Evergreen Lodge Limited

Evergreen Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Evergreen Lodge is a care home that provides accommodation for up to 40 people who need help with their personal care or nursing care. At the time of the inspection 40 people lived in the home.

People's experience of using this service:
The overall rating for this service is 'inadequate' so therefore the service is in special measures. During our inspection we found breaches of regulations 9, 11, 12, 13, 17 and 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no adequate or effective systems or processes in place to monitor the quality and safety of the service. This resulted in people being exposed to ongoing risks with regards to their care.

Some people's needs and risks were not properly assessed or care adequately planned. Information on people's preferences and wishes with regards to their care was also limited. Records showed that some people did not always receive the care they needed in accordance with their care plan.

Some people lived with behaviours that challenged due to issues associated with their mental health. We found that staff had little guidance on how to support the person appropriately when these behaviours were displayed so that risks to the person or others, were minimised.

We observed that restraint techniques were commonly used to manage people's behaviours and movements. These techniques had not been risk assessed, formally agreed upon or legally authorised by following the Mental Capacity Act 2005 (MCA). This meant the techniques in use were unlawful. There was also no adequate system in place to monitor and manage the use of this restraint. This placed people at risk of significant harm.

Some people had deprivation of liberty safeguards in place and we saw some evidence that the MCA had been followed with regards to this. However consent for other decisions in relation to people's care had not. For example, decisions relating to the administration of covert (hidden) medication and do not resuscitate orders were not made in accordance with the MCA to ensure people's consent was legally obtained.

We found the management of medication to be unsafe. It did not comply with best practice guidelines from the National Institute of Social Excellence (NICE) or the Royal Pharmaceutical Society.

Robust recruitment procedures were not always followed when recruiting new staff. The provider's staff rotas showed that sometimes they were one staff member short but people told us there were enough staff on duty to meet their needs.

The majority of staff had completed sufficient training to do their job and had received supervision from

their line manager. Staff members told us they felt supported in their role.

During our inspection, we observed that staff interacted with people respectfully and were patient when providing support. They chatted to people socially and people were observed to be relaxed and comfortable in their company.

People told us they had enough to eat and drink and said the food was satisfactory. People's special dietary requirements were catered for and people had a choice of what to eat and drink.

People told us staff were kind and that they felt safe living in the home. Relatives we spoke with confirmed this and spoke positively about the staff team and the manager.

There was a range of activities for people living in the home to become involved in and their feedback about the activities was positive.

The home was adequately clean, maintained and suitable for the people who lived there.

Rating at last inspection: The rating at the last inspection was good. At this inspection, the rating has not been maintained.

Why we inspected: This was a scheduled inspection.

Enforcement : We are currently considering what action we need to take with regards to the serious concerns we identified at this inspection.

Follow up: Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below

Inadequate

Is the service effective?

The service was not effective

Details are in our Effective findings below

Inadequate

Is the service caring?

The service was not always caring.

Details are in our Caring findings below

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Evergreen Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: An inspector, a specialist advisor in medicines, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type: Evergreen Lodge is a care home. People in care homes receive accommodation with nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced on the first day of inspection. We advised the manager of the date of our second day of inspection.

What we did: We reviewed information we had received about the service since the service was last inspected. We also contacted the Local Authority for their feedback on the service and the care provided.

During the inspection we spoke with five people who lived in the home and four relatives to ask them about their experience of the care provided. We spoke with two members of care staff, a team leader, the activities co-ordinator, the home's cognitive behaviour therapist, the administration officer, the registered manager, the area manager and the provider.

We reviewed a range of records. This included seven people's care records and people's medicine records. We looked at staff files belonging to three members of staff recruited since the last inspection. We also looked at other records in relation to staff training and supervision, policies and procedures and records

relating to the management of the home.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- We observed that staff used methods of physical restraint to manage the challenging behaviours some people experienced as a result of their declining mental health.
- We looked at people's care records and found that the use of restraint had not been risk assessed or care planned. This meant there was no evidence that the use of restraint was safe, appropriate or proportionate to the risk of harm posed by the person's behaviours.
- By law, providers must ensure that the use of restraint is in the person's best interests and legally authorised by following the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards legislation. The provider had not done this.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's care included acts of control and restraint that were unlawful.

