The Salvation Army Social Work Trust

Youell Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16, 22, and 30 August 2016. The first inspection visit was unannounced, with the second announced to ensure the registered manager and head of care had sufficient time to meet with us. The third visit was an unannounced evening visit, to ensure actions the provider assured us they would take after our second visit, were in place. Due to the seriousness of concerns found during our first two visits we held a meeting with the registered manager and one of the provider's senior managers. During the meeting we shared our concerns with them and requested that immediate actions were taken to ensure people's safety. At the time of our third visit we were assured that these actions had been taken.

Youell Court is a residential care home which provides care for up to 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. On the first day of our visit, there were 37 people who lived at the home.

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. The registered manager had been registered with us since March 2016. Since then, they have had periods of absence from the home and due to ill-health. They had only recently returned when we visited.

Since our last inspection, the provider had undergone changes in the management team at the home. There had been periods of time when there was either no registered manager in post, or when both the previous registered manager, and the current registered manager were absent. There have also been changes to the head of care, and periods where no head of care has been available to support staff.

People were not always safe. There were not enough staff to meet people's needs. The provider was trying to fill the gaps in the rota with agency and bank staff. The use of agency and bank staff to cover staff vacancies meant people were not provided with continuity of care by people who knew them well. The 'staffing tool' (the system which determined how many staff were needed to meet the needs of people who lived at the home) used by the provider did not provide sufficient staff to meet the needs of people or take account of the size and layout of the building.

Risks to people's health and well-being were not always known by staff, and written risk assessments and care plans did not have up to date information to support staff in their knowledge of people. Senior staff had not had the time to update the care records, and care staff told us they did not have time to read them. During our visit we saw one person's safety was compromised as a result of staff not knowing what their risks were. Medicines were not always managed safely.

Not all staff had received training the provider had deemed as necessary to meet people's specific individual

needs or ensure their safety. Until very recently staff had not received sufficient supervision or support from the management team to help them work effectively.

Staff knew the importance of seeking consent when providing care to people, but did not have knowledge of the principles of the Mental Capacity Act, and had not received training to help them understand them. Where people had been diagnosed as having a condition which impacted on their capacity to understand, there were insufficient assessments to determine what decisions the person could make, and what needed to be made in their best interest. Deprivation of Liberty safeguards were in place for people whose reduced capacity had meant their liberty had been restricted.

Formal complaints had been addressed appropriately through the provider's complaints policy and procedure. However informal verbal complaints had not always been addressed to the satisfaction of relatives; and these had not been recorded to determine whether there were any trends or learning points from the concerns raised.

People enjoyed the meals provided, but we could not be assured that people who required support to eat and drink were getting sufficient support to maintain their health and well-being. People were provided with activities but these were mostly group activities, and individuals who either could not, or did not want to attend the organised activities, had limited opportunities to engage in other interests.

Individual staff members were kind and attentive to people. However, due to insufficient numbers of staff available, staff interaction with people was mostly when supporting people with care tasks. Friends and relatives could visit the home at any time during the day and evening.

The provider had not supported the management and staff team to ensure the home provided safe, and good quality care to people. Staff felt the new management team at the home were open and supportive to them. However, not all felt the provider's senior management team were as supportive, and felt they had not listened to their concerns about the service when they had been raised.

The provider was in the process of improving its responsiveness to people who lived with dementia. They had arranged for a nationally respected organisation to support staff in improving the care provided to people with dementia.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to

varying the terms of their registration.

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

During this inspection we found the service to be in breach of several 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?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs, and the high use of agency staff meant people were often supported by staff who did not know them. Staff told us they did not have time to read people's care plans and risk assessments and records did not support staff to understand people's risks. This meant people were at further risk of unsafe care. Medicines were not always managed safely. Staff knew how to safeguard people from abuse, and the premises and equipment were safe for people to use.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received training to support people effectively. Staff had limited knowledge of the Mental Capacity Act, although knew the importance of getting people's consent before carrying out any actions or tasks on their behalf. Deprivation of liberty safeguards were in place for people whose freedoms had been restricted. People enjoyed their meals, although people with complex nutritional needs were at risk because staff did not know their risks and had not monitored their well- being sufficiently. People had access to healthcare professionals, but information and advice from professionals was not always documented so staff knew how to support people's care.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff tried their best to provide a caring service to people, but there were not enough of them to ensure people with complex needs received the care and support they required. Staff understood how to support people's dignity and how to treat people with respect. Staff told us the provider was not always supportive.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not provide staff with accurate and up-to-date information about each person and people did not always receive care that was centred around their individual needs and preferences. An activity programme provided people with trips out of the home and organised activities within the home. However, there were limited opportunities for individualised activities for those who did not wish to, or could not, take part in the planned programme. Concerns raised by relatives or people were not always addressed by the management team.

