff, as and when required.

Staff told us they had the right equipment they needed to safely carry out their roles, and there was enough personal protective equipment, such as gloves and aprons. One member of staff we spoke with told us, "If we ever notice any equipment is needed, we go to the manager and they supply it for us." Staff we spoke with had no concerns about the maintenance of the premises or the equipment. The acting manager told us the provider always supplied equipment when this was requested. They told us, "If I tell (the provider) I need a profiling bed for someone, I have it in a matter of days." We saw that routine maintenance checks were carried out to ensure equipment and the premises remained safe and where any concerns were identified, these were promptly acted upon. The acting manager had introduced a 'resident of the day' initiative, which they told us was an "additional safety measure." When a person was resident of the day, their bedroom had a deep clean; their care plan and risk assessment were reviewed and updated; and maintenance checks were carried out on their aids, such as walking frames. This was in addition to routine cleaning and safety checks.

People were protected from the risk of infection. For example, one person at the home had been treated for a bacterial infection, and the provider had ensured barrier care was in place. The person's care plan contained a specific risk assessment regarding this infection, and detailed how to keep the person, other people living at the home, and staff safe. Staff we spoke with were aware of the risk assessment in place and told us the actions they took to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

At the time of our inspection, not all staff working at the home had received any form of structured induction when they started working at the home. An induction is a way of ensuring staff's roles and responsibilities are explained to them, making sure they receive essential training, and also providing them with opportunities to 'shadow' (work alongside) more experienced staff members before being placed on duty. One member of staff we spoke with told us, "It (my induction) was very, very poor. I was basically brought in (by the former manager) and I didn't have one." The member of staff told us this had since been addressed by the acting manager. However, prior to this, they had worked at the home for over a month without having been inducted into their role.

We also found that not all staff had received training in a key area of care- safeguarding. As detailed previously in the report, staff had witnessed abusive practice but failed to report this. Without safeguarding training, staff may not understand their roles and responsibilities in this regard. We raised this with the acting manager and the provider, who told us any gaps in staff training and inductions would be addressed.

Staff were able to give us examples of training they had received which they felt had enhanced their practice. One member of staff told us, "I really enjoyed the virtual dementia training. It helped you to understand how it feels to have dementia." Relatives we spoke with commented on the skills and knowledge staff had, particularly in relation to dementia. One relative told us, "Staff are aware that people living with dementia need stability. They are very good at providing emotional support, and at defusing difficult situations. "The acting manager told us about further plans to develop staff training and guidance, and making sure staff received training which was tailored around the needs of people living at the home.

At the time of our inspection, there was no visible signage around the home to help people navigate their way around. One person we spoke with told us, "I like my room- when I can find it." A relative we spoke with told us they felt people would benefit from having a board displayed with photos of staff who were on duty that day. We also heard one person ask staff what day of the week it was; there was nothing displayed in the communal areas to let people know the day of the week, or the time. As the majority of people at Evendine House Residential Home were living with dementia, it is important that providers ensure the living environment is dementia-friendly. Signage is one way to create such an environment for people. We spoke with the acting manager, who told us about their home improvement plan and the work they planned to undertake in making the home more dementia-friendly. One of the plans was for a member of staff, with a particular interest and knowledge of dementia care, to take a lead role as a dementia champion. We spoke with this member of staff, who demonstrated a good insight into improvements which could be made.

People told us they enjoyed the choice and variety of food provided. One person we spoke with told us, "We are always eating! Breakfast, coffee and biscuits in the morning, lunch, tea, supper…" Another person we spoke with told us, "I've never had so much food; the food's very good." We spoke with the cook, who was aware of people's dietary needs and preferences. For example, one person was allergic to shellfish, which the cook was aware of and made sure the person did not receive. The cook was also aware of people who had conditions such as diabetes, and people who needed specialist diets. The cook told us how they tried to

cater for people's preferences, and how they tried to introduce variety into the menu. They told us, "[Person] likes curries, so I introduced them onto the menu and they have become a general favourite."

We saw people had a choice of mealtime and drink options, including alcoholic drinks if this is what people preferred. Staff, the cook and the acting manager knew the people who needed additional support with eating and drinking, including people who had been assessed as being at risk of malnutrition or dehydration. We saw the acting manager encouraging one person, who was at risk of malnutrition, to eat their evening meal. The person had not attempted to eat this, so the acting manager spent time with the person suggesting other things they might like to eat instead. The person mentioned they would like some cheese and biscuits, so the acting manager brought this to the person straightaway. Where there were concerns about people's weight, nutritional or fluid intake, appropriate referrals had been made to GPs and to the speech and language therapy team.

