The Salvation Army Social Work Trust

Youell Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 5 April 2017 and was unannounced.

Youell Court is a residential home which provides care for a maximum of 40 older people, and people who live with dementia. The home has three floors. The ground floor is primarily used to support people on respite; the first floor supports people who live with dementia; and the second floor supports people who are more independent. At the time of our visit there were 30 people who lived at the home.

At our previous inspection on 16, 22 and 30 August 2016, the provider was rated as 'Inadequate' overall, and placed in 'special measures'. We identified three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to improve staff numbers, staff training and support; improve staff understanding of the risks related to people's care so they could minimise these; improve the administration of medicines and the implementation of the Mental Capacity Act; improve management responsiveness to concerns and complaints raised; and improve management checks and audits to support the home becoming a better place for people to live.

The provider responded immediately to the concerns raised at our previous inspection. They sent us an action plan detailing the improvements they were going to make and were in regular contact with the CQC informing us of how they were progressing.

During this inspection we checked if improvements had been made. We found sufficient action had been taken in response to the breaches in regulations and the home was no longer in 'special measures'. However, there were some areas where further improvements were required. The provider had plans in place for on-going improvements to be made.

At our last inspection the home had a registered manager but they had been unwell for much of the time they had been employed at the home. 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.

Since our visit the registered manager had left the service and the provider had put interim management measures in place to support staff. The most recent interim manager secured the permanent manager position the day after our inspection visit.

There were enough staff on duty to keep people safe. There continued to be a high level of agency staff employed at the home however the provider tried to ensure they were staff familiar with the needs of people who lived at Youell Court.

Risks to people's health and well-being were now known by staff, and written risk assessments and care plans mostly had up to date information to support staff in their knowledge of people. Medicines were mostly managed safely.

Staff had received training to support people with their health and social care needs, and specialised dementia care training meant people who lived with dementia received much more responsive and effective care than previously.

Staff now understood the principles of the Mental Capacity Act, supported people to make informed choices, and where necessary acted in people's best interest when it had been assessed the person was unable to make their own decision.

People and relatives now felt their concerns or complaints were listened to and addressed. Complaints were managed in accordance with the provider's complaints policy and procedures.

People received choices of meals, and food which met their specific dietary requirements. Most people enjoyed the meals provided.

Staff had time to provide care which met people's physical, social and emotional needs. They supported people's dignity and privacy and treated people with respect.

People were much more engaged in individual activities, group activities, and activities that supported and maintained levels of independence. Visitors were made welcome in the home.

Previously the morale of most staff, people and relatives was low. This time, staff told us they were happy in their work, there was a relaxed and calm atmosphere in the home, and people and relatives reported there had been big improvements to the quality of people's lives.

The home had continued to have a lack of continuity in management. The most recent interim manager had been in post for two months and had secured the confidence of people, staff, and relatives. Whilst they had made big improvements during their time working at the home, these had not been tested over a longer period of time to ensure they could be sustained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

There were enough staff to meet people's needs, but there continued to be a high number of agency staff who worked at the home. Risk assessments were mostly up to date and mostly informed staff of what the risks were and how to manage them safely. Medicines were mostly managed safely. Staff understood how to safeguard people from harm and people felt safe living at the home.

Is the service effective?

Good

The service was effective.

Staff had received training to meet people's health and safety needs. Additional specialised dementia training had greatly improved staff's effectiveness in working with people who lived with dementia. People received food and drink which met their specific needs, and all people received a choice of meal. When necessary, people were referred to the relevant healthcare professional to support their healthcare needs.

Is the service caring?

Good

The service was caring.

Staff were kind and considerate of people's needs and wants. They treated people with respect and dignity and supported people's right to privacy. Visitors were made welcome in the home.

Is the service responsive?

Good

The service was responsive.

People received care that was centred round their individual needs and preferences. Individual and group activities supported people's interests and hobbies and engaged them well. Concerns and complaints were managed well, and meetings for people and relatives who lived at the home gave people and relatives opportunities to have a say about the care provided to people

who lived at Youell Court.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

The registered manager had left the service and interim management was put in place to support staff. The provider had worked with interim managers, local authority commissioners and the CQC to improve the service provided to people. The latest interim manager had just been recruited to the permanent manager position. They had won the confidence of people, staff, and relatives because of the changes they had made, however these changes had been recent and it was too early to assess whether they would be sustained.