Is the service well-led?

Inadequate

The service was not well-led

Since our last inspection there has been inconsistent leadership at the home, with a number of management changes and periods of management absence. This has had a negative impact on the care and support provided to people who live there. The provider had not given the home proper oversight to ensure people were safe, and staff had been managed appropriately.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16, 22, and 30 August 2016. Our first inspection visit was unannounced, with the second visit announced to ensure the registered manager and head of care had sufficient time to meet with us. Two inspectors conducted this inspection. After our visit we had serious concerns about the safety of people who lived at the home. We contacted the provider on 23 August 2016 and informed them of our concerns, and asked for an action plan to be sent to us within 24 hours outlining the action they would take to ensure people's safety. On 30 August 2016, we went back to the home in the evening, to check there were enough suitably qualified staff on duty to keep people safe.

We looked at information received from statutory notifications the provider had sent to us, and contacted commissioners of the service. 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 the NHS. The local authority commissioners had concerns about this service.

We spoke with seven people who lived at the home, seven relatives, and 17 staff members (this included maintenance, domestic and kitchen staff, and care staff). We received written information of concern from a family of one relative. We also spoke with the head of care and the registered manager. After our visits, we spoke with a person from the Youell Court senior management team, the police, and the local authority.

A number of people who lived at the home, lived with dementia and were unable to share their experiences of the care and support provided. We therefore spent time observing care in the lounge and other communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed six people's care plans to see how their care and support was planned and delivered and

looked at the medicine administration records of four people. We looked at other records related to people's care and how the service operated. These included daily records of people's care, additional care records for specific care issues such as monitoring of foods and fluids, recruitment records, meeting records and checks management took to assure themselves that people received a good quality service.

Inadequate

Is the service safe?

Our findings

There was not enough staff to care for people safely. The majority of people, relatives and staff we spoke with, told us there were not enough staff to care for people and staff were often not available at the times people needed them.

Thirty seven people lived at Youell Court at the time of our visit. Care was provided in five 'suites' over three floors. The ground floor suite provided care to a maximum of eight people on respite, and one member of staff was on duty on this floor to support people. The first floor had two suites which supported a maximum of eight people in each suite who lived with dementia. Two staff covered both units, alongside a team leader who was based on the floor. The second floor also had two suites catering for eight people in each suite. People on this floor were considered less dependent, although in practice this was not always the case, and had two members of staff cover both units.

The layout and design of the building, provided people with a lot of space to mobilise as they wished. Due to an insufficient number of staff on duty, it was difficult for staff to observe and supervise people at the times they required, in order to keep people safe. For example, when staff attended to the many people who required personal care, there was no member of staff available to ensure people in the communal areas or corridors were safe. Staff were often not available to meet people's needs if they used the call bell to ask for support. The team leader was responsible for supporting staff on all three floors and therefore did not have the time to supervise effectively and undertake their role.

During our first two visits we saw numerous occasions where there were not enough staff to meet people's needs and keep people safe. For example, two people were left alone in one of the dining areas for 40 minutes. Both people were sat in wheelchairs waiting to move from the dining room table. The care worker apologised to them for the wait, saying, "I am sorry, I will be with you as quick as I can but I am on my own." We saw three incidents in the dementia units which put people at risk because staff were not available to supervise them. One person was cleaning a worktop in the kitchen, and whilst this was a positive move in terms of independence, the person was next to the 'hot food trolley' which had been left plugged in and was hot to touch. We also saw another person take a knife from the dining table and place it in their pocket and a person who had diabetes eating cakes which had been left out on the table. None of these people had capacity to understand the potential risks of their actions.

People who lived at Youell Court told us of their concerns about staffing. One person told us, "There was a lady who wanted to get up and get to her walker. I had to really make her stay so she wouldn't fall." During the time this person was talking to us, we saw another person trying to walk with the person's walking frame which was not suitable for them. The other person was able to tell them and alert us to the fact this was not the correct frame, so we could guide the person to their equipment. Another person told us of their experience of staffing on the unit where they lived, "There are not enough staff. Of a night time you get one person to do the lot upstairs and down. In the morning they have two people with all sorts to do, they're flitting from one job to another – then they have medication (to do) – it's not fair on the girls."

