Greenheart Enterprises Limited

Evergreen

Inspection report

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14 June 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 June 2016. This was an unannounced inspection.

This location is registered to provide residential and nursing care for up to 16 people. People who used the service were older adults with personal care and nursing needs. At the time of the inspection, fourteen people lived at the service.

The service had a registered manager. 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.

Staff had completed training in safeguarding people from possible abuse. However, not all staff could explain what processes they needed to follow to keep people safe. We have made a recommendation about this.

The provider had not put in place full records to demonstrate safe recruitment practices. We have made a recommendation about this.

The provider had not routinely recorded that they reviewed people's care plans and risk assessments regularly with people's involvement. The provider had not consistently recorded people's views and wishes as to how their care should be provided. We have made a recommendation about this.

The provider had completed induction and supervision to address staff training and development needs to ensure people received effective care. Records of staff supervision were not made available to demonstrate that staff development needs were met to ensure people received effective care. We have made a recommendation about this.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications to restrict people's freedom had been submitted to the appropriate DoLS office. People's mental capacity was not appropriately assessed about particular decisions. When necessary, appropriate meetings were not held to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005. There was no recorded evidence people's relative's involved in best interest decisions had lasting power of attorney in place. This is required to enable them to lawfully make health and welfare decisions on the person's behalf. Staff training in mental capacity and DoLS was not effective. Staff were not able to identify how people were subject to DoLS and how to apply the principles of the MCA in practice.

The provider had not considered accessible ways to inform people about services available to them, to include advocacy. We have made a recommendation about this.

People's care plans were not personalised in all cases to enable staff to meet people's individual needs, goals and preferences. Some people were not fully satisfied with the activities available to them. We have made a recommendation about this.

The provider had consulted people to obtain their feedback to influence how the service was developed. However, there were no records of how the provider responded to people's requests and suggestions.

The provider's quality assurance system did not identify service shortfalls we found during the inspection, to ensure service improvements were made.

Medicines were administered and recorded safely and correctly.

Fire safety measures were in place to ensure people would be safely evacuated in the event of a fire. The provider completed health and safety assessments to ensure the environment was safe for people.

There was sufficient staffing level to meet people's assessed needs.

People consistently had access to appropriate health professionals to effectively meet their health needs. People's care and treatment was routinely reviewed with the involvement of relevant health care professionals to ensure their health, safety and welfare.

The service supported people to have meals that were in sufficient quantity, well balanced and met people's needs.

People told us staff treated them with kindness, compassion and respect. People's privacy and dignity was respected by staff. Staff promoted people's independence and encouraged them to be as independent as possible.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had completed training in safeguarding people from possible abuse. However, not all staff could explain what processes they needed to follow to keep people safe. We have made a recommendation about this.

The provider had not put in place full records to demonstrate safe recruitment practices. We have made a recommendation about this.

Medicines were administered and recorded safely and correctly.

The provider completed health and safety assessments to ensure the environment was safe for people.

There was sufficient staffing level to meet people's assessed needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records of staff supervision were not made available to demonstrate that staff development needs were met to ensure people received effective care. We have made a recommendation about this.

Staff were not knowledgeable in the principles of the Mental Capacity Act (MCA) 2005 and about the Deprivation of Liberty Safeguards (DoLS). The documentation in regard to MCA and DoLS processes was not fully compliant with legal requirements.

People had access to appropriate health professionals to effectively meet their health needs.

People were provided with a choice of suitable food and drink.

Is the service caring?

Good

The service was caring.

The provider had not considered accessible ways to inform people about services available to them, to include advocacy. We have made a recommendation about this.

People told us staff treated them with kindness, compassion and respect. People's privacy and dignity was respected by staff.

Staff promoted people's independence and encouraged people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Staff had not consistently recorded people's views to demonstrate they were fully involved in their care plans and reviews. We have made a recommendation about this.

People's care plans were not personalised in all cases to enable staff to meet people's individual needs, goals and preferences. Some people were not fully satisfied with the activities available to them. We have made a recommendation about this.

People's care and treatment was provided with the involvement of relevant health care professionals to ensure their health, safety and welfare.

A complaints process was in place to ensure service improvements were made.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had consulted people to influence how the service was developed. However, records were not consistently in place to demonstrate how the provider responded to people's requests and suggestions. The provider had not routinely consulted staff to inform service improvements.

A quality assurance system was in place to identify service shortfalls and to ensure service improvements were made. However the system was not sufficiently robust and did not identify shortfalls we found during the inspection.

The registered manager was passionate about providing high quality care. There was an open culture and staff felt supported in role.

