Caliburn (Care Homes) Ltd

Evergreen Residential Home

Inspection report

22 Prince of Wales Terrace
Scarborough
North Yorkshire
YO11 2AL

Date of inspection visit:
16 March 2016
17 March 2016
24 March 2016

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 16, 17 and 24 March 2016 and was unannounced. On the 14 March 2016 the Commission had received concerns from two whistle-blowers and we inspected the service in response to those concerns. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation that is either private or public.

At our last inspection on 27 January 2015 we had identified breaches of Regulation 9 Person centred care, Regulation 10 Dignity and respect, Regulation 11 Need for consent and Regulation 15 Premises and equipment. We had also made seven recommendations about cleanliness, skills and knowledge of staff and their deployment, food choices, the manner in which staff care for people, the development of a quality assurance system and gathering feedback from people to improve the service. The provider sent us an action plan outlining the improvements they intended to make saying they would be completed by 30 September 2015.

During this inspection we looked at whether or not those improvements had been made. We also looked at areas of concern raised with us by the whistle-blowers. We found that improvements still needed to be made in regard to all the previously identified breaches of regulations and the seven recommendations. We also found breaches of Regulation 12 Safe care and treatment, Regulation 13 Safeguarding service users from abuse and improper treatment, Regulation 14 Meeting Nutritional and Hydration needs and Regulation 17 Good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

Evergreen Residential Home is a care home for up to 17 adults living with dementia, cognitive impairment or a learning disability. The building is a converted hotel over six floors and is situated in the South Cliff area of Scarborough. At the time of our visit there were 15 people living at the service.

There was a registered manager in post at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Although people and their relatives told us they felt safe we found that this service was not providing consistently safe care. Safe care practices had not been used when moving people. We observed staff moving people by transferring using an unsafe manoeuvre when a hoist should have been used. Staff had not been trained to use a hoist and there was none on the premises which compromised people's safety.

Risk assessments had not always been completed or been amended to reflect people's changing needs which meant that staff may not be aware of the current needs of people. When risk assessments were in

place we saw that staff had not always followed the guidelines within them. In one case there was a delay caused by staff not following guidance provided by a doctor which could have had led to a poor outcome for the person.

The provider had not carried out servicing and maintenance checks within all areas of the service which meant they were not carrying out their duties under the Health and Safety at Work Act 1974.

Medicines were not managed safely. There was no record of nutritional supplements received into the service. Creams were found in one person's room but were prescribed for a different person. There were no records of who had these creams applied which meant that someone may have been receiving the wrong topical medicine. There had been no audits of medicines carried out.

We found the service had met the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). However, some people at the service were not able to tell us if their freedom was restricted but we could see that there were no recorded decisions about why, for instance, those people did not go out in the fresh air. The registered manager had made applications to deprive people of their liberty lawfully but was not working within the principles of the Mental Capacity Act. They did not accept that people should be allowed to make unwise decisions. In one case they had applied three times to have a person deprived of their liberty when they had been deemed to have capacity. This showed a lack of understanding of the legislation.

Staff were not trained consistently and therefore did not have the skills required to meet everyone's needs. They were not supported through supervision or appraisal and did not have development plans in place.

Adaptations had not been made to the environment to make it more suitable for people living with dementia. Servicing and maintenance of the property was not up to date which placed people's safety at risk.

People looked well cared for but were not animated unless they received visitors or were engaged fully in activity because they were not stimulated. There was no dedicated activities organiser, only a volunteer who came and organised activity when they could.

These were examples of institutionalised practice which denied the dignity, privacy, choice and independence of people. For example clothes were accepted from families to share out amongst others and some rooms only had access through a toilet.

Personal life history documents were not completed for people and so staff did have guidance about peoples history and what was important to them. We did not see staff taking time to talk with people at length and so there was insufficient evidence that staff knew people well.

Pre admission assessments had not always been completed for people before coming to live at the service. Care plans were not detailed and risks had not always been identified which meant that people were at risk of not receiving the appropriate care.

No complaints had been made to the service according to the registered manager so no records were available. There was a complaints policy and procedure. We saw records of compliments being received.

Some documents were available which the registered manager called audits. However they only identified whether documents were present in the care plan audit. The home weekly audit identified that some areas

were good or very good when in fact we saw that there were hazards and poorly maintained areas within the service. In addition the links between the services advertised and the training organised for staff had not been made. Record keeping was poor and statutory notifications had not always been made to CQC.