One relative told us, "I'm very clear there are not enough staff. There has been a very high turnover of staff since mum came here. I visit all the time and see people having to wait for assistance. I have to go and try to find staff to help. On occasions when I visit I haven't seen any staff about. People ask me for help but I can't because I don't know their needs." This comment echoed the comments made by most other relatives.

Staff told us they felt there were not enough staff on the rota to meet people's needs, and this included night time staffing. There were also a number of staff vacancies and staff absences which were covered by agency staff. Whilst the service tried to ensure the same agency staff were used to provide continuity of care, we were told they often did not know people's needs. One person told us, "We have agency staff during the day and night. They have no idea what to do. I've had one or two that come up to me and say, 'What do I do?'". A relative told us, "It's worse when agency staff are on, and that is often the case. They are nice and obliging but they don't know people or their needs." Another relative told us that during a recent week-end, four of the six staff on duty were agency staff. They said the staff did not know who people were or know where things were kept. We spoke with the registered manager who confirmed this was an accurate reflection of staffing that week-end.

There was only one team leader on duty available to support people across the three floors to take their medicines. We observed the team leader was constantly interrupted when they supported people with medicines because they also had responsibility to support people with their care needs. For example, during a time where they should not have been disturbed to ensure safety in the administration of medicines; the team leader had to leave the lounge to assist a person to change their clothing; and, they later needed to collect a mop to clean a spillage from the floor to reduce the risks of people falling. This meant that on one floor people only started to receive their morning medicines at 10am. This could have compromised people's safety if they received medicines which required a four hour gap between each dose (for example, paracetamol). It also meant there was a potential for the staff member to make mistakes because they could not focus on medicine administration alone. A staff member said, "Team leaders shouldn't be included in the staffing numbers. Trying to do care and running around going from one unit to another makes it really difficult."

The provider told us they were in the process of recruiting new staff. However, this was to support a new dementia care initiative and only related to the care provision on one floor. We found staffing concerns on all floors.

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

We were very concerned about the staffing levels at the home and the risk this posed to people who lived there. We therefore asked the provider to take action and provide assurance that staffing would be increased. With immediate effect the provider increased the number of staff on each floor at all times of the day to provide people with a safer environment in which to live. We went back to the home on 30 August 2016 to check that staffing had been increased. We found that it had. We spoke with staff about whether the changes had started to make a difference. One member of staff said, "Before the staff increase it was frightening, we couldn't be in different places all at once." They felt the staff increase had made it safer for people. Two other members of staff told us they now had time to give people the personal care they wanted, and had more time to be with people.

The provider agreed to recruit new staff on a permanent basis to ensure people's safety and needs continued to be met.

The administration of medicines was not managed safely and people did not always receive the medicines prescribed to them. One of the team leaders told us that none of the people on the floor they administered medicines to, had been prescribed medication which needed to be given at a specific time. This information conflicted with what we saw on one person's medication administration record. This said, "Give at least 30 minutes before breakfast." The person was given their medicines after they had eaten their breakfast.

We checked a sample of five medicine administration records (MARs) and saw mistakes and omissions had been made in the recording of some medicines. We found medicines prescribed for two people, had not been recorded as given, but the amount in stock suggested they had. On another MAR we saw that a barrier cream used to protect the person's skin from irritation from bodily fluids had been recorded as out of stock for four days. After our visit, we contacted the manager to ask when the person started to receive their medicines again, and were told the cream had arrived into the home and had been administered to the person on 30 August 2016, 18 days after it was first recorded as out of stock. The registered manager informed us during our visit they had already identified this as a concern and confirmed they were meeting with the GP practice nurse to discuss how best to ensure medicines were received into the home on time.

The record of a person who had stronger medication administered through patches placed on their skin, did not show the places on a body map where the last patch had been placed so they could ensure the patch was rotated in accordance with the manufacturer's guidance. There was no other record which showed this information.

There was not always enough information for staff about when to administer medicines prescribed on an 'as required' basis. For example, one person who struggled to communicate their needs verbally, had been administered two types of medicine for pain. There was no medicine plan to inform staff when to consider giving the person their medicine. The team leader knew the signs and symptoms to look out for. They told us the person walked 'strangely' when in pain and leaned to the side when they were in distress. They said they would administer one type of pain relief first and then the other. This was not written down to ensure a consistency of approach with staff.