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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 checked whether the provider was 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 13 and 14 June 2016. This inspection was unannounced. The inspection was undertaken by two inspectors, a specialist advisor and an expert by experience. The specialist advisor had professional experience of services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We checked the information we held about the service and the provider. We reviewed notifications that had been sent by the provider as required by the Care Quality Commission (CQC).

The registered manager had received a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before our inspection we looked at records that were sent to us by the manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports.

During our inspection we spoke with seven people and three visiting relatives. We also spoke with the registered manager who was the owner of the service, the training consultant and two members of staff. We looked at ten care plans. We looked at three staff recruitment files and records relating to the management of the service, including quality audits. After the inspection we received written feedback from four professionals with direct knowledge of the service. The last inspection of this service took place on 10 June 2014. The provider was compliant with the outcomes we inspected at that time.

Good

Is the service safe?

Our findings

People said they felt safe with the staff that supported them. People said, "I feel safe. I know and get on with all of the staff" and "There's no problem with the people who work here" and "I feel safe. You would go a long way to find a home like this." One person who needed support to keep safe told us, "Sometimes when I am moved into my chair, I have four staff to help." One relative told us, "X is absolutely safe here."

People had been protected against the risks of potential abuse. One person had pressure sores which had deteriorated due to non-compliance with their care plan. The registered manager referred their concerns to the person's funding authority in a pro-active way to ensure their safety. They followed recommendations made from the safeguarding investigation. They referred the person to a Tissue Viability Nurse (TVN) for an assessment of their needs. They ensured the person understood the risks of not accepting care from staff. They ensured the person's pain management was reviewed with involvement of their G.P. The registered manager ensured a positive outcome for the person and their pressure areas subsequently healed.

Although staff had completed the required safeguarding training, not all staff were able to identify different types of abuse and how they would act on these to keep people safe. There was a whistleblowing policy in place. However, not all staff were aware of the policy or how to effectively report any concerns they had about potentially poor care practices. Staff told us that they did not discuss outcomes of any safeguarding investigations completed to support lessons learned. However the registered manager told us they had discussed a safeguarding investigation in a team meeting and that staff had signed to confirm their attendance at this meeting. We found there was no evidence of poor safeguarding outcomes for people.

We recommend the provider reviews staff knowledge of safeguarding practice and protocols and robustly evidences staff competence in practice.

The provider had not consistently put in place full records to demonstrate safe recruitment practices. Staff files included appropriate records of references, criminal records checks and job application forms. Criminal record checks had routinely been made with the Disclosure and Barring Service (DBS) to make sure people were suitable to work with vulnerable adults. There was no protocol in place to ensure full risk assessments would be completed where DBS checks may record historic spent convictions. There was no evidence of poor outcomes for people. Staff retention was high at the service; therefore recruitment of new staff had been infrequent. However recruitment practices required review to robustly evidence that future staff were fit and suitable for their role.

We recommend that the provider considers current guidance on safe recruitment practices and reviews their policies and practice for future recruitment purposes.

People were supported to take their medicines safely. They told us, "They [staff] see to my tablets and I get them when I should." One relative told us, "[My relative] gets their medication when they should have it. They give X [medication] if they are in pain." One visiting professional wrote, 'I visit the home once a year and do an enhanced pharmaceutical service audit. All the staff I see are trained and know how the medicine

dosage system works. I have no concerns.'

All Medicine Administration Records (MAR) were accurate and had recorded that people had their medicines administered in line with their prescriptions. Where people were independent with managing their medicines, this was clearly recorded. Any allergies people had were clearly recorded in their care plan. Staff gave people the correct medicines, followed the correct procedures, signed that people had taken their medicines and locked all medicines away afterwards.

The medicines trolley and stocks were properly controlled and regularly monitored to ensure medicines were stored securely for use. However, although medicines were checked twice daily, this was not recorded in the medicines book and signed by two qualified members of staff. In addition the medicines refrigerator temperature was recorded, however the room temperatures were not recorded where medicines were stored in people's rooms and in the clinic room. If the temperature rises above 25 degrees centigrade, this could cause the degradation of medicines. Room temperature checks were not routinely taken and recorded to ensure medicines were kept at the correct temperature to ensure they remained effective for use. The registered manager was responsive to recommendations we made on the day of the inspection and put in place a system to record and monitor this.