- The provider had a system in place to identify and respond to incidents of potential abuse.
- People we spoke with said they felt safe living in the home.

Assessing risk, safety monitoring and management

- Some people's risks in relation to their care had been assessed. For example risks with regard to moving and handling, nutrition and pressure sores. Other risks were not. For example those associated with choking, wandering or physical health conditions such as diabetes. .
- Some people required clinical checks to be undertaken to monitor changes in their physical well-being. We found that these checks were not always undertaken in accordance with the person's care plan. This placed the person at risk of harm.
- For example, one person had a health condition that required staff to monitor their blood sugar and their weight weekly. Records showed that these checks were not undertaken as required. This meant staff had no way of knowing whether the risks to this person's health and welfare were safely managed.
- People's personal emergency evacuation plans (PEEPS) did not contain sufficient information about their needs and risks to assist staff and emergency personnel to support them appropriately in an emergency situation.

This evidence demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks in relation to people's care and treatment were not always properly assessed or managed.

Learning lessons when things go wrong

● Accidents and incidents were recorded and the manager reviewed this information monthly
● Accident and incident information however in relation to the use of physical restraint was not accurately or sufficiently recorded to enable staff to learn from and reduce the use of restraint in the day to day delivery of care. This aspect of staff practice and learning required improvement.

Using medicines safely
● We looked at a sample of people's medication records. The amount of medication some people had left at the end of each medication cycle was not always carried forward to the next. This meant it was impossible to tell if the right amount of medication had been administered.
● Some people's medication records had been handwritten by a member of staff without a second member of staff checking that the information was correct. This was not good practice and increased the risk of errors.
● Some people were prescribed 'as and when' required medications such as painkillers or anxiety medication. There were no suitable 'as and when medication plans in place to advise staff when and how to administer these medicines. This meant there was a risk that these medicines would not be given appropriately.
●Some people needed their medicines to be given covertly (crushed or hidden in food or drink). Some medicines can become unsafe or unsuitable when given in this way. Despite this pharmacy advice had not been sought to ensure it was safe to do so.
● The competency of staff to administer medication had not been properly checked.

These issues demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the management of medicines was unsafe.

Staffing and recruitment
● We looked at the recruitment records for three staff. Proof of identification was sought and a criminal conviction check undertaken prior to each staff member's employment. This was good practice.
● Other safe recruitment practices had not been followed in accordance with the provider's recruitment policy. For example, references from the staff member's last employer were not always obtained or verified as being received from a reliable source prior to employment.
●This meant the provider had not gathered all of the information available to them to assess whether the person was suitable for the role they had applied for.

This is a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as safe recruitment practices were not fully followed.

● During our visit, we found that the number of staff on duty was sufficient to meet people's needs.
● Staff rotas however showed that the number of staff on duty did not always correspond with the staffing levels determined by the provider as safe. For example on some days, there was one less staff member on duty than there should have been.
● We asked the manager to consider whether the use of agency or bank staff could be used in future when there were gaps in the staff rota to ensure that staffing levels were sustained.

Preventing and controlling infection
● We looked around the home and saw that overall it was adequately clean.
● Gloves, aprons and antibacterial gel were readily available for staff to use as and when required.
● Antibacterial gel was available in corridors for visitors to use whilst in the home.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People were not safe and were at risk of avoidable harm. Some regulations were not met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found the implementation of the MCA required improvement in order to ensure people's right to consent was properly respected.

Ensuring consent to care and treatment in line with law and guidance

- We looked at capacity assessments for people whose ability to make certain decisions about their care and welfare was in question.
- We saw that some people had mental capacity assessments and DoLs in place where they had been unable to understand and consent to living in the home on a permanent basis.
- Other decisions in relation to people's care however had not been assessed in accordance with the MCA legislation.
- For example, some decisions were made on people's behalf with regards to covert medication; do not resuscitate orders; the use of bed rails and the use of restraint.
- Some people's capacity to consent to staff providing personal care had been undertaken but the way in which people's capacity was assessed was not in accordance the MCA. This meant it was not a fair or accurate assessment of the person's ability to understand and consent to the way in which their care was provided.
- As part of the provider's mental capacity processes, there was limited evidence that any best interest discussions had been facilitated to ensure that decisions made on people's behalf were in their best interests.
- Records showed that some people received support for their personal hygiene from three members of staff at the same time. There was no documentation to show why this level of support was needed, that the person's consent to this had been obtained or that this level of support was in the person's best interests.
- Their care plans indicated that this was to ensure the person 'compiled' with their personal care routine. This type of wording was inappropriate as it suggested that the support people received with regards to their personal hygiene was mandatory and they did not have right to refuse it.