People told us, and we saw in their care records, they had access to a range of health professionals, as and when required. One person we spoke with told us, "They are very good here at calling the doctor." A relative we spoke with told us, "I am satisfied that staff access healthcare appropriately." On day one of our inspection, a GP carried out a scheduled visit to the home in order to see a person the staff were concerned about. We saw from people's care plans they had access to a range of healthcare professionals, including opticians, chiropodists, mental health professionals and occupational therapists. Staff we spoke with were aware of people's current healthcare needs, and were vigilant to any changes in people's conditions.

We considered how people's rights were protected under the Mental Capacity Act. 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.

Staff we spoke with were aware of the key principles of the Act and how they should influence their daily practice. This included an understanding that people could have the capacity to make some decisions, but not others, and also that people should be supported to make decisions for themselves where this was possible, One member of staff told us how one person could not always communicate verbally, but staff still encouraged them to make decisions about what to wear by holding up different items of clothing and letting the person point to what they wanted to wear. Where capacity assessments were in place for people, we saw these were decision-specific and kept under review. Where decisions were made on behalf of people who lacked capacity, we found the best interest decision-making process had been followed. For example, a decision to administer a person's medication covertly had been made with the person's family, the GP and other relevant health professionals.

The acting manager told us the importance of least-restrictive practice. Following two incidents at the home where this principle had not been followed, the acting manager had ensured there was a clear "no restraint" policy in place for staff, and that they had all been reminded that the least restrictive option should be explored. For example, one person was reluctant to have assistance with their personal care needs in the day, but were receptive to this in the early hours of the morning by night staff. The manager and staff told us as a result, all staff worked around the timing which suited the person, rather than making the person receive help at a time which did not suit them.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within

the principles of the MCA. The acting manager and staff knew who had authorised DoLS in place; what these restrictions meant for each individual, and whether there were any conditions in place as part of the authorisations.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with dignity and respect by staff. We saw attention was given to people's preferences in terms of their appearance. For example, make-up and jewellery were worn if this was the person's preference, and staff assisted people to apply this. People looked clean and well-presented, and they told us staff helped them with personal grooming, such as hair and nail care. Staff we spoke with understood the importance of maintaining people's dignity. One member of staff told us, "I feel very strongly about it. Why should we think their appearance doesn't matter to them anymore just because they live in a care home? So I always make sure I find out how people want to dress." We saw staff were discreet in their approach when offering people personal care and when discussing people's personal care needs with other members of staff.

However, there were two specific incidents of physical restraint prior to our inspection in which a person was placed in an undignified situation and staff did not demonstrate a caring and respectful approach towards them. Therefore, we could not be assured the service was consistently caring.

People and relatives we spoke with praised the warm, respectful and caring approach of staff working at the home. One person we spoke with told us staff cheered them up if they were having a "down day." Another person we spoke with commented on the atmosphere at the home and told us, "Shut your eyes and you can hear people talking; it's very pleasant. " A relative we spoke with told us, "[Person's name] is very content. The staff are very good, and they are also very kind to me- I can visit any time." Another relative we spoke with told us, "(Person) was very anxious about moving into the home, but all the staff were so welcoming; the perfect welcome. All the staff spoke directly to (person) on their first day and not through me, which is exactly how it should be." We saw many spontaneous and natural gestures throughout the inspection, such as staff holding people's hands and shared jokes and laughter.

People's care plans showed they were involved in decisions about the care and support they received. For example, whether people preferred male or female staff. One person chose to wear the same items of clothes every day and this was important to them, so their care plan set out guidance for staff about ensuring the clothes were washed every night and placed back in the person's wardrobe for the following morning. Relatives we spoke with told us they had been involved in the care plan process, as well as any subsequent reviews. One relative we spoke with told us about this process, "There was a real sense of collaboration and individualisation." Staff we spoke with told us they had time to read people's care plans, and saw this as an important part of their role.

People's independence was promoted, as much as possible. Staff told us about ways they ensured this, such as prompting people who were able to attend to their own personal care needs. Where people needed staff assistance, staff told us they always ensured they only helped people with areas they were unable to do themselves. We saw people were encouraged to mobilise independently, as much as possible. People also had access to the kitchen area, which meant they were able to go into that area and make themselves drinks, with staff being able to assist if this was required.