Because there has been a lack of improvement at this service since our inspection in January 2015 and because further serious issues have been identified at this inspection we have concerns about the provision and management of this service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.
The service 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and safety had not been identified resulting in unsafe care being provided. Safe care practices had not been used when moving people. Management plans were not always followed by staff.

Staff were not all trained in safeguarding adults and had not recognised where alerts to the local authority were required. Staff were not deployed appropriately in order to maintain peoples safety and wellbeing.

Environmental risks had not been identified and we saw evidence of trip hazards and areas of the service which caused an infection control risk.

Maintenance and servicing of the equipment was not always carried out or was out of date.

Is the service effective?

Inadequate

This service was not effective

Staff did not have the necessary knowledge and skills to meet people's needs because they had not received the appropriate training in all cases. Training was out of date for some people. Staff were not supported through supervision or appraisal.

Although the service had followed the procedure for making applications for DoLs authorisations they did always work within the principles of the MCA 2005.

The environment was not adapted for the needs of people living with dementia. There was a lack of meaningful signage and no use of colour to assist people when finding their way or in continence promotion.

Nutritional assessments had been completed by staff but people living with dementia were not offered alternatives such as finger foods. In addition it was not clear what fluids people had been

given.

Is the service caring?

Inadequate

This service was not caring. The staff used institutionalised practices which did not show respect for people's privacy and dignity.

People were not animated unless they had a visitor and lacked stimulation from staff. There was a volunteer activities organiser but they said they only came when they could. There were no organised activities which were meaningful to people who used the service.

People at the service were supported with end of life care. Staff worked with the local hospice to make sure that people were supported at this time

Is the service responsive?

Inadequate

This service was not responsive to people's needs.

Pre admission assessments were not always carried out in person before people went to live at the service. Care plans were not well written and some information was out of date with risks to people's health not always identified. People did not always receive the care that they were assessed as needing.

People were left for long periods without a position change or any personal care being provided.

There was a complaints procedure at the service but the registered manager told us that no complaints had been made.

Is the service well-led?

Inadequate

This service is not well led.

There was a lack of improvement at this service since our inspection in January 2015 and because further serious issues were identified at this inspection we have concerns about the provision and management of this service.

There were inconsistencies in the approach of the registered manager to staff and their response to them.

The quality assurance system in operation was ineffective. Record keeping was poor.

Statutory notifications had not always been made to CQC.

Evergreen 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.

This inspection took place on 16, 17 and 24 March 2016 and was unannounced.

The inspection team was made up of three inspectors. The timing of this inspection was brought forward in response to concerns from two whistle-blowers and we took account of the information they had given us when planning our inspection. In addition we read the previous inspection report, read statutory notifications sent to us by the provider and looked at all the information we held about the service. Statutory notifications provide information about significant events or incidents that affect the running of the service or people who live there.

We held conversations with three people who used the service, one relative; one person's friend, three care workers, the registered manager and two mental health professionals. We looked at the care records of six people.

Prior to the inspection we contacted the local authority commissioners who had no current concerns. Following the inspection we contacted them to inform them of our findings.

After the inspection we contacted the fire officer to request that they assess the fire arrangements at the service, spoke with the community pharmacist to confirm they would be carrying out an audit of the service. We attended meetings with the local authority where a representative of the community mental health team was present.

Inadequate

Is the service safe?

Our findings

One person we spoke with told us that they felt safe at the service and a relative said, "Yes they are safe. I can compare because [relative] has been elsewhere and this place is right for them." We observed practice throughout the inspection and saw that this was not always safe.

We found that people did not always have appropriate risk assessments in place. When risk assessments were in place they did not always identify the current risks to people. The manual handling risk assessment for one person identified that they required two staff to assist them with transfers but did not identify that they were not weight bearing and therefore should be moved with a hoist. We witnessed them being moved by two members of staff using the drag lift, also known as the underarm lift, which is considered to be unsafe because it can cause injuries to people being moved. They used this lift in conjunction with a handling belt which is normally used to support people who are weight bearing, to stand and transfer. There was no hoisting equipment on the premises. In addition there were no staff with any up to date practical manual handling training. We made a safeguarding alert to the local authority the same day and asked them to re-assess the needs of this person as their safety was being compromised. We observed unsafe moving and handling practice with a second person. We also alerted the local authority about them and asked for them to be reassessed.

Where risk assessments were in place staff had not always followed the instructions. For example on the risk assessment for one person it stated they had 'Epilepsy – regular fits'. The instruction was that they should be observed at all times and should never be left alone with other residents. A change to the risk assessment on 11/11/2015 stated "Plan changed. As soon as fitting starts [person] is to be blue lighted straight away and placed in recovery position." In January 2016 this person had two seizures and on the second occasion staff called 111 rather than 999. They did not follow the prescribed plan which may have caused a delay in treatment and could have caused harm to the person.