Youell Court

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 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 5 April and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our visit, we reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority or clinical commissioning group (CCG). We also reviewed the provider's action plan which was sent to us after our last visit.

We spoke with two people and seven relatives. We spoke with eight care staff, the chaplain, the activity worker and the interim manager. We spent a lot of the inspection observing the interaction between staff and people.

We looked at a sample of medicines records, six care files, two staff files, the complaints record and management checks and audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection 'Safe' was rated as 'inadequate.' The provider had breached Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not enough staff to meet people's needs and to keep them safe, and a high use of agency staff meant people were often supported by staff who did not know them. Medicines were not managed safely because when staff administered medicines to people they were constantly interrupted.

We contacted the provider after we had completed our previous inspection because we were very concerned about the low staffing levels and people's safety. The provider immediately acted on our concerns and increased the number of staff in the home to ensure people were safe. A relative confirmed this by saying, "I feel the home responded overnight to the inspection report. We noticed a big difference."

The provider informed us the dependency levels of people had not been accurately identified and this had contributed to there not being enough staff to meet people's needs. Soon after our visit they started to look at people's dependencies to determine how many staff would be needed to provide sufficient support to keep them safe. The provider had also stopped admitting new people into the home until they were assured they had enough staff.

During our previous inspection visit there was a high use of agency staff. During this visit there continued to be a high use of agency staff. The interim manager told us it had taking longer than anticipated to recruit the 'right' staff to work at the home. They told us they had new staff ready to start work once pre-employment checks had been completed. We were told the home tried to use the same agency staff to provide people with continuity of care. A team leader told us, "We still use agency but we have dedicated ones. It works really well because they [agency workers] have inductions (to the home) and know our service users [people] as good as we do." A person told us, "I'm much happier now but they still need more regular staff."

During this visit we saw there were enough staff to meet people's needs, and staff had clear direction from management about what their roles and responsibilities were for the shift they were working. This contributed to people's safety and well-being. People and their relatives mostly told us staffing levels and deployment kept them safe. For example, one relative told us, "I've no concerns currently. I had some concerns last August due to staff shortages. It's improved now there are more staff and the 'Butterfly Project' (a project to support the needs of people who lived with dementia) has made a difference." Another relative told us, "They've definitely got more staff. The difference is huge, people seem a bit calmer, there is a calmer atmosphere and it seems more homely."

Staff told us there were now enough staff to meet people's needs. One member of staff told us, "Staffing since the last inspection is no longer a problem. I really do feel it has been addressed. Staffing levels are now good." Another told us, "There is usually enough staff to meet people's needs. It is only when someone is absent is it a problem."

At our last visit we had concerns about the administration of medication. This was because there was only

one team leader responsible for administering medicine to all the people who lived at the home. This team leader was constantly interrupted during the administration of medicines because they were also responsible for other care duties as well. During this visit we saw one member of staff on each floor administered people's medicines. A member of staff explained how the increase in staffing had had a positive impact on people and staff. They told us, "For example now I do medication for four people not 30. It means I can take my time and not rush which makes it so much better for the service users."

This meant the home was no longer in breach of Regulation 18 (Staffing). However improvements are still required in reducing the number of agency staff working at the home.

At our previous inspection, the provider had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe care and treatment). This was because the administration of medicines was not managed safely, and risk assessments relating to the health and safety of people were not up to date and reviewed by staff who had the experience to do so.

During this inspection we found medicines were mostly managed safely. Previously people were not receiving the medicines they required at the time they required, and there were gaps and omissions in the medicines administration records. During this visit we saw that people had received the medicine they needed at the right time. One relative told us," I come at various times, her medication seems regular." A person told us, "I do take medicine. They are in the locked cupboard up there, staff do it. There are no delays in giving me my medication."

The medicine administration records for medicines in tablet form were completed correctly. Records for topical medications (these are usually prescribed creams which are applied to the body) did not always record where on the body the creams should be applied. A team leader told us there should have been a body map to inform staff where the cream was to be applied and the frequency. They informed the interim manager of this concern who said they would address it.