There was an adequate number of staff deployed to meet people's needs. People told us, "There is always someone on hand. If you ring the bell, someone comes" and "If I ring the bell, they come very quickly." Staff told us that there were sufficient numbers of staff on shift. One staff member told us, "I am happy with the staffing levels. The home has never used agency or bank staff, but we cover each other's' shifts if the need arises. The manager will provide cover if necessary." As staff covered additional shifts in case of sickness, no agency care staff were needed. People were cared for by staff who knew them well. The registered manager completed staff rotas four weeks in advance to ensure that staff were available for each shift. There was an on-call rota so that staff could call the manager out of hours to discuss any issues arising. Our observations indicated that sufficient staff were deployed in the service to meet people's needs. Staff were not rushed, supported people in a calm manner and were able to spend time talking with people.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. For example, one person was supported to keep safe when walking. Two members of staff supported them to stand using a hoist to transfer out of bed and chair. Staff followed guidelines which stated 'explain to X that they needed support from staff to sit up in their chair and move their arms and legs.' Staff explained to the person what equipment they needed to use and gave the person lots of reassurance. The person was provided with a specialist bed to help them get in and out of bed safely and had access to a call bell if they needed staff assistance. The risk assessment in place supported the person to maintain their independence whilst reducing the risk of falls to keep them safe.

Staff reported accidents, incidents or concerns to keep people safe. Records of accidents and incidents were kept at the service. When incidents occurred staff completed incident forms, informed the registered manager and other relevant persons. For example, one person had a fall that was not witnessed. Staff ensured the person was checked over for any injuries, they cleaned the person's wound and ensured vital observations were recorded and monitored. The person was referred to their G.P. and they were provided with an alarm mat to alert staff should they have a fall in future. This reduced the risk of future falls to keep the person safe.

People were kept safe from the risk of emergencies. The provider had a robust fire procedure in place. People had an individual Personal Emergency Evacuation Plan (PEEP) in place. PEEPs identify people's individual independence levels and provide staff with guidance about how to support people to safely

evacuate the premises. PEEPs recorded support and equipment they would need in the event of fire evacuation. Fire protocols were in place which recorded how people would respond or how staff would ensure their safety in the event of a fire.

There was a business contingency plan in place that addressed possible emergencies such as extreme weather, infectious diseases, damage to the premises, loss of utilities and computerised data. Procedures were in place to ensure continuity of the service in the event of adverse incidents.

People's home environment had been adequately assessed for safety hazards. The provider had completed health and safety assessments to ensure people lived in a safe environment. For example, portable electrical and gas appliances were serviced regularly to ensure they were safe to use. Water was routinely tested for legionella every year. Call bells, lifts, air mattresses, and all equipment to include hoists were routinely serviced. Equipment checks were completed every six months. There was a maintenance system in place and maintenance work was routinely completed. A maintenance person attended the home daily. Recent repair work had been recorded for repairs to hoists, a wheelchair and bed rails.

People were supported to live in a clean home and there were safe infection control standards in place. People told us, "The home is always being cleaned. They look after my room" and "It's clean here, they do my room every day." Relatives wrote, 'Whenever I visit, I have always found [my relative's] room to be spotlessly clean' and 'I have found the home to be very clean and hygienic.' The home was clean and tidy and no unpleasant odours were noted. The home was regularly refurbished and was in good decorative order throughout. There was a formal deep clean schedule and regular cleaning schedule in place which ensured the home was kept clean. We observed cleaning charts on the bathroom doors to indicate that daily checks and cleaning had taken place. The registered manager completed a weekly infection control audit to ensure essential infection control standards were maintained.

The service had been inspected by the Food Standards Agency in August 2013. The service attained the food hygiene rating of '5' which demonstrated high standards of cleanliness in the kitchen and food preparation practice. This is the highest level that can be achieved.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about staff and told us staff met their needs. People told us, "Some of the staff attend college and take exams" and "They (staff) are definitely well trained" and "I think they are well trained to do what they do." People told us that staff talked to them when supporting them. They said, "They (staff) do sit down and chat. They are very good like that" and "They do talk with me when giving me care" and "I have choice and they do talk with me about [my care]." One relative told us, "[My relative] is always dressed and spotlessly clean. Their choices are met and they are happy." One visiting professional wrote, 'I have always found the staff professional, friendly and efficient.'

People were supported by staff that completed supervisions (one to one meetings) to discuss any training needs or concerns they had. Staff said they had daily contact with the registered manager as a form of supervision. They told us they usually had supervision every six weeks. However, staff records of supervision were not available to us during the inspection. Not all staff had completed an annual appraisal to review their performance and development needs. Not all appraisal records were available to us during the inspection. One staff member's appraisal in October 2015 identified some development issues. There was no recorded evidence that their development needs had been addressed.