One person used eye drops to reduce the pressure in their eyes. We found two solutions were open at the same time, and the opening date had not been marked on either. This was important because the medication began to lose its effectiveness on opening and might have meant it was no longer fit for use. Another person on respite care had come into the home with a gel for use on dry eyes. This medication had been accepted into the home and was being administered to the person despite the expiry date being August 2015.

We saw that in September 2015, an internal inspection of the service by the provider's senior management team had identified the same concerns as we have during this inspection. In March 2016 they had again identified that medicines were not managed safely but no further action was taken to ensure more robust medicine management was put in place.

We were aware the provider was moving towards a more person centred approach to medicines, and was introducing medicine cabinets in each person's room so their medicines could be given to them individually, rather than as part of a more institutional medicine round. Arrangements had been made with a pharmacy company to provide staff with medicine training to support this initiative.

We looked at five people's risk assessments. Risks to people's individual health and wellbeing had not been appropriately assessed and risk assessments were not up to date. The risk assessments should have explained to staff what the health, safety and wellbeing risks were to each person, and action the staff

should take to minimise the risks. The local authority commissioning team visited the home two days after our initial visit. They checked seven care records and found risk assessments were not accurate and up to date. One relative told us, "On reviewing [person's care plan] I was surprised and shocked that nothing in the plan had been updated despite the fact [person] had deteriorated in all aspects of ability and is a lot less able to look after herself than on entering the home…a new member of staff reading this would be completely misinformed of the care needed for her."

The police had been involved in investigating a person's care at the home. Whilst they did not pursue their investigation, they told us they were very concerned about the lack of information in the person's care plan and inadequate risk assessments. After our visit the provider gave us assurances that the management team would as priority, update all people's risk assessments and these would be audited by the assistant director of older people's services for the organisation.

During our visit we were made aware of a person who lived at the home who had risks which related to food and nutrition and catheter care. The person had been identified as having risks with swallowing, which may lead to choking; and a healthcare professional had advised the person to have smooth soups and soft foods. The person's relative told us staff had previously given the person cornflakes and sandwiches despite the advice of the professional. On the second day of our visit, we saw staff gave the person soup which included pieces of chicken. This could have potentially led to the person choking. We informed the management team of this, who told us they would ensure there was a dedicated member of kitchen staff responsible for ensuring this person received the correct food.

We looked at the accident and incident records. We saw a record had been completed of each accident or incident, and learning points identified for each incident. However we did not see that falls had been sufficiently analysed to see whether there were patterns which emerged in relation to when people fell or why. After our visit, the provider gave us assurances they would ensure incidents (including falls) and accidents were monitored to identify any required actions to support people's safety.

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

People were mostly protected by the provider's recruitment practices. We looked at the recruitment files of three recently recruited staff. We saw that checks had been made with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. References had been obtained, but for one of the three staff, these references were not from their previous care employer. Instead they were from a relative. This meant the provider had not received satisfactory evidence of a person's conduct in their previous employment to ensure they were suitable for their role at the home.

The registered manager had been on leave of absence when these staff had been recruited. They said they would ensure that references were received from the person's previous employer and they would check the records of other recently recruited staff to ensure they were recruited in line with our regulations. The registered manager later confirmed they had carried out these checks and no other staff had been recruited without references from their previous employment. Staff confirmed they were not able to work alone until the recruitment checks had been completed.

Staff understood their responsibilities and the actions they should take if they had any concerns about people's safety. Staff had a good understanding of 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. One member of staff told us they had witnessed an incident

where a person was not being safeguarded, and had immediately informed their manager. Management took this seriously and referred the incident to be investigated by the appropriate safeguarding authorities.

Staff also demonstrated their commitment to people's safety by informing senior management of their concerns about staffing levels. Minutes of a meeting held with senior management in November 2015 demonstrated that care staff had informed the provider of their concerns about people's safety, and requested more staff to support them in their work. Their concerns were not accepted by the management team. Staff told us they felt the senior management team did not listen to them. The registered manager notified us when there had been any safeguarding concerns raised.

The premises and equipment were safe for people to use. The maintenance worker ensured fire, water and electrical checks were carried out within timescales to ensure people's safety. Equipment such as hoists, was maintained by the company which supplied the equipment.

We checked whether there were systems in place to ensure, if necessary, people would be evacuated from the building safely. We saw in each person's file there was a personal emergency evacuation plan (PEEP) detailing how staff should support the person if the building needed evacuated. There was also a colour code by the person's bedroom door to inform staff of those who required least or most support to evacuate. However, not all staff knew about these plans. One care worker told us, "I don't know about any emergency plans, but I know what to do to get people out if there is a fire. I don't know if people have their own plans." Another care worker told us, "I only started in April, so I am not sure about any emergency plans."