Staff administered medicines on an 'as required' basis. This was usually when people were in pain, or when their behaviour had changed. We found some of the medicine plans for these medicines did not give staff enough information to help them know when medicines were required. For example, a person who would not be able to communicate to staff their needs was prescribed a medicine for 'extreme agitation'. The medicine plan did not inform staff how to identify if the person's behaviour was extremely agitated. This might lead to an inconsistency in administering this medicine, particularly with the higher levels of agency staff at the home.

We found medicines were ordered in time for people to receive their medicines, they were stored safely, and any unwanted or unused medicines were returned or disposed of correctly. People's medicines were now stored in lockable cupboards in their bedrooms and this meant people received their medicines in the privacy of their own rooms. A relative told us, "The medication in rooms is a better idea. She [person] feels she has ownership of them." A staff member told us, "Having medication in the bedrooms is much better. You have everything you need in one place. It is better for the service users because it's more private and personal."

Staff had undertaken training to administer medicines safely, and their administration practice was checked by senior staff to ensure they continued to administer and manage medicines safely. The interim manager had arranged for the supplying pharmacy to provided further medicines training including, 'Care of medicines foundation and advanced training.'

During this inspection we checked whether staff understood and acted on risks associated with people's care needs. We found there had been improvements in managing people's risks but there continued to be some areas where risks had not been recorded correctly or acted on. For example, one person's weight was being monitored monthly. We found by looking at the monthly weights the records informed us the person had lost 3.1kg in a month. This was a significant weight loss which would normally trigger further action by the home for a GP visit. We saw the GP had visited the person, but the loss of weight had not been discussed. The interim manager was informed of this. They investigated this after our visit and confirmed that the person had not lost weight, but there had been an error in reading and recording the weight which had not been identified by staff. The interim manager told us they had met with staff to discuss what went wrong and what could be done in future to make sure this did not happen again.

We were told by staff that one person was at risk of choking, however this information was not in their care plan on the day of our visit. Another person was identified as being at risk of 'insufficient diet and intake of fluids'. The action required to minimise the risk was to 'monitor and encourage'. There was no further information to tell us why the person was at risk and how staff should monitor the person, and what sort of encouragement was necessary to support the person with their eating and drinking. However in both instances, whilst the records did not provide this information, staff had a good understanding of how to support people. The interim manager told us they would address the shortfall in records.

At our previous visit we had concerns that patterns or trends in people's falls had not been analysed to see whether action could be taken to minimise the risks of people falling again. During this visit we found the interim manager had looked at how and when people had fallen to see whether action could be taken to reduce these from re-occurring.

We found the home was no longer in breach of Regulation 12, (Safe care and treatment) but we continued to require improvements in the management of risks and medicines.

Staff understood how to safeguard people from harm. We gave staff different scenarios where a person was at potential risk of abuse. They knew their responsibilities were to report their concerns to their team leader. We saw where people needed safeguarding from harm, the safeguarding authorities had been made aware and action taken to minimise risks. A relative told us, "I have never seen a staff member being abusive or agitated with people here."

Whenever there is an allegation or evidence a person has been placed at harm, the provider is required to notify the Care Quality Commission to enable us to check that people are being kept safe. During our checks on people's care records, we saw one person had been harmed by another who lived at the home. Whilst the safeguarding authority had been contacted, the provider had not informed us at the CQC of this incident. The interim manager told us they would follow this up and ensure we received the notification.

People were protected by the provider's recruitment practices which minimised risks to people's safety. The provider ensured, as far as possible, only care workers of suitable character were employed. Prior to staff working at the service, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff told us they had to wait for DBS checks and references to come through before they started working in the home. Records confirmed this.

Good

Is the service effective?

Our findings

At our last inspection, 'Effective' was rated as 'requires improvement' and there was a breach of Regulation 18 (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received the necessary training, supervision and support to carry out their duties safely and effectively.

Previously, many staff had not received training the provider considered essential to meet people's health and social care needs, or received updated training to refresh their knowledge of such issues.

During this visit we found staff had received training to effectively work with people. One person told us, "I think they are very good, very skilful indeed. They seem to do the right thing that's needed." And a relative told us, "Yes they are (well trained). They have got the new staff up to speed."

Staff had received training to support people's health and safety. This included training to safeguard people from harm, move people safely and understand food and nutrition. Staff were also booked onto external training to support them in understanding how pressure sores developed and how to detect early signs of skin breakdown.