The provider had not met all their duties under the Health and Safety at Work Act (HSWA) 1974 because risk assessments and safety checks were not carried out for all areas of the service putting people at risk of harm. Employers have a general duty under the HSWA, so far as reasonably practicable, to protect the health, safety and welfare of people who might be affected by their business.

The gas certificate that we saw had expired in November 2014, however the nominated individual told us that the certificate had expired on 11 October 2015. We were not shown the certificate but we saw that no further checks had been carried out since then so was at least five months out of date. The fire risk assessment in the service was dated 20 October 2011. The Regulatory Reform (Fire Safety Order) 2005 states that 'the responsible person must make a suitable and sufficient assessment of the risks' and 'any such assessment must be reviewed by the responsible person regularly so as to keep it up to date'. Fire alarm checks that the fire safety maintenance log book stated were to be carried out weekly were only completed on three occasions since 19 January 2016. We made a record of the dates of these checks. We were later sent a document by the nominated individual which had two additional dates recorded when the provider said checks had been carried out. We had not been shown this record during the inspection. There was a fire

escape but the doors to the fire escape led off some people's bedrooms which was a falls risk and could harm people if they left using that route as the service was six floors high. We requested that the local fire officer visit the service which they did on the 18 March 2016. They were satisfied with the arrangements in place for evacuation. There still remained a risk of people falling.

The registered manager told the inspector they could not find the certificate showing that the water had been checked for legionella bacteria and they said they did not know how often this should be checked. The lift was not levelling correctly meaning that there was a step to get out from the lift which was a trip hazard. We were not shown any servicing documentation for the lift only documents that showed repairs had been carried out.

The environment was not consistently safe. We were shown around by the registered manager and saw that in one ensuite bathroom the bath panel was damaged and had sharp edges. In addition a bath hoist had been removed leaving a gap in the flooring which meant that it was not impervious. Two bedrooms smelled of urine. When we entered two other bedrooms we found ourselves in a toilet before going through another door into the bedroom. There was no separating wall. In a different room the toilet base was not sealed. These were infection control risks. We saw trip hazards in two bedrooms where wires from sensor mats had been left trailing at the side of the bed. Another bedroom had wallpaper missing off the wall and some of the skirting board missing. There were holes in the wall which had not been repaired. We have requested a visit by the NHS community infection control nurse.

Medicines were not managed effectively. Some nutritional supplements had been received into the home for one person but there was no record of that happening and no record on the medicine administration record (MAR) of them having being given. The only evidence of any nutritional supplements was a note in a handover book saying "[name of supplement] given every two hours." When we asked why they were given that often we were told by the registered manager, "Night staff are good; they push fluids." When we asked to be shown records of the supplements being prescribed and then accepted into the service we were shown a blank record provided by the pharmacy as proof of delivery. To confirm where they had come from we telephoned the services pharmacy who confirmed they had been prescribed by the GP and supplied by them. Clear records of medicines accepted into the service and administered by staff should be kept. In addition when we looked around the service we found creams labelled for one person in the room of another person which had been used. Medicines including topical creams should not be used by anyone other than the person for whom they are prescribed. The senior care worker administered the medicines during the inspection and we saw that they had received online training to enable them to do so. They were no staff who had received training in the administration of medicines but certificates supplied by the provider show that five people had received training in the use of the supplying pharmacies systems which meant that medicines were given by people who had not being trained to do so. No competency checks had been completed to ensure staff were following correct procedures and we observed someone being given their medicines from the hand of the care worker who did not wear gloves which was an infection control risk. A medicine audit was completed on 22 March 2016 following the first two days of our inspection but prior to this no audits had been completed. This highlighted a number of areas for improvement. The community pharmacist contacted us to say they would be visiting the service to carry out an audit on 30 March 2016. The service agreed that the report could be shared with CQC.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Because of the number and scope of the concerns we required the provider to take urgent action to address the issues identified. The provider sent us an action plan saying what they would do and we went back on 23 March 2016 as part of this inspection to ensure that immediate safety issues had been addressed. We

were shown documents identifying that the lift had been serviced on 22 March 2016. There were issues identified which required repair or renewal and the provider said they had requested a quote for the work to be done. We also saw documents which showed that the gas boiler had been serviced on 23 March 2016.This had also identified issues and recommended that the equipment was brought up to date. However both documents identified that the equipment was safe to use having passed safety checks.