This is a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not always ensured legal right to consent to the care they received was obtained.

Supporting people to eat and drink enough to maintain a balanced diet
● We observed staff supporting people with their meal as and when required. Some staff chatted to people whilst they provided assistance but others did not talk to the people they were supporting. This required improvement.
● People told us they received enough to eat and drink. Their comments included "The food is really good and very filling"; "I get food and drink four times a day and I really like my hot chocolate at night" and "There is always more than enough, but I feel they should change the menu more often".
● We spoke with the cook. They told us about people's dietary requirements and how they ensured people's special dietary requirements were met.
● A relative we spoke with said that "Staff are extremely careful with my relative's dietary needs".

Staff support: induction, training, skills and experience
● Some of the staff we spoke with did not have a full understanding of the provider's philosophy of care or the evidence based practice that underpinned the care they provided. For example, National Institute of Clinical Excellence (NICE) dementia or person centred care guidance.
●The majority of staff had completed the training they needed to do their job role effectively.
● New staff who had recently started working in the home were still in the process of completing the provider's mandatory training programme at the time of the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Not all of people's needs and choices were assessed and people's support was not always provided in accordance with standards or best practice guidance.
● The provider had not ensured that the MCA was properly followed and embedded in service delivery.
●The support people received with regards to their behavioural and cognitive needs did not follow best practice guidelines. For example, NICE guidelines in dementia care, Positive Behaviour Support guidance issued by the Challenging Behaviour Foundation or the Optimisation of treatment guidance developed by The Alzheimer's Society.
● The use of restraint did not adhere to the MCA or the standards set out in the Department of Health's Positive and Proactive Care guidance.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure the quality and safety of the service was in accordance with recognised standards.

Adapting service, design, decoration to meet people's needs
● The home's physical environment was designed to accommodate the people living there.
●There were handrails to assist people's mobility, suitable flooring and pleasant areas both inside and outside the home for people to sit and chat.
● A small summer house was outside in the garden which the manager was in the process of developing into a quiet sensory area for people to use.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had received support from speech and language therapy, dieticians, GP's, and other health and

social care professionals as and when required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were not always well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

● People's care plans did not advise staff of their preferences in respect of their personal care for example, whether they preferred a male or female member of staff; a bath or a shower or support in the morning or evening.
● Some people's personal hygiene support was provided by three staff members. There was little evidence to show that the service had considered the impact this had on the person's right to privacy and dignity or that they had sought their views about receiving this level of support.
● We saw that the area manager visited the home in January 2019 and September 2018. As part of this visit we saw that people's views on the support they received were gained and used to assess the quality of the service provided.

Ensuring people are well treated and supported; respecting equality and diversity
● Some staff used unauthorised restraint techniques to manage people's behaviours. This did not show that people were always supported in the best way possible
● We did however see many positive interactions between staff and people who lived at the home. For example, we observed a staff member comforting a person when they became upset by speaking to them calmly and using positive touch to reassure them.
● We observed staff chatting socially to people about everyday things in the communal lounge and saw that people looked comfortable and relaxed in the company of staff.
● One person told us "The staff are very nice to me" and another person said ""All staff are good, but I do have my favourites". A third person said, "I get on very well with staff and really appreciate all their efforts". Another person told us "I feel like I was at rock bottom, but my confidence has grown and that is down to the care home staff". This showed that staff cared about the people they looked after.
● The relatives we spoke with told us that staff always made sure they felt welcome when they visited their loved one. One relative said "Every time I visit I am made to feel very welcome".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

● People needs and wishes had not always been properly assessed prior to or on admission to the home to support the delivery of person centred care.

● People's preferences and wishes with regards to their care were not adequately documented for staff to be aware of. For example, what people liked to eat and drink, day to day routines, religious or spiritual needs and sleeping preferences were not always stated.