We spent a lot of our visit in the presence of staff and people and saw in comparison to our last visit, how effective staff were in meeting people's needs. Since our last inspection, staff at the home had been working with a specialist dementia care training organization to be accredited as a butterfly home. A butterfly home is one where emotional connection with people, and understanding people's unique lived experience is given as much priority as the tasks staff have to undertake to keep people safe and secure. Staff who had received this training told us how much more they understood the needs of people who lived with dementia and how this had helped them provide people with better care. One member of staff told us, "The approach is so different. We would watch the way other carers' would do things. It made me look at my own practice."

During this visit we saw people who lived with dementia were much more calm and happy than they were during our previous visit. Staff understood their needs. A relative told us not only had they seen their relation become calmer and more settled but they had also seen, "A couple of ladies when they first came here were agitated and screamed, but that has now stopped." They went on to tell us their relation had constantly been on the phone to them but that had completely stopped too because they were more settled. Another relative told us, "The butterfly project has made a big difference. There is more interaction and it is more stimulating (for people). The staff seem more involved now. The training must have helped them."

A team leader gave an example of applying the learning gained from training to practice. They said, "Now at mealtimes we have picture cards and beads on the tables for the service users. It keeps their [people's] hands and minds busy whilst they are waiting for their food. It really does work as a distraction technique."

At our previous visit, staff had not received individual support (supervision) sessions to help guide them with their work. During this visit we found staff were now receiving regular supervision and support. A member of

staff told us, "Supervision is good. You can talk about any concerns, what you are doing right and things that can be done differently."

Previously, new staff had not undertaken the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The interim manager told us the Care Certificate modules were incorporated into the 13 week induction process which new staff had either started or were due to start.

This meant the home was no longer in breach of Regulation 18 (Staffing).

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw staff support people to make decisions about their care and ensured people who were able to, had given their consent before care tasks were carried out. For example, one care worker was heard asking a person if they were ready to get out of bed. The person declined. The staff member asked if the person would like a drink. The person declined. The staff said, "Ok [person's name] I'll pop back after breakfast." We then saw the care worker returned to the person room with a cup of tea. The care worker said, "Hi [person s name] I thought you might be ready for a nice cuppa." The person replied, "Oh yes I am."

The provider had used the Mental Capacity Act assessment framework to determine whether people had capacity to make decisions. However, these were not linked to specific decisions about their care and were not reflected in the written care planning process. For example, a person who was assessed as not having capacity to make decisions was in practice continuing to make some decisions. Staff were supporting them to make choices about the meals they were eating and the clothes they were wearing. The interim manager said they would incorporate this into the care planning process.

Staff understood the importance of giving people practicable support to enable the person to make their own decisions. A member of staff told us, "Some days people can (make decisions) and other days they can't...we always try to see if they can make decisions first." We saw staff carried in their aprons, miniature booklets from 'skills for care' which reminded them of the five important principles of the Mental Capacity Act.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the supervisory body. One person's DoLS gave permission for the provider to not allow the person to leave the home. This decision was not reflected in the person's care plan. Two care files of people who did not have capacity to make their own decisions, did not have proof of who had the legal authority to make decisions about their finances or health and welfare. This meant the home could not guarantee that people taking decisions on the person's behalf had the legal authority to do so. The interim manager told us they would check all files and make sure they had proof where necessary.

People received food and drink which met their needs. The home comprised of five units, each had a lounge/kitchen area. This meant staff could make people drinks throughout the day without leaving people unsupported. And, if people were able to, they could make their own drinks. During our visit we often saw staff asking people if they wanted a hot or cold drink. People and their relatives confirmed this always happened.

Most people we spoke with liked the food provided. People received a choice of food, and food which met their dietary needs and preferences. One person told us they were diabetic and lactose intolerant and they received a special diet because of this.

The home supported people with dementia to make choices about their meals. At lunch time the two meal options were put on plates and shown to people so they could make a choice based on what they could see and smell; instead of relying on their memory of what the dishes were called.

Staff were attentive and provided support with meals in a discreet manner. For example, one staff member noted a person appeared to be having difficulty cutting their food. The staff member knelt by the person and offered assistance. The person was heard to say, "Thank you so very much." The meal service was relaxed. People and staff chatted away discussing their families, the weather and what plants they liked. One person said, "You don't get this level of service in a restaurant. It's wonderful."