There was no policy or procedure for staff to follow relating to safeguarding people in the policy and procedure file. In addition when we checked staff training we saw that only two people were recorded on the training matrix supplied on the 19 March 2016 by the registered manager as having training in safeguarding adults. This had been carried out in 2014 and was out of date. We asked staff what they would do if they witnessed any potential or actual abuse at the service. One care worker said, "I would inform the manager in writing and tell the person to stop what they were doing. If the manager didn't act I would contact CQC" but another said, "I have reported things but nothing changes and so I lose the will to say anything." This demonstrated inconsistency in the staff responses which could affect whether or not incidents were reported appropriately to protect people.

We had been told by both whistle-blowers and two staff during the inspection that one member of staff had shouted at people who used the service. We asked the registered manager if they were aware of the allegations and they said that they were. We asked if the person had been suspended whilst the allegations were investigated but the registered manager said they preferred to, "Look into it in their own way." We asked what they meant by that and they explained that they would work with the person to see if they were shouting at people. This meant that the registered manager did not recognise the seriousness of the allegation and was not being thorough or objective in their investigations. We reported the matter to the local authority's safeguarding team who are still investigating the allegations made.

Following this inspection eight safeguarding alerts had been made which should have been identified by staff at the service. This meant that staff did not have the required information available to be able to recognise and report any suspected or actual abuse and therefore people were not protected from abuse.

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

Recruitment was not consistently safe. We looked at three out of ten recruitment records and saw that one person had started work 19 days before the Disclosure and Barring Service (DBS) check had been issued. We saw that other staff all had DBS checks in place before their employment started. The DBS carries out background checks for people who wish to work in social care and helps employers make informed recruitment decisions. All the staff records we looked at had evidence of two references and proof of identity. Staff told us that during their induction period they were supervised which mitigated the risks.

On the days we inspected there was the registered manager, a senior care worker and two care workers on duty. The cleaner was absent and so we saw that one of the care workers did some cleaning during the day which meant that there were only two care workers available for part of the day. Staff told us that, "Staffing is OK."

Staff were not always deployed appropriately so that they could provide good levels of supervision and support. For instance we saw that people were left for long periods without staff available to support them. One person whose care plan said they should be checked every 30 minutes had been left for long periods without being checked. The layout of the building was such that if two care workers were providing personal care the third person would not be able to monitor peoples wellbeing in the lounges, which were on different floors or in bedrooms, which placed people at risk.

This was a breach of regulation of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service effective?

Our findings

One person's relatives told us that, "They [staff] have dealt with any issues that have cropped up. They do their best for [relative]. They are on the ball with things and they get the best treatment for [relative]". However, we observed that staff did not always have the necessary knowledge and skills to meet people's needs. One person had developed a pressure ulcer which is an area of skin damage caused by pressure. Staff had been advised by a district nurse to assist the person to bed for a few hours a day to relieve the pressure on the area. This is accepted practice in the treatment of pressure ulcers. We asked a care worker when this happened as we had noticed that the person had been sitting in the same place all day. The care worker told us, "We don't put her on the bed we normally put her feet up and cream her [area of damage]." This showed a lack of understanding of the reason for the advice given around this persons treatment which meant that their needs were not been met.

Staff did not receive effective support from the registered manager. We noted that one person had only had four supervisions since June 2014 and another person who had worked at the service for nine months had had only one supervision. We spoke with the registered manager who said she "Aimed to complete supervision with staff every three months but this was not always completed on time." In addition she told us that staff meetings were not held but that she was available to staff and chatted informally with staff every day. A care worker whose file we had looked at told us that they regularly had supervision every three months as, "I think it is important to go through things and the manager has put time aside to talk to you." This account did not correspond with the supervision records in their file or what the registered manager had told us. Staff had no structured formal support in place. No appraisals had been carried out which meant that staff had no plans in place to aid their development.

The complex needs and differing age range of people at the service meant that we would have expected to see how the registered manager had determined what staffing levels were required and what skill mix was necessary to meet people's needs appropriately. We did not see evidence of this.

Some people's needs were beyond the capabilities of the staff at this service. They had received no training for any mental health condition other than dementia. We were told by the registered manager that one person had been admitted to Evergreen in order to avoid admission to hospital for assessment. Another person attended the service daily with a view to starting respite care. Their needs were complex and it was confirmed by a mental health professional that they were still being assessed. Both of these people had shown aggression to others and required suitably trained people to assess and care for them. One person had been trained in challenging behaviour and breakaway techniques but that was six years ago. The community mental health team supported staff at the service but were not able to visit the service daily. This meant that people were being put at risk. Staff were not trained in mental health conditions and therefore were not working within their competency to meet people's needs in this area of care.