One person's hydration needs had not been robustly recorded by the provider. The person had recently been unwell and staff were monitoring their fluid intake to ensure they kept sufficiently hydrated. The home's policy was to provide each person with two jugs of water daily. However, staff did not record people's fluid intake or output. Dehydration is a major cause of ill health in older people, leading to health concerns. Although there was no evidence of poor health outcomes for the person, staff had not recorded how much the person drank on a daily basis, to demonstrate the person had taken the required fluids.

Whilst appropriate care was provided to meet people's needs, current information had not been recorded in a person's care plan about their care and health needs. For example, it was recorded they had diabetes and took medication to manage this condition. There was no evidence of a prescription in the medication section of the care plan or records of blood tests or appointments with a diabetic nurse. We followed this up with the trained nurse who told us the person's condition had changed and their condition was now diet-controlled only. They needed to have monthly blood sugars tests completed at the home, on the instruction of the person's G.P. We followed this up with the registered manager who confirmed this change. Although staff were aware of this change in the person's health need, this information was not recorded in their care plan.

The registered manager reviewed people's care plans every month. However, there was no recorded evidence they completed an analysis of the person's care plan at each review, involved people or recorded outcomes for people. For example, it was not recorded whether people's care and treatment was working, whether the care plan was effective, whether the person was happy with the care and treatment provided or if any changes in their care delivery had occurred.

Handover between staff at the start of each shift ensured that important information to include health

needs was shared, acted upon where necessary to ensure people's progress was monitored. Staff told us updates concerning people's health and welfare were appropriately communicated between staff at handover meetings to support people's continuity of care. However, information from these handover meetings was not recorded to demonstrate and enable information to be shared with staff and relevant health care professionals.

We recommend the provider reviews the record keeping process to ensure all records, such as care plans, supervision and appraisals, handover and hydration records are detailed, up-to-date and available.

The provider told us they supported new staff to complete an induction programme before working on their own. There was induction paperwork available to demonstrate staff had completed an effective induction before starting in role. The provider had not implemented the new 'Care Certificate' training or an equivalent induction programme. However this was due to be implemented with all new staff. This is based on an identified set of standards that health and social care workers adhere to in their daily working life.

Improvements were required to ensure people's consent to care and treatment were obtained in line with legislation. We discussed the requirements of the Mental Capacity Act (MCA) 2005 with the management and staff. 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. The registered manager had referred some people for a DoLS application to lawfully restrict their freedom to keep them safe. However,in one case, there was no recorded mental capacity assessment to demonstrate the person lacked capacity to make a specific decision about their care and treatment prior to completing the DoLS application. The registered manager told us the person's G.P. completed the capacity assessment; however there was no record of this made available to us. The registered manager had not received confirmation that DoLS applications had been received by people's funding authorities to ensure DoLS assessments would be completed appropriately and in people's best interests. During the inspection the registered manager followed this up with people's funding authority on our recommendation.

The registered manager did not demonstrate sufficient understanding of processes they needed to follow when completing mental capacity assessments for people to decide a DoLS was needed. For example, bed rails risk assessments were in place to reduce the risk of falls for some people. The registered manager recorded permission obtained from one person's relative to use bed rails, as the person was deemed to lack the capacity to make this decision. The registered manager had referred the person for a DoLS. However, there was no mental capacity assessment in place for the person or recorded evidence of the decision made in the person's best interest. When a person is assessed as not having mental capacity to make a specific decision about their care and treatment, a meeting with an appropriate representative must take place to decide the least restrictive care provision in the person's best interest and this meeting should be recorded. Records were not made available by the provider, to demonstrate the relative involved had lasting power of attorney in place. This is required to enable them to lawfully make health and welfare decisions on the person's behalf.

All staff and the registered manager had completed training in the principles of the Mental Capacity Act (MCA) 2005 and DoLS. This training provides staff with guidelines about seeking people's consent, assessing people's capacity to make decisions and what to do in the event people may not have capacity to make decisions. The training consultant told us, "With the MCA, we also do case scenarios alongside the DVD to support understanding. Staff also have access to the policy which they've signed to indicate they have read it." However, care staff were not able to explain how they applied the principles of the MCA in practice, when supporting people.

People's consent had not consistently been recorded as obtained in line with legislation. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff that had access to a range of training to develop their skills and knowledge. Staff said training was readily available, and they could ask for specific training. For example, one staff member was completing a National Vocation Qualification (NVQ) 5 in management. Staff were supported to obtain health and social care diplomas in level 2 and 3. Training records were up-to-date. The provider had monitored staff training needs and scheduled training courses for staff. Staff had completed training courses in all mandatory training subjects, such as moving and handling and first aid. The training consultant told us, "Training is held every Monday morning and a rolling schedule is in place. We offer specific training when required. For example, if people had diabetes, I would organise for the specialist diabetic nurse to come and talk to staff."