We found the contingency plan (a document which provides details of people who can be contacted, and what to do in the event of emergencies such as fire, gas, electric or water emergencies) was not up-to-date, and this included the PEEPs. The registered manager was aware this needed updating and told us this was being addressed. The provider told after our visit that the home had an emergency evacuation bag which included updated PEEPs. They also told us there was a fire liaison officer on duty during each shift. Neither the staff we spoke with, the care manager or registered manager informed us of this at the time of our inspection.

Requires Improvement

Is the service effective?

Our findings

Staff had not received enough training to meet people's individual needs. Many staff had not received all the training expected by the provider, or updated training to refresh their skills and knowledge to meet people's health and social care needs at the home. This included training about how to support people's nutrition, dementia care, skin care (pressure ulcers), and continence care.

A relative told us about concerns they had in relation to staff knowledge of catheter care. They had previously seen the person's urine bag had not been appropriately strapped to their leg or correctly positioned to ensure urine could flow freely, and the wrong size tube had been used. This increased the risk of the person developing an infection. We looked at the person's leg during our visit, and saw the urine bag had not been attached correctly because it was by the person's ankles. The head of care acknowledged that staff had not received sufficient training to support catheter care. After our visit the provider told us they would ensure that all staff who had not undertaken training in catheter care would receive this, and all other staff would receive training to refresh their skills in this area.

Another relative told us they had concerns that staff had not received sufficient training to understand and support people who lived with dementia. They told us that one person who lived in the home was quite often "Upset and disturbed", and they often had to go and help by diffusing the situation as staff did not appear to know how to. The staff training record showed us that many of the permanent care staff had not received dementia care training.

We asked new staff how, when they first started work at the service, they had learned about the home and the needs of people who lived there. They told us they had completed an induction. This included working alongside a more experienced staff member and undertaking some specific training the provider considered essential to meet people's health, safety and care needs. One recently recruited member of staff told us, "Even though I have been in this work for many years I had to complete an induction. It's a requirement. I did three days induction which for me was good." They then went on to say, "I think inexperienced staff need more." The provider told us new staff worked alongside other more experienced staff for three days, and the induction lasted three to six months.

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 head of care informed us they had the paperwork available to start the Care Certificate but had not the time to implement this. The Care Certificate requires observed practice so that the person in charge of the training can be assured that the new member of staff has the attributes which are necessary to provide high quality of care.

The head of care also acknowledged they had not had the time to provide all staff with individual staff support such as one to one supervision sessions. They hoped that with the registered manager having returned from a leave of absence, and the recruitment of a new team leader, they would be able to do so soon. One member of staff told us, "I haven't had supervision since I came here (they had been in post eight

months) but I think they are planning one." Another staff member said, "We have just had new team leaders so supervision has just started again. It's good because you can express how you feel and talk about what you are doing or need to do."

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

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.

The registered manager understood their responsibilities under the Act, however the principles of the Act had not been followed. Written assessments in people's care records to show how the home's staff were aware of what decisions people had the capacity to make, and which decisions needed to be made by others in the person's best interest were not in place. This was important as staff who were unfamiliar with people's needs and abilities did not have information whilst supporting people whose capacity to understand might be compromised.

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. The registered manager had notified us to tell us that 11 people who lived at the home were under a DoLS. This information was not available in people's care records. Staff we spoke with did not know who had a DoLS in place and what safeguards had been approved that staff needed to work within. They had limited understanding of what constituted a deprivation of liberty. One staff member said, "I don't know about DoLS. I think I have to do training." A team leader told us, "It's about having locked doors and protecting people."

The majority of staff told us they had not received training in the MCA. We checked the training matrix and the provider's last audit in March 2016. Both of these confirmed staff had not received this training. Staff we spoke with did not have a clear understanding of the MCA, however they understood they should not force people to do anything against their will. One staff member said, "We always ask people if they are ready for us to help them, if they decline we go away and try again later."

We saw this happen in practice. We heard a care worker ask a person if they would like to get out of bed and dressed. The person declined. The care worker said, "OK, would you like me to fetch you a nice cup of tea?" We saw the care worker return with a drink.