The registered manager told us that staff did nearly all their training through an independent provider. They provided a range of health and social care training courses through computer based distance learning. The nominated individual told us on day one of the inspection, "In the past months we have put more energy

into training" but they said they knew this was not up to date which meant that staff did not receive the support they required to carry out their role with confidence. Their training was either not completed or out of date.

This was a breach of regulation of Regulation 18 of the health and Social care Act 2008 (Regulated Activities) 2014.

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 so that they can 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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Although the registered manager had made applications for DoLS following the last inspection in January 2015 this was a continued breach of Regulation 11 identified at that inspection. The registered manager did not seem to be clear about when applications should be made and how. One person had had an application rejected three times. The person made what could be considered unwise decisions but had a right to do so because they were deemed through assessment by a professional to have the mental capacity to do so. The registered manager did not agree and continued to make applications for authorisations. We spoke to the person in question and they were able to answer our questions fully and appeared to have capacity.

Only three staff had completed training in MCA and DoLS and one of those had not had an update since 2014. This meant that staff did not all have the knowledge and understanding required to enable them to work within the principles of the MCA. We observed that staff did not always ask people for consent but told them what was going to happen. For instance we heard one member of staff saying, "Time for the toilet [name]" and "Sit over here [name]." The care plans for these people did not set down that people required this approach due to their medical condition. People were not asked whether they would like to do those things and we saw that staff acted without waiting to hear what they wanted to do. One person's games console had broken and we were told that it had been thrown away by staff. There was no record of the person giving consent for this.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We found that the premises were not of a suitable design or layout for people living with dementia. The house was a converted hotel which was six storeys high. Most people were older people living with dementia and had some cognitive impairment. There was no meaningful signage to help them find their way around the building. The service was in breach of Regulation 15 at the inspection in January 2015 and the action plan provided following that inspection said, "Signage has been in place but has at this time not made a significant difference to our resident's needs, we are currently researching other systems that might support our resident's movements around the home."

The provider had redecorated the ground floor communal lounge which looked clean and bright but the flooring was non slip linoleum which did not give the service a homely feel. There was no sensory stimulation or use of contrasting coloured features such as hand rails to aid those people who were living with a dementia or to act as a memory stimulant. No aids to continence promotion such as contrasting coloured toilet seats had been used. This meant that the environment was not adapted to suit the needs of people living with dementia.

There were noticeable differences in the décor in people's bedrooms. Two were well decorated and furnished and others were devoid of any personal touches making them drab and austere. We did visit one person whose room was a reflection of their interests and life. However, not everyone had access to personalised surroundings which reflected their likes, dislikes and interests. There was no garden and we only saw people go out when relatives came and accompanied them. Although the provider could not change the property they had not made concerted efforts following the breach of regulation found at the January 2015 inspection to ensure that the building they had was as suitable as possible for the needs of people living with dementia.

This was a breach of Regulation 15 Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

People's specific needs around eating and drinking had been considered with a nutritional assessment and in some cases a risk assessment with information about support required. However, these were not always effective in helping staff to meet people's needs. One person was diagnosed with Type 2 diabetes which was controlled by tablets. The staff had put them on a weight loss diet by reducing their portions with no record of input from a dietician. Between November 2015 to January 2016 there was a weight loss of 16.7 kg. Since January 2015 and January 16 they had lost 31.4kg. NHS advice is to aim to lose 0.5 -1 kg per week and although this target was met over the course of the year they had lost half of that amount between November 2015 and January 2016 which was not a safe weight loss over two months. One care worker told us "We just reduced [persons] portions." Although the person was now at a healthy weight here was no record of discussions around this decision or of staff having sought consent. There was no best interest decision making visible. There was no member of staff with current training in diabetes working at the service.

Food was prepared and provided by the nearby sister home so only simple meals were made on the premises. The environmental health officer had last checked both services in March 2015 and given them the highest rating which meant they met all the standards relating to food safety. We were told that people had a choice of food but every person on day one of the inspection had chicken for lunch. Staff did understand the need for soft or pureed diets for some people. Most people sat in the lower ground floor lounge were not able to move without assistance. They relied on staff to make sure they had drinks and snacks. We saw that people were offered tea, coffee and juice with their meals and then between meals a trolley was brought around with a choice of tea and coffee for people.