People's care plans contained information about their communication needs, styles and preferences. Consideration had been given to the best way to approach people, how to explain things to them in a way they could digest, and how to respond to certain phrases a person may repeat. We saw staff respond consistently with tact and patience to one person who repeated a particular derogatory phrase. One member of staff told us, "That is just (person's way) and part of their dementia. There is no point in reacting to it with anything than an acknowledgement of how they feel."

The provider had an equality, diversity and human rights policy in place. Staff had received training in this regard, and we saw they showed an understanding of these areas in their daily practice. The provider had recently updated their pre-admission assessment, which now included consideration about areas such as people's sexuality and how people's diverse needs would be met in an inclusive manner.

Requires Improvement

Is the service responsive?

Our findings

The service had not always been responsive to people's individual needs. As previously referred to in the report, a specific approach had been taken by staff when supporting someone who declined assistance with personal care, which was not person-centred and did not look at the reasons the person had declined. The approach also failed to consider the best way to meet the person's needs, such as having behaviour monitoring and support plans in place. At the time of our inspection, this had been addressed by the acting manager and there was now clear guidance for staff to follow in this regard.

We found that staff knew people well as individuals. This included information about their life histories, personal preferences and likes and dislikes. One relative we spoke with told us, "(Person's) needs are being listened to." One member of staff we spoke with told us, "When new people move in, I always take the time to get to know them. Everyone here is an individual, and everyone is at a different stage with their dementia." We spoke with the activities coordinator, who told us they made time to get to know people well so they could cater for their likes and dislikes. They told us, "I try to be the one who meets the person when they first arrive at the home and get the conversation going. We complete a 'This is Me' booklet and try and find out what their interests are." 'This is Me' is a recognised Alzheimer's Society tool which care staff can use to find out about people's individual life histories, personal preferences and interests.

People were encouraged to enjoy social and leisure opportunities, as well as to continue to enjoy their individual hobbies and interests. One person we spoke with told us, "In the past, I did quite a bit of embroidery. " We saw this person enjoyed doing some embroidery on the afternoon of our inspection. Group activities were provided throughout the week for people to enjoy, and we saw that residents' meetings were used as a way of gathering people's ideas about what they wanted to try. People had suggested trips to the Cosford Aircraft Museum, the Spring Garden Show and to a local cider factory, and these were being arranged. On the day of our inspection, we saw people enjoying doing puzzles, chair exercises and decorating cakes. One person we spoke with told us, "There's always something going on (at Evendine House Residential Home). Look at (the activities coordinator) doing that chair exercises with feathers and everyone is enjoying it." Another person told us, "We go out quite a bit into the garden; it's a huge area. In the summer, it is lovely." A third person we spoke with told us, "It's all very friendly- I just like to join in with whatever is going on."

Where people chose to spend time in their rooms, or were cared for in bed, the activities coordinator told us they visited them in their rooms daily to discuss the daily newspaper, or to discuss the 'Daily Sparkle.' The Daily Sparkle is a reminiscence newspaper which is used to aid discussions with people living with dementia. Staff we spoke with told us there needed to be an activity provision for people at weekends, as well as during the week. We discussed this with the acting manager, who told us plans were already in place to address this as a result of staff, relatives' and people's feedback.

Handover meetings were used as a way of sharing any changes to people's health and wellbeing needs. A handover is a meeting between staff at the end of one shift and the start of the next. Staff told us the communication was good at the home, and key information about any changes were responded to. One

member of staff told us, "I only work (hours) a week, and I am always updated about any changes to people since I last worked." We saw examples of information which had been shared amongst the staff team to ensure everyone was up-to-date about people's current health and wellbeing.

People and relatives told us they knew who to go to if they had any complaints, concerns or feedback. One person we spoke with told us, "I know who the top dog is and that is who I would go to." A relative we spoke with told us, "I talk directly to the manager or to the owner. I have been satisfied that any matters I have brought to their attention have been appropriately addressed." Another relative told us about a complaint they had made and told us, "The complaint was handled well." Complaints, comments and feedback were used as a way of making improvements to the service and we saw all feedback received had been responded to and acted upon.