People's needs and preferences were clearly recorded in their care plans. People were supported to have a meal of their choices by staff. One person told us, "Staff ask me what I would like. They know I like watercress and tomatoes in my sandwiches." Other people told us, "The meals are very good and you can change it, if you don't fancy something" and "We get plenty to drink" and "They [staff] write the meal up on that board" (displayed in lounge) and "If I did not like what's on the list, they would do something else for me." We observed lunch being provided. The meal was freshly cooked, well presented and looked appetising. It was hot and in sufficient amounts. The meal consisted of two main courses, one of which was a vegetarian option and desserts with water and juices available. The menu of the day was displayed in the lounge. Tea, coffee, juices and biscuits were provided to people in the morning and in the afternoon.

Staff were aware of people's dietary needs and food preferences, and acted in accordance with people's choices. One person needed support with eating as they had swallowing difficulties. The person had been referred to a Speech and Language Therapist (SALT) and dietician to assess their needs. Staff followed SALT guidelines which were available in the person's care plan to ensure the person's specific dietary needs were met. The SALT and dietician prescribed food supplements to meet the person's nutritional needs. Staff supported the person with a modified diet. Staff told us that people needed to sit upright whilst eating to reduce the risk of choking. They were able to explain where people needed pureed food and thickened fluids to reduce the risk of choking.

People had health care plans which detailed information about their general health. People were supported to attend health appointments where needed. People told us, "If I'm not well, they [staff] will call my doctor in" and "The chiropodist and others are organised by the home." A visiting G.P. told us, "People and family give me positive feedback about this home. Staff call me as needed. They look after people and call me when people need a review of their medication. They alert me with any concerns and are responsive to changes in people's health needs. "Another professional wrote, 'They [staff] are prepared with background information and an understanding of their clients. Whatever staff I see, they have the knowledge of how the client has been. They provide good information about people's physical and mental status, prior to my visit.' Records of visits to healthcare professionals were recorded in people's care plans.

Good

Is the service caring?

Our findings

People were happy with the care they received. People told us, "The staff are so nice and kind" and "I feel I am looked after well here. If I can't be at home, this is the next best thing" and "The staff are excellent, exceptional. They are all lovely" and "They all go the extra mile for you." People appeared happy and relaxed when talking to care staff. One relative told us, "Staff are kind and caring. They are excellent." One relative wrote about the registered manager, 'You have shown a genuine understanding and sensitivity in your dealings with myself and the rest of X's family.' In one person's care records there was a 'thank you' letter from a relative containing the following comments: 'Genuinely cared for at a high level. I have nothing but praise for the way X is looked after. I would have no hesitation in recommending Evergreen to anyone who was looking for a nursing home for a loved one or relative.' The registered manager told us they aimed to ensure a, 'nice, open, friendly, caring, comfortable and happy' environment for people.

The registered manager told us advocacy services were available to people at the service. However, people did not have access to information about how advocacy services could support them or how to contact them. The registered manager told us that everyone at the service had relatives who acted as advocates for them. It was not clearly recorded how staff ensured people were informed of their rights and supported to access this service to make independent decisions about their care and support needs. Advocacy services to include access to Independent Mental Capacity Advocates (IMCAs) or Independent Mental Health Advocates (IMHAs) help people to access information and services; be involved in decisions about their lives; explore choices and options; defend and promote their rights and responsibilities and speak out about issues that matter to them.

We recommend the provider reviews how people access information on advocacy services.

People's dignity was respected by staff. People received care and support from staff that knew them well. People were treated with kindness and compassion in their day-to-day care. People told us, "They [staff] definitely are respectful" and "They respect me when attending to me" and "Staff do treat me with respect by knocking on my door." A professional wrote, 'I have at all times found the staff to be courteous and prepared for my visit. They show me and resident's respect.' One staff member told us about how they promoted people's dignity when they supported people with personal care. They said, "I ensure doors are shut and people are covered up. I always explain to people what I am doing. I ask people if they would like a wash and for example, help people to lift their arms up. Where people are independent such as washing their face, I give them a flannel." One relative wrote, 'we have been impressed by the high standards of care shown by staff, who have done everything they can to maintain not just [our relative's] health and hygiene but their dignity too.'