We had noticed that every person that required fluids had them recorded in multiples of 100mls. We asked a member of staff to show us what they were giving people. Spouted beakers used held 100mls of fluid and mugs 200mls. We saw that one person had been given a beaker which we had been told contained 100mls of fluid but when we checked their fluid chart it had been recorded that they received 200mls. The member of staff said that they would have been given two beakers but we were present when drinks were given and did not see this person offered a second drink. We asked a second member of staff about this who told us, "Sometimes people only take sips but it is still recorded as 200mls regardless." In addition we noticed that no fluids had been recorded as given at night on most occasions. A member of staff who worked on nights told us, "If we think someone is dehydrated we will give them regular fluids but we don't usually give drinks

at night." It was not clear how staff decided that people may be dehydrated when staff were not recording actual fluids given. This put people at risk.

We did not see finger foods being offered or snacks between meals which meant that people who may not eat at regular times because of their dementia had no other source of nutrition. This put them at risk of malnutrition. We saw that people were weighed and in one case saw in the care plan that a person had a large weight loss. We were told that this was a mistake in the recording and the original weight was incorrect. We discovered that the service had no scales and carried them from their sister home each time they needed them. Because they were carried from one place to another there was a risk that they were not correctly calibrated. The registered manager told us that they had now ordered scales.

We observed a lunchtime period and one person living with dementia needed assistance with eating and drinking. We saw that the member of staff kept talking to other people and were not focused on the person they were assisting. They did not take care over the time spent making sure the person was not rushed which demonstrated a lack of understanding of dementia and did not promote a calm eating experience for this person.

This was a breach of Regulation 14 of the Health and Social care act 2008 (Regulated Activities) Regulations 2014.

We saw from people's care plans that the service had contacted GP's whenever people needed additional input. On the day of our inspection we saw a GP, a social care coordinator and two mental health professionals visiting people at the service.

Inadequate

Is the service caring?

Our findings

We found that this service was not caring. One person told us they thought staff were caring and a relative said, "Staff are supportive and caring." However, we saw during the inspection that people were left for long periods of time with little to occupy them other than the TV because staff were task orientated and had little spare time. It had been recommended at the inspection in January 2015 that staff work in a more caring way to support people. We felt that although individual staff were doing their best to do this the culture of the service was such that it was not universally accepted practice.

People looked well cared for but were not animated unless they received visitors or were engaged fully in activity because they were not stimulated. A relative we spoke with said, "Staff are very friendly." However, there was little or no meaningful conversation started by staff during the inspection. One care worker did try to engage with a person in a quiz on day one of the inspection but when they failed to respond to their repeated question of "Who is Kevin Keegan?" they put the book down and moved away saying, "Oh well." This showed that staff lacked the skills required to develop relationships with people living with dementia.

One person's behaviour became distressed and staff managed it by moving the person away from others. This just caused them frustration and then they became angry throwing papers on the floor. Staff did not provide any useful diversion with which the person could be distracted. They did however intervene in order that other people were not distressed. This meant that staff were not working in a personalised way to maintain their wellbeing.

When we looked around the service we saw that there was a pile of clothes in one bed room with no name or names of people who did not live at the service marked on them. When we asked the registered manager what they were they told us, "There is no stock clothing as such but sometimes when people have died family left the clothes to be used by other residents." We also saw in the daily handover book that people were being dressed before day staff arrived. We spoke to a care worker who worked on nights and they told us," Night staff get everyone up. I usually start around 6am but others can start at 5am. The service had been in breach of Regulation 10 in relation to privacy and dignity at the inspection in January 2015. The action plan stated, "We are increasing our privacy and dignity training programme and will ensure all staff are providing a service which supports the resident's privacy and dignity." This was not the case and these were examples of institutionalised practice which affected the whole setting and denied the dignity, privacy, choice and independence of people.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Visiting at the service was allowed at any time. People were encouraged to go out with their relatives if they wished. Visitors to the service were made welcome. One relative said, "Staff always offer us a cup of tea and make us welcome."

People were supported at the end of their life. During the inspection we were made aware that one person

had been receiving end of life care. The registered manager told us that staff were being supported by the local hospice care homes team in their care of this person. This was confirmed when we contacted a registered nurse working for the care homes team at the hospice. They told us that in their opinion the service was not fit for purpose. However they said that the care provided by one particular member of staff was good and they described them as doing their best with very little support from other staff or management.

Personal life history documents were rarely completed for people and so staff did not have written guidance about people's history. We did not see staff taking time to talk with people at length and so there was insufficient evidence that staff knew people well. We did, however, see an example of one staff and service user having a very good trusting relationship during our inspection. However, generally there was little evidence to suggest that people received personalised are and support.