We spoke with the acting manager about the Accessible Information Standard ("AIS"). The AIS requires all publically-funded bodies to ensure they are providing key information about the service to people in an accessible format. At the time of our inspection, information such as service users' guides and complaints procedures were not provided in formats such as Braille or audio, which was because no one living at the home needed information presented to them in this way. However, the acting manager told us they would always ensure that different formats were provided when people's needs changed, or when any new people moving into the home required this.

Requires Improvement

Is the service well-led?

Our findings

The acting manager had started work at the home in January 2018. In February 2018, the manager became aware the Care Quality Commission had not been notified in November 2017 of a Grade 3 pressure sore a person had sustained, which is notifiable by law; all other relevant authorities had been informed. As soon as the acting manager became aware, they notified the CQC of this injury.

The provider had notified the CQC of one incident of abuse in January 2018. However, there had been two separate incidents and no notification was submitted when the provider became aware of the second incident. We discussed this with the provider during the course of our inspection, and they submitted the relevant statutory notification to us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Relatives and staff told us there had been an unsettled period at the home, with a sudden change of management. One relative we spoke with told us, "Clearly something has occurred. There's been a lack of leadership and a feeling of insecurity. (Person) has picked up on that and commented to me." Another relative told us, "The recent changes have been difficult for residents and for the staff." However, staff and relatives told us they felt the manager would make any necessary improvements. One relative we spoke with told us, "I am completely assured by (manager) and their way of working." A member of staff we spoke with told us, "I can't sing (manager's) praises highly enough. You can approach them for any reason." Another member of staff told us, "They (manager) are so supportive, and you feel you can ask them anything." All staff we spoke with told us they had been part of a team meeting the provider had arranged after the two incidents of abuse at the home. They told us the whistle-blowing and safeguarding policies had been reiterated to them, and they were all clear about their duties in this regard. Staff told us they were fully confident in approaching the provider with any concerns, and that they would be investigated.

Since taking over the day-to-day running of the home in late January 2018, the manager had completed audits and reviews of everyone's care plans to ensure they were reflective of their current needs; they had also arranged medication reviews for each individual. The manager told us, " My priority has been coming in and firstly, ensuring everyone is safe. Once (the provider) and I had investigated the safeguarding incidents and had made sure there was no ongoing risk to people, I started to look at people's care to make sure they were getting the right care and support." They had also identified staff had not been receiving regular supervision meetings, and so had made sure these were arranged. Supervisions are one-to-one meetings between staff and their line manager and are used to discuss practice, provide feedback, and to discuss any training or development needs. The provider carried out monthly management review meetings to discuss findings of routine checks and audits and to ensure any identified shortfalls were acted on. We saw a range of audits were carried out, including in regard to areas such as weight monitoring, medication and health and safety.

The provider and the acting manager had devised a home improvement plan for Evendine House Residential Home. We saw that all aspects of people's care had been reviewed, with clear agreed actions in

place as to what the next steps were. For example, people, staff and relatives had provided feedback about the activities provision at the home and had asked for there to be a weekend provision as well. The acting manager was in the process of making sure a seven day a week activities time-table was in place for people. There were also plans and a time-table in place for changes to the physical building, including an extension for the benefit of people living at the home.

Staff we spoke with were motivated and enthused in their roles. One member of staff told us, " I have always wanted to work at Evendine because of its reputation in the community. I feel so lucky to be here." Another member of staff told us, "I love all the residents, and we are a really good staff team now. We've all been told about the plans to extend the home and develop it further, and we are excited about all the positive changes." Another member of staff told us, " I can honestly say I am happy to be a part of Evendine." The atmosphere at the home was relaxed, but upbeat and positive. Relatives we spoke about were complimentary about how homely the atmosphere was, which they praised the staff team for creating.

Links with the local community had been established for the benefit of people living at the home. These included with a theatre and arts group; the church; and with a college, with a volunteer attending the home from the latter. The activity coordinator and manager told us they were always looking for further ways to develop links locally and to ensure people were part of their community.

The provider had ensured the current CQC rating was displayed visibly for people, staff and visitors both at the home and on their website, as they were required to do.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified the Care Quality Commission of notifiable events at the home, including injuries sustained and allegations of abuse or harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Where people had been subjected to abuse or harm, staff had not always reported this. This inaction placed people at further risk of harm or abuse. Not all staff had received training in safeguarding adults at the time of our inspection, which is essential to help them to understand, and to fulfil, their roles and responsibilities in this regard.