People received support to maintain their health and wellbeing. People saw other health and social care professionals when necessary to meet their physical and mental health needs. One person told us, "The GP comes in once a week, they're assigned to the home. The chiropodist, optician, and dentist comes. I'm quite happy with the service." A relative told us, "The GP comes regularly also the chiropodist…the community dental team comes here." Records also demonstrated staff contacted the relevant health care professional when there were concerns about a person's health.

Good

Is the service caring?

Our findings

At our previous inspection we found improvements were required in 'Caring' because care records did not provide up to date information about people's care needs, and agency staff did not always know what people's care needs were. Relatives told us staff did not know how to manage some of the more challenging behaviour of people who lived at the home, and staff did not ensure their relations wore their hearing aids or glasses. There were also not enough staff to support staff in being caring towards people.

During this visit we found improvements had been made. Care records had up to date information about people's needs, and whilst there continued to be agency staff at the home, most of these had worked at the home for some time and knew people well. A staff member told us that management tried to get good agency staff to come back to the home so people weren't supported by strangers.

People were treated with kindness during their day to day care. One relative told us staff were, "Definitely very caring." Another relative, whose relation had recently died at the home told us the care had, "Improved 100%," they went on to tell us, "The level of care was unbelievably good, so much one to one care."

A visiting GP told us, "The staff are really caring. They have a genuine interest in the people they care for. I consistently see staff being affectionate towards patients [people]." They went on to tell us, "The best thing I can say to explain is, I would be happy for my grandparents to live here." Staff also told us the same. One member of staff said, "I think it is amazing here, everyone works really hard, If my Grandad was here he would love it."

During our visit, staff were respectful and kind towards people in the way they spoke and behaved. For example, we saw one care worker, who did not normally work in one unit, come to the unit to collect a care file. The care worker went into the lounge to speak with people. They knelt by the side of a person, gently touched the person's arm and said, "Good morning [person name], I am just passing through but couldn't pass without saying hello. And may I say how lovely you look today." The person smiled, took the staff members hand and said, "How lovely that you stopped to talk to me. You have made my day."

Another care worker sat by a person and said, "I know you don't want to join the others so what can I do to make your day special? I know, how about starting with a nice hot milky coffee. I know that's your favourite?" The person responded, "Oh, wonderful." The staff member added, "Would it be ok if I made myself a drink and joined you. Perhaps we could have a chat?" The person said they would like that.

Staff understood people's individual needs. We saw people who needed to wear glasses and hearing aids, were wearing them. One person told us they had recently broken their glasses, but they were replaced quickly and they were given a spare set whilst they were waiting. We saw staff responded quickly to people's needs. For example, we saw one person lift their dress up and indicated they needed the toilet. Immediately the staff member called for assistance, helped the person into a wheelchair, put a blanket over them to preserve their dignity, and took them to the toilet.

Throughout our visit we saw staff engage with people and support them make day to day decisions about their care. For example, staff asked people if they wanted to be involved in the activities, people decided what meals they wanted to eat, and they decided when they wanted to get up and go to bed. One person told us, "I'm an early riser. They say 'do you want to get up?'. It's usually 5.15am, that's my regular time, I prefer that. I have stayed in bed until 9.00am by choice". In the morning of our visit we saw a number of people were still in bed asleep and woke up of their own accord at different times in the morning.

People's right to privacy was respected. A relative told us that they were always asked to leave the room and close the door before their relation was supported with personal care. During our visit we saw a care worker noted a person was using the bathroom and the door was open. The care worker immediately closed the door whilst explaining to the person what they were doing. The staff member remained outside the door giving verbal reassurance so the person did not become anxious.

Visitors were welcomed at the home. Relatives told us there were no restrictions on visiting time and they could, "Come when they liked." During the day we saw visitors coming at different times of the day and staying for varying lengths of time. Visitors joined in with their relations when they undertook activities, as well as meeting with them privately or being with them in the communal lounge/kitchen areas.

Good

Is the service responsive?

Our findings

At our last inspection, the home was rated as 'requires improvement' because care planning did not focus on the needs of each person as an individual, people and relatives did not feel there were enough activities to engage people who lived at the home, and some people and relatives felt the management did not respond well to day to day concerns they had raised.