We could not see any referrals to or involvement with advocates recorded in care files. We did not see any posters or information for people to access advocates. Staff spoke only of relatives advocating for people. This meant that some people may have no one to advocate for them when making decisions and choices.

Inadequate

Is the service responsive?

Our findings

The statement of purpose for the service stated "Evergreen is registered to serve the needs of men and women with no age barrier" The statement of purpose goes on to say, "Primarily provides care and accommodation to meet the needs for up to a maximum of 17 persons with dementia and related illnesses. Also persons with cognitive impairment or other learning disability which leads to them require personal care. All clients will be assessed on an individual basis according to their needs before a decision regarding admission can be made."

People did not receive person-centred care and treatment that met their needs or reflected their personal preferences. There were people living at the service who had not had a pre admission assessment carried out. Instead the registered manager had discussed their needs over the telephone and agreed to their admission without going to meet them.

The registered manager told us that one person had been admitted to avoid admission to the local mental health hospital. They were still been assessed and this was confirmed by a visiting mental health professional. An initial assessment had been carried out by staff at the service which staff said was done for everyone within seven days of admission. This was a two page form and staff circled statements identified by letters A to E in relation to a range of mostly physical and personal care tasks such as climbing the stairs, dressing and needs relating to continence identifying the persons level of ability. There was no additional information on the sheet relating to what the person wanted or needed only their capabilities.

There were care plans in place but in some cases the details of people's needs were not recorded. In some care records there were risk assessments but these were not always updated or relevant to the current situation. For example one person was identified in their manual handling assessment as requiring two people for transfers when in fact they were unable to bear their own weight. Another had information about a person's dislike of animals when there were two dogs living at the service. One risk assessment that identified one person as displaying behaviours which may challenge staff on occasions. There was no management plan telling staff what they should do if this happened. Staff were not using people's information in a way that made their care and support personal to them.

People did not always receive the care that they were assessed as needing. One person was assessed to receive one to one care for three hours a day. We saw that during the last week there had been two occasions when only 1.5 hours were recorded and another occasion when nothing was recorded so it was not clear if any care had been provided. The manager said it was flexible but when we asked the local authority they confirmed that they should receive three hours each day.

Reviews had been carried out regularly by staff up to November 2015 but at that stage it became less consistent. Some reviews had been completed by healthcare professionals and we spoke to one mental health nurse who said, "The service do everything I ask them to do." Some care plans and risk assessments had not been updated if those people did not have regular input from a health or social care professional. In some cases the care plans did not reflect the current situation.

During day one of the inspection we observed a person shouting out continuously. We observed this person was left for long periods of time and they had not had their position changed or escorted to the toilet for the entire afternoon. The inspector spoke to a care worker about this and they said that they required frequent attention and staff assistance with their personal care. We only observed staff attend to their needs when they gave food or drink on day one of the inspection. One day two this person spent the whole morning from 9am to 11:45am asleep in a chair. Staff did not suggest that they go to the toilet or attempt to change their position throughout that period. Staff were not caring for this person according to their needs or in a personalised way.

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Although one of the mental health workers told us they had seen music and karaoke activities at the service during the first day of the inspection the majority of people we saw spent most of their time in the lower ground floor lounge with no stimulation. On day two we met a volunteer activity organiser who was engaging with a group of people in this lounge as they led a quiz in the morning. People were more animated when this took place and appeared to be happier. The volunteer told us they just came whenever they could as they worked elsewhere so this did not happen every day. There was no dedicated activities coordinator at the service. We were told that staff organised activities and we did see a care worker doing a quiz on one day but apart from that there was very little activity.

There was no evidence of memory work with people living with dementia, such as the use of visual prompts, pictures, newspapers or magazines to stimulate conversation. This meant that the care offered was not focused on individual needs. The inspection in January 2015 identified that the provider was in breach of Regulation 9 (Person centered care) and the action plan provided following that inspection had told us, "We have a new person centred care plan process which we are introducing at Evergreen which will identify resident's needs, likes and dislikes. We will use this to inform a needs analysis of appropriate stimulation to support their cognitive function. We will involve our residents in the development of rummage boxes. We have introduced daily newspapers and discussion around current affairs. We have weekly set activities which will be reviewed once the needs analysis." They had not met the action plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had received compliments from people whose relatives had used the service. We saw two recent ones which said, "No words can adequately thank you enough" and "Thank you for all your kindness and professionalism."