● Some people's care plans were generic and not specific to them. For example, People did not have person centred end of life care plans in place to advise staff how they wished to be cared for at the end of their life. This meant staff lacked clear information on people's individual needs and the person centred support they required.

● Information in some people's care files was contradictory and confusing. For example, one person's care plan stated they were able to walk without support but their personal emergency evacuation plan said they required staff to assist them.

● People's care plans were reviewed monthly but these reviews were not meaningful. They did not show that staff had fully considered any changes in people's needs in order to ensure the care they received remained responsive and appropriate.

●There was no evidence that people had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis. This meant there was little evidence that people had any choice or control over their own support.

This evidence demonstrates a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people's care and treatment was appropriate, met their needs and reflected their preferences.

● People told us staff looked after them. People's comments included "The staff in this home look after you well"; "All the staff are there for you if you need help" and "If I need help, I know the staff will come quickly to help me".

● People had access to a range of activities provided by the home's activities co-ordinators such as reminiscence, massage, singing and music, arts and crafts, movie evening and takeaway night, quizzes and bingo. .

● During our visit we saw staff playing scrabble, chess, cards, drawing and watching the TV with the people they cared for. This was good practice and we observed that people enjoyed this time with the staff team. On the second day of our inspection, six people enjoyed a trip out to a local farm and a trip out to see a play was also planned in the next couple of weeks.

● People's comments on the activities provided were overall positive. Comments included "I really like

joining in the music quizzes, but my favourite routine is going for a morning walk to the local shop" and "There is always something to do, but Monday is my favourite as I go to Market Street for activities that I like, such as Bingo and Arts and Crafts".

Improving care quality in response to complaints or concerns

- There was a complaints policy in place but at the time of our inspection it required review.
- The policy was not easy to understand. It failed to give the name of the home manager and regional manager or the correct outside organisations to whom people could complain to, if they were dissatisfied with their care. The manager told us they would review this without delay.
- We looked at the manager's complaint records. We saw that any complaints received had been investigated and responded to appropriately by the manager.
- People and their relatives told us they would have no problem discussing any concerns or worries they had with staff or the manager of the home. They told us the manager was approachable and easy to talk to.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- We discussed the concerns we had with the manager and the area manager. They were not able explain why the concerns we had identified during the inspection had not been picked up by them and addressed.
- For example, they were unable to explain why the MCA legislation had not been followed or why the use of restraint was not properly monitored or managed in accordance with best practice guidelines issued by the Department of Health and CQC.
- It was clear that their knowledge of the health and social care regulations and associated best practice guidance required improvement.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving

- There were no effective systems in place to monitor the quality and safety of the service. For example, people's needs and wishes were not fully assessed or regularly reviewed to enable person centred care to be planned and delivered.
- The delivery of people's care was not always safe, up to appropriate standards or in accordance with their care plan.
- People's consent to the care they received and any decisions made on their behalf were not always legally obtained.
- The use of restraint and other restrictive practices was not assessed or legally authorised. Alternative positive behaviour strategies to support people's mental health were not clearly defined for staff to follow.
- Medication management was poor and did not follow best practice guidelines
- Staff recruitment was not sufficiently robust.

The above issues demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not well managed with regards to people's care.

- During our visit, we found the atmosphere at the home to be pleasant. The culture at the home was positive and the manager and the staff team were open and honest throughout the inspection.
- Staff were observed to work well as a team and were a visible presence in communal areas to support people as and when needed.
- The staff members spoke fondly about the people they cared for and were able to tell us about the support they provided to each person. It was clear they wished to provide people with good care that met

their needs.
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People had access to a range of other health and social care professionals such as mental health professionals, dentists, opticians, doctors and social workers in support of their needs.

● Relatives told us that the staff team communicated with them well and kept them involved in their loved ones care as much as possible.

●One relative said, "The Care Home staff have shown that they are quick to respond and will communicate any changes or issues as soon as practically possible".

● Another relative commented "The staff here do seem to work well as a team and you are encouraged to engage with them".

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's care and treatment was appropriate, met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks in relation to people's care and treatment were not always properly assessed or managed. Medication management was unsafe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not well managed. Risks to people's health, safety and welfare were not managed in accordance with legal standards and best practice guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment was not always robust as safe recruitment procedures had not always been followed.