During this visit we found all areas which required improvement had improved. Care plans focused on the needs of each person as an individual, and included information about 'things I can do for myself, and things I need help with.'

Where possible, the home had found out as much as possible about people's personal histories and their likes and dislikes, and had included people in the care review process. A relative told us, "They ask me at reviews several times about her likes and dislikes and her history." A person told us, "They sit and discuss my care with me about every month. You can see what they have written. I can give my opinions, they act on them." We saw people's likes and dislikes were acted on. For example, one person's care record told us the only hot drink a person liked was hot chocolate. We saw this person was offered hot chocolate throughout our inspection visit.

Care plans were expected to be reviewed every month to ensure the staff responded to people's changing needs. Some care plans had not been updated since November 2016. The interim manager was aware of this and was taking action to ensure care plans were updated monthly.

Staff had a good understanding of people's personal histories and used this information when engaging with people. For example, one person used to be a nurse and had previously lived in Ireland. We heard a member of staff use their knowledge of the person's previous history to engage with them about their experiences over their meal at lunchtime.

Some care practices had changed to reflect the training staff had received as part of the butterfly project. For example, staff no longer wore uniforms to make the units feel more of a home-from-home, and night staff wore their pyjamas to work. This was to help people who lived with dementia understand it was evening time or night time because people had changed into their night wear. The interim manager and non-care staff also joined people who lived at Youell Court at lunchtime. This meant lunchtime was more sociable, and provided care staff with more time to respond to people's social needs as well as their physical needs.

The butterfly project training had improved the way staff responded to people who lived with dementia. For example, some people took great comfort in having dolls which they looked after as living babies. We saw staff supported people who saw the dolls as babies. For example, a person was walking in the corridor with their baby in the pram. It was mealtime and staff encouraged the person to come to the dining area to eat their meal. They reassured the person the baby was nice and settled in their pram and was sleeping. They said they would keep an eye on the baby whilst the person had their meal. The person was then happy to leave the pram and have their meal.

The environment had been improved to support people who lived with dementia. There were pictorial and word signs to assist people to navigate around the units; and outside people's bedroom doors there were memory boxes which contained artefacts to remind people of their past, and to assist people in identifying their bedrooms.

Different coloured paint on walls and doors helped people to know where they were located in the unit, and doors to rooms where people might be at risk if they entered (storage rooms), were painted the same colour as the walls to stop people's attention being drawn to them. A mural on one of the walls was painted by one of the care staff. Tactile objects such as necklaces and clothing were hung in hallways to provide interest to people as they were walking through.

People were encouraged to maintain their independence in the home. We saw people help to wash up and lay the table. One person was folding napkins whilst another person was placing the cutlery. Staff were heard giving, continuous, verbal encouragement. One staff member said, "You are doing a fabulous job. I'm getting worried this could mean I will be out of a job." Once the table was laid one person said, "Well how beautiful does that look." A member of staff told us, "Residents have more activities, they go out now. I have been here two years it is now absolutely brilliant, residents get more involved."

At our last inspection, the home was waiting for their new chaplain to commence employment. They hoped this would improve the individualised activities provided to people as the chaplain was known to have an interest in working with people who had dementia. At this visit we spoke with the chaplain who confirmed their interest in supporting people with dementia and demonstrated they supported the home with a lot of activities. The chaplain had become the 'project lead' and trainer for staff working with people on the butterfly project.

The individualised activities for people, and the group activity programme devised by the activity worker, as well as the chaplain's engagement with people, provided people with a range of activities to promote their social, emotional and spiritual well-being. On the day of our visit there was a group activity in both the morning and the afternoon which were well attended by people.

At our previous visit, some people had not been made aware of the activities which were available to them. During this visit we saw staff remind people on the different units of the activities and ask if they would like to be part of them. People and their relatives enjoyed the activities. We overheard a member of staff ask a person if they were okay. The person replied, "I'm happy."

We discussed with the manager and chaplain how responsive the home was in relation to equality, diversity and human rights; and how it promoted inclusion for people of all religions, cultures and sexual orientation. The chaplain told us whilst the home was a Salvation Army home which was a Christian organisation, people from all faiths were welcomed to stay in the home and part of their responsibility was to ensure people of different faiths had access to those faiths. They told us people from the LGBT community (Lesbian, gay, bi-sexual and transgender) would be welcome in the home but acknowledged they had not considered how they could ensure people would know they would feel included and welcomed. They said they would link in with the wider Salvation Army to see how they could promote inclusivity from this community.