Staff knew people's individual communication needs. Information on people's communication needs was recorded in their care plans. We observed staff supporting someone to eat who was living with dementia. The care staff introduced themselves and held the person's hand to focus their attention. They asked if they could turn the television down to reduce distractions and support effective communication with the person. They reminded the person what was on the menu and gave them small spoonful's of food. The care staff

gave the person food at their pace and did not rush them. They encouraged the person when they stopped eating and gave praise when the person ate some food. They gave the person simple instructions to follow such as, 'you can swallow it' and 'there's still a little bit [of food] left on the spoon.' They checked how the person was feeling and gave them regular drinks to wash down the food. The person's relative told us, "Staff communicate effectively with X. X is relaxed and responsive to staff." They also wrote, 'Thank you for the excellent care you provide for [my relative]. It is appropriate and compassionate. You care for all of their needs which they are unable to express.'

Staff told us they encouraged people to be as independent as possible. People's care plans indicated their abilities and independence skills. For example, where someone's independence with walking had reduced, staff had worked with other healthcare professionals. People were provided with walking frames and other equipment which gave them greater independence in their home environment. Staff told us about how they supported someone to maintain their independence with personal care. "X likes a male carer and likes to wash and dress independently. I am there to give a little support and help them to put on their shoes."

People were supported responsively and compassionately with their end of life care. One relative had written, 'Thank you for the wonderful care you gave [my relative]. They were lucky to receive such wonderful care in their final days.' The registered manager and nurse had completed training in end of life care. Training for all staff was scheduled to take place. Where people required end of life care, measures were in place to support people appropriately. For example, people's family and G.P. were involved in all aspects of their care. People's pain management and medicine needs were routinely assessed and reviewed. The registered manager told us they planned to implement the 'Gold Standards Framework' for end of life care to develop their care practice in this area. This is an evidence based approach to optimising care for people approaching the end of their life.

Good

Is the service responsive?

Our findings

People and relatives gave positive feedback about how staff responded to their needs and preferences. One person told us, "I believe I get all the care that is necessary." People told us that where they had a preference for a specific gender of staff, this was facilitated. One relative told us, "Staff keep me informed about [my relative]. Staff always involve me in X's care and keep me updated with any concerns. I am really happy with the home. I have recommended it to other people" and "Staff have good conversations with X. They know what they like and dislike." One relative told us, "The manager is always making suggestions about easing [my relative's] pain. She organised an air bed for them." One relative wrote to the registered manager, 'I know that you will inform me immediately if there is a problem and will contact [my relative's] G.P. in a timely manner."

Some people's care plans contained personal histories and information about how to meet people's individual preferences. Some people's care plans included personalised information about people. However this information was not included in all cases. Some people's care plans contained limited life history information. Care plans did not routinely provide information about the person, what was important to them, their hobbies, interests, likes and dislikes. The registered manager had not routinely recorded people's views and wishes as to how their care should be provided as part of routine care reviews. Care records did not provide information on how people were supported to meet their goals and individual preferences. People's progress in meeting their goals was not routinely recorded in people's care records to ensure people could meet their individual goals.

We recommend the provider reviews and consistently records evidence of people's involvement in their care needs and their person-centred needs to include their preferences and goals.

The provider supported people living with dementia at the home. Detailed information on people's life histories can support staff to more effectively engage with people with this condition. The registered manager told us they would be developing 'life story work' and reviewing dementia care resources available to people in the home living with dementia. Life story work is an activity which involves reviewing a person's past life events and developing a biography. This can be used to help staff understand more about the individual and their life experiences. The potential benefits for people living with dementia includes promoting individualised care, improving assessment, building relationships between care staff and family carers as well as improving communication. The registered manager told us they were looking to implement life story work at the home. At the time of the inspection this was not fully developed.

People had a range of activities they could get involved in. However, some people told us there were not enough activities or opportunities to pursue hobbies and interests. Some people said, "We mainly watch TV" and "There could be more activities" and "There is a lack of things to do here." One person said, "What I am not happy about is there is no one to talk to. I am bored and I get depressed because of it." We spoke to the registered manager who told us they would look into this concern reported. Some people preferred not to take part in activities. One person told us they liked to stay in their room, to read books, watch television, and to people watch from the window in their bedroom. They told us they didn't want to take part in

activities. Their relative wrote, 'Many attempts were made [by staff] to encourage [my relative] to take up knitting and crotchet again. Unfortunately to no avail as they find it too difficult now.' One person said, "I do what I can, crosswords and play cards" and "The staff will read newspapers to me and bring in animals for me to see."

One person's care records stated they liked, 'to play the piano, classical music, singing, painting and drawing.' The pre-admission records stated they 'will not do activities.' There was no record of how the person was encouraged to engage in hobbies and individual interests. People's care records stated where people did not wish to participate in any activities. The registered manager told us they were frustrated that people did not wish to get more involved in activities at the home.