The service had a complaints policy and procedure but there were no complaints recorded since the last inspection. The registered manager told us that no complaints had been received. They told us that they spoke with visitors informally and people who used the service to gather feedback. However, these conversations were not recorded. At the inspection in January 2015 we had seen that no complaints had been made and we had recommended that the provider consult best practice advice on how to consult with people effectively to improve the service. There had been no improvement as a result of this recommendation and no written evidence of any changes to care made as a result of consultation with people. As no staff meetings were held there had been no forum to discuss any concerns raised.

Inadequate

Is the service well-led?

Our findings

There was a registered manager employed at this service who had been registered with CQC since March 2014. They had a national vocational qualification (NVQ) at level three in care but had no management qualifications although they told us they were registered with a training provider to complete an NVQ level five management qualification. The qualification levels are used in education and work to compare different qualifications; they also show how one qualification can lead to another. To achieve an NVQ, candidates must prove that they have the ability (competence) to carry out their job to the required standard. NVQs are based on national occupational standards that describe the "competencies" expected in any given job role. The registered manager had worked at this service for eight years as a care worker and had then been promoted to a management post.

One care worker told us, "I can approach the manager about anything. I trust her and have respect for her." However another care worker said, "She's not rude, not a bully but you know who's boss. You have to be sweet with her." This showed inconsistency in the manager's approach to staff and their response to her.

At the last inspection in January 2015 we had made a recommendation that the registered manager developed a quality assurance system which was meaningful to them and to use this to demonstrate improvement to the quality of care for people who live at the service. No action had been taken to act on the recommendation.

We saw at the inspection in March 2016 that no real improvements to the quality of care for people had been made. Some technical matters such as applications for authorisation to deprive people of their liberty had been addressed but there was a lack of understanding of the Mental Capacity Act by the registered manager which meant that some people were not treated according to the principles of the Act. This meant that the registered manager lacked the knowledge to apply legislation to people's lives in order to protect them.

We saw during our inspection in March 2016 that the statement of purpose for the service stated "Evergreen is registered to serve the needs of men and women with no age barrier." The statement of purpose goes on to say, "Primarily provides care and accommodation to meet the needs for up to a maximum of 17 persons with dementia and related illnesses. Also, person's with cognitive impairment or other Learning disability which leads to them require personal care." The registered manager had not ensured that staff were trained to care for people in the categories highlighted in the statement of purpose which meant that people may not receive safe and appropriate care to meet their needs. No one working at the service had received any training in relation to learning disability, only five out of elven staff had done any training related to care of people living with dementia and there had been no training for people relating to any other mental health condition.

Regular audits of the service were not carried out to assess, monitor and improve the quality and safety of the service. For example we saw a document entitled 'care plan audit' in two peoples care records. These were typed lists of documents that had been ticked by staff to say these documents were present but no one had signed the document. There were no actions identified when documents were not present. It did not

identify whether people's needs and associated risks had been identified therefore making it ineffective as an audit tool. The registered manager told us they had completed a weekly home audit which we saw. This had audited areas within the service but did not accurately reflect what we saw during the inspection. For instance one room had been identified as very good for tidiness but we identified wires across the floor which were a trip hazard. It was also identified that the lighting was working but there was no light in the room. The room audits only considered the environment and not whether that environment met the needs of the people in the room. This meant that the audit did not identify that the toilet arrangements for this room were not hygienic and did not show respect for people's dignity and privacy. This showed that the audit tool was not effective and there was no other audit which would have identified these issues making the system ineffectual. There was also a basic plan which outlined what maintenance and decoration was required for the building. This had no action plans or time scales attached and did not identify what specific improvements would be made for people living with dementia.

Systems and processes enabling the provider to identify and assess risks to the health, safety and/or welfare of people who used the service were not in place. When we inspected the service we found that servicing and maintenance checks were not consistent which meant that people's safety was compromised. The registered manager was not up to date with the timescales within which certain checks should be completed. For example they told us they did not know how often tests of water for legionella bacteria should be carried out.. No other audit tools were used to check the quality of care and safety in the service.

Surveys were not formally carried out in order to gather the views of people who were involved with the service. The most recent ones in the entrance hall were from 2012. However one relative told us, "I have spoken to the manager and given feedback." This corresponded with what the registered manager had told us about them collecting feedback informally.

The manager described their role as 'leading by example'. We observed that the manager had some skill when interacting with people who had a dementia related illness. They obviously had knowledge of people who used the service and their families. However, because such knowledge was not captured in care plans in sufficient detail and therefore not communicated fully to staff this resulted in care that was inconsistent.

Record keeping was poor with care records that were out of date or lacking in detail. In addition statutory notifications had not always been made to CQC.

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