At our last visit some relatives felt that whilst management listened to their concerns, they did not act on them or make changes in response to their concerns. During this inspection relatives were much more positive that when they raised a concern or complaint, the issue would be dealt with effectively. One relative told us, "I haven't made a complaint, I have spoken informally. Once I mentioned that [person's] nails were dirty, they resolved it straight away. I've not noticed it happening since." Another said, "I know there is a

complaint policy. I would speak to the team leader about minor issues, they are always resolved. Last August a carer gave her the wrong food, she is celiac. Now they put notices up to avoid this happening."

The interim manager had recorded all concerns and complaints raised and the actions taken in response to these concerns. We were satisfied all issues had been properly investigated and where necessary, improvements had been made. A relative told us, "Their (management) communication is so much better and is still improving."

Since our last visit, the home had introduced a relatives' forum This was for relatives to discuss any issues at the home. One relative told us, "It's going well, it has just started. It is somewhere to go with problems that we can share as a group." Another said, "I do know about relatives meetings. I have been to lots of them. The last one was six weeks ago. Some families run these meetings." There was also a 'residents meeting' for people who lived in the home to discuss their views about life at Youell Court. A person told us, "It goes on the board when there's a resident meeting, I've been sometimes. They ask you if you want points raising. They put the minutes on the board in large print. The action points can take a long time."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we rated 'well-led' as 'inadequate'. The provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).This was because the provider had not been consistently compliant with the regulations. We also had concerns the provider had not provided sufficient support to the home during the registered manager's absence and had not listened to the concerns raised by staff and visitors to the home about there not being enough staff to meet people's complex needs. Records were not always fit for purpose.

The provider accepted our inspection findings and had worked with the Care Quality Commission and the local authority commissioners to improve the service provided to people. The new regional manager for the service had been in regular contact with the CQC to provide updates on how their actions to improve the service were shaping up. Members of the senior management team had regularly visited the service to provide support to staff and to help with leadership of the home.

At the time of our previous visit, the provider had instigated an initiative with a highly respected dementia training company to improve the support provided to people who lived with dementia. We had concerns this initiative would not succeed because the fundamentals of care were not in place. However, we saw a lot of hard work by staff and management combined with the specialist dementia care training had now resulted in good dementia care provided by the home.

The home no longer had a registered manager. In the last six months the registered manager left the service, and two interim managers had provided support to the staff team. This meant the service continued to have management changes. People told us, "We have had several people as acting managers. Not sure who the latest one is," and, "From what I have seen I am happy with the interim management. It's far better to have a permanent one."

The interim manager present at our inspection had gained the confidence of relatives at the home. One relative told us, "The atmosphere is much better now with the new manager. (She is) a very approachable person." Another said, I see [the manager] walking round a lot. She is very approachable and effective. She's the best manager they've had."

Staff also told us they had confidence in the interim manager. One member of staff said, "[Manager] is really nice. I never felt I couldn't speak my mind. If I have problems I could go and see somebody. I don't feel as pressured as I used to." Another said, "Things are lovely. Communication, organisation, hand overs are so much better. We are a 'happy little family' [manager] is spot on. Everyone is told on handover when we have breaks so you know where everyone is."

The interim manager had been in post for two months. During this period of time we saw they had identified areas in the home which needed improving and had either improved them, or were working towards those improvements.

Whilst we saw the provider and interim manager had made good progress in improving the quality of care provided by the home, this had not been sustained for a long period of time for us to be certain that changes had been fully embedded into the organisation. We also found some of the leadership responsibilities of other staff in the home had not been undertaken as well as expected. For example, we found some of the care records which had been audited and 'passed' by team leaders had errors or omissions that had not been identified by them; and a statutory notification informing us of a safeguarding incident had not been sent to us by the person responsible at the time for doing so.

This meant the home was no longer in breach of Regulation 17 (Good Governance) but improvements were still required.

The interim manager contacted us after our visit to inform us they had been interviewed for the permanent manager position and had been offered the job. They informed us they had accepted the manager position and would be applying to the CQC to become the registered manager for the home.