There was an 'Activity timetable' in place and displayed. This included activities such as, current affairs, TV, radio, puzzles and crosswords, gentle exercises, board games, music therapy, films and information that 'Pet pals therapy' was coming next on 28 June. However, the registered manager told us that the activities timetable was rarely adhered to. The provider's 'statement of purpose' stated that, 'Evergreen will hold the following groups during the week, inclusive but not limited to: Craft therapy, gardening, games/activities, music, sing-alongs, coffee mornings and cooking.' There was no dedicated activities co-coordinator to motivate people and focus on meeting people's occupational needs. The registered manager told us they were recruiting to this post.

We recommend the provider reviews activities to ensure they consistently meet people's individual needs and record activities people are involved in.

Staff responded pro-actively to people with clinical needs to include pressure sores. Where needed, people had been assessed using the Waterlow scale for risks of skin breakdown. The Waterlow scale gives an estimated risk for the development of a pressure sore in a patient. Where required, the registered manager had put in place appropriate pressure relieving mattresses and cushions. One person's skin had healed with appropriate input from clinical staff. The person's progress was recorded accurately. Wound information was recorded on a body map, and the registered manager took advice from a Tissue Viability Nurse (TVN). Where people's skin was at risk of breakdown, photographs and measurements of this were sent securely to the TVN. In the person's care plan was a separate wound dressing care plan which gave staff guidelines on treatment prescribed by the TVN. The registered manager followed the protocol where people were at high risk. They contacted the person's GP, arranged a dietician appointment, and set goals such as increasing calorie intake, encouraging the person to eat and reviewed this monthly.

Staff responded proactively to review people's physical health needs. In the past, one person had physiotherapy sessions. This did not prove successful in this case. The registered manager arranged a domiciliary visit by a consultant neurologist to provide treatment to relax the person's muscles. This proved effective in reducing their pain and discomfort. The registered manager had showed innovative thinking in looking at alternative ways to support the person's well-being and respond to their health needs.

The provider had a complaints policy in place that people could follow. No complaint had been recorded in the last twelve months. People told us, "I've never had to make a complaint" and "I've never complained. They [staff] are very good here" and "I have no reason to make any complaints." People told us they believed the registered manager would respond to any concerns they had. They said, "Staff would definitely listen and sort things out."

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. People told us, "I get visitors and they can come to see me" and "My

visitors can come anytime" and "My family visit and they are made to feel welcome." Where people wanted to maintain relationships with important people, this was encouraged and recorded in people's care plans. One visiting professional told us, "I have been invited to Evergreen's summer and Christmas parties, both of which are well organised and a great way to include family members who visit relatives at Evergreen. The manager does a great job of making visitors and family members feel welcome." We observed photographs in the dining room which showed people enjoying various parties and celebrations at the home.

Requires Improvement

Is the service well-led?

Our findings

People were satisfied with the management of the service. People told us, "The manager is very good. She is definitely approachable" and "The manager is wonderful." People gave us feedback about how the service was managed. They said, "As far as I can see, they run this well." One relative told us, "I am entirely pleased [my relative] is here." Another relative told us, "The manager is very involved. She is here every day." People and relatives told us the management listened to comments and would sort issues out. Staff told us, "We have a good manager. She has a good attitude" and "I like the work environment here. It is friendly" and "The manager is approachable and is accessible in person or by telephone." Staff morale was high at the service and there was high retention of staff. This supported the stability of the service and people were cared for by staff who knew them well.

The registered manager was passionate about providing high quality care and had a caring and compassionate approach to the service they provided. One relative had written, 'You are to be complimented on your caring management and pro-activeness in endeavouring to do the best for those given into your care.' One visiting professional wrote, 'Whenever I attend my appointments at Evergreen, the residents all speak very highly of the manager and her team of carers.' Another visiting professional wrote, 'The service provided by the management and staff is very professional. The manager is very knowledgeable and very efficient. The support provided by the home is of a high standard and on dealing with people/family the feedback to me is of the highest standard.'

The provider obtained people's feedback and suggestions to develop the service. People told us, "They would listen to comments by residents." One relative said, "The management listens." The last survey was completed in April 2016. The majority of the feedback from this survey was positive. Comments included, 'Excellent care and support given' and 'Very friendly and caring staff' and 'provide a comfortable, family atmosphere.' One person commented that, 'X feels that staff do not always respond quickly enough when the buzzer is sounded.' The registered manager told us that this issue was addressed with the person and their relative. We spoke with them and they confirmed that staff listened and acted on their feedback. However, there was no record of action taken to address this concern. An action plan had been recorded for the previous survey in 2015, which stated 'It is proposed that the residents are asked for their thoughts and preferences.' However, this did not specify what action was needed to ensure this requirement was met.

The provider held monthly resident meetings to obtain people's feedback about the service. Some people told us that they had not attended these meetings. In February 2016 meeting minutes recorded that, 'All residents currently said they were happy with the running of the home and did not have any suggestions.' In January 2016, 'One resident requested a change to the menu and wanted a jacket potato instead of lasagne.' Another person wanted more staff to come and visit them in their room. The records did not provide evidence of follow up or that the registered manager was acting on people's feedback. Overall, the records of meeting minutes did not evidence how people's suggestions were acted upon. Where people did not attend resident meetings, other methods had not been considered or recorded to ensure their feedback was obtained.

We asked staff whether they provided feedback to promote continuous improvement of the service. Staff could not provide us with examples of how suggestions they had made had contributed to improved practice and service quality. The training consultant talked to us about feedback from staff about training they completed. They said, "Staff usually say they have learnt something, but they rarely give feedback on the training material or what could be improved." Staff consultation systems were not in place to ensure feedback from staff led to service improvements.

There was a quality assurance system in place; however improvements were needed to ensure continuous service improvements were made. For example, there was a care plan audit system in place to ensure people's care plans were up-to-date and reflected their most current needs. The last audit was completed in February 2016. This audit recorded there were no issues that needed addressing. The audit did not identify shortfalls that we found at this inspection. One person's care plan did not reflect their most current needs. Some people's care plans did not contain person history information to ensure people received care that met their individual needs. Where people were not motivated to undertake activities, there was no recorded evidence of creative ways of promoting people's participation in individual activities. The provider's audit system had not ensured that all records such as supervision and appraisals, handover and hydration records were consistently up-to-date, sufficiently detailed and available to support effective care planning and for the purposes of the inspection.

The provider did not complete an internal medicines audit to promote continuous improvements in medicines management. Improvements that we identified as part of the inspection had not been identified by the provider. No internal audits were carried out during the year in conjunction with the pharmacy audit to provide a more robust medicines audit system.

An independent person visited the home monthly to review essential standards of care. However, the audit framework was out of date and did not reflect the current regulatory framework for inspection of care services. The last report recorded that the home had substantially met all essential standards of care. This report had not identified the shortfalls we found at the inspection. The audit had not scrutinised the home or identified how improvements could be made. No objectives had been recorded and no subsequent action plan devised following each visit. Therefore no follow up actions were available or had been recorded.

The registered manager talked to us about plans they had to improve the service. For example, they wanted to introduce the 'Gold Standards Framework' in end of life care. They told us they planned to work in conjunction with the local hospice for end of life care, to promote and develop best practice. They wanted to develop dementia care services for people living with dementia. However this information was not recorded in a service improvement plan to demonstrate how and when service improvements would be achieved.

The registered manager told us the home was refurbished every year or as needed. For example, due to high winds the roof tiles came loose from the gazebo in the garden. This maintenance work was prioritised and completed. The lounge contained new chairs and new flooring had been laid in January 2015. New bed linen had been purchased recently. The home was refurbished to a high standard. However there was no refurbishment plan in place. There was no record of refurbishment work completed and future work to be carried out at the service to demonstrate that quality standards were continuously met.

Staff attended team meetings to discuss people's support needs, policy and training issues. Staff meeting minutes did not reflect discussions about policies, safeguarding investigations taking place or lessons learned from incidents and investigations. There was no evidence that staff were encouraged to make

suggestions about how to improve the service. Actions from meetings were not recorded; therefore outcomes were not routinely recorded to demonstrate action had been taken.

Comprehensive audits were not in place to ensure service quality improvements in all areas. There was a lack of records to demonstrate actions taken in response to audit shortfalls and consultation processes. Records such as care plans, supervision and appraisals, handover and effective hydration records were not consistently up-to-date, detailed and available. There was no service improvement plan in place to demonstrate how service improvements would be achieved. This is a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The registered manager was responsive to suggestions for improvements during the inspection. They said, "The inspection has given me insight into how I can improve on evidencing outcomes for people. This was also an opportunity to reflect on good areas of practice. We want the highest possible outcomes for people and high quality care." The registered manager acknowledged that improvements to audits and record keeping were needed to promote service improvements at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent 1. Care and treatment of service users had not been provided with the consent of the relevant person. 2. Paragraph (1) is subject to paragraphs (3) and (4). 3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*. * Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 1. Effective systems were not in place. 2. Systems did not enable the registered person to: a. assess, monitor and improve the quality and safety of the services provided b. assess, monitor and mitigate the risks relating to the health, safety and welfare of people c. maintain complete records of the care provided to people and of decisions taken about their care e. seek and act on feedback from people f. evaluate and improve their practice in

response to information received