On the first day of our visit, we arrived at the home at 7am. We were able to see into people's bedrooms because many of the doors were open. We saw a few people asleep on their beds in their day clothes from the previous day. We were told these people had declined staff support in getting ready for bed. We were concerned that night staff did not have the time to go back to people who had refused personal care, to encourage them to receive personal care and get into the night clothes. During our third visit to the home in the evening, we saw most people were ready for bed. Some were still in their day clothes. Staff told us they had asked people if they wanted to get ready but had declined. It was 8pm, and staff told us they would try

again later to encourage people to change into their nightclothes.

People with more complex needs did not always receive food and drink which met their needs. We were aware the local authority had visited the home in between our first two visits. They had identified that people at risk of dehydration or poor nutrition did not have adequate records in place to monitor their intake.

During our second visit we saw that staff had started to record food and fluids taken but the recordings were insufficient to give an accurate account of people's intake. For example, for one person, the record for a whole day showed the person as having 'water' on one occasion, and 'tea' on another occasion. We could not be sure whether this meant the person only had two opportunities during the day to have a drink or whether the record was inaccurately completed. The record also gave no indication of the person's daily fluid intake goal, or how much of the water or tea the person had drank.

Care records did not provide us with reassurance that people who had been identified as being at risk of malnutrition were receiving the support they required to improve their health and well-being. For example, one person's care plan identified in March 2016 that the person had lost weight and asked that staff, 'Ensure [the person] is eating and drinking enough.' The nutritional risk assessment showed the person as at risk of weight loss but did not identify any actions staff needed to take. The head of care confirmed they had contacted the GP to seek advice, but the advice had not been recorded so we could not see if this had been acted on.

People told us they enjoyed the meals. One person said, "I can't fault the food at all, and there's plenty of it. There is two hot meals a day here." Another said, "The food is very good. We are given a choice. [The food company] send the meals here and it is warmed up. Considering it is for a large number of people, it is excellent." We saw that staff, when in the kitchen/living rooms made good use of the facilities to support people with drinks and choices. We saw them make sandwiches and toast for people, and hot drinks of tea and coffee when people requested them.

People mostly received support to see other health and social care professionals when necessary to meet their physical and mental health needs. On person told us, "You only have to ask and they will make an appointment for you." A relative told us, "They do get the GP…I was kept fully informed, it was good." However, relatives told us, and records showed that advice given by healthcare professionals was not always documented and acted on.

Requires Improvement

Is the service caring?

Our findings

People who had more complex needs did not always receive good care. Care records did not provide up to date information to staff of people's needs, and some people were not able to communicate with staff what their needs were. The home had relied on agency staff to support gaps in the staff rota, and they did not always know what people's needs were. A person told us, The staff they bring in are helpful, it is not their fault they don't know. Half the time they don't have time to do it [care tasks] because others need help."

Relatives we spoke with, whose relations had more complex needs, voiced their concerns about people's care. They told us they felt staff were doing their best to provide care, but the staff team's lack of knowledge meant their relations' care needs were not addressed to a standard they would have expected. Their concerns included, people's personal hygiene not being adequately met and staff not ensuring people wore their glasses and/or hearing aids. This meant people could become more confused because they could not hear or see properly. One relative told us, "The fact that with them (hearing aids) she was much abler to engage with activities and conversations within the home…thereby enhancing her quality of life, did not seem to factor in her care."

Relatives were also concerned that staff did not respond quickly to people whose behaviours could challenge others. A relative told us they had seen staff struggle to understand how to meet a person's behavioural needs. They told us if the person was spoken to about when they were younger, their worries quickly receded, however some staff did not know this, and instead the person could appear threatening. Staff told us of their concerns about people being 'demanding' or 'challenging'. We saw there were insufficient staff to respond quickly to diffuse potentially difficult situations which then led to staff being challenged by people's increasing frustrations and changes of behaviour. One member of staff told us, "We have residents that call out for you all the time, and they become a nuisance, but they're not, it's just they need (staff) time."

During our visit we walked into a lounge where no staff were present. One person was stood up and pulling their skirt up to their shoulders. By doing so, they, exposed the lower half of their body and made the person who sat at the table near them angry. The person at the table repeatedly asked the person to pull their skirt down, but because of the person's complex needs, they were not able to understand what the person was asking them to do. We intervened because no staff were present, to ensure the person's dignity was not compromised and to reduce the agitation of the other person. A member of staff told us, "You have to monitor as much as you can. But you regularly have to leave the lounge because someone needs you."

People were supported and encouraged to maintain relationships important to them, and visitors were welcomed at the home. During our visit we saw many friends and relatives visit the home. However a relative told us they visited more often because they did not feel their relation would have their needs met if they did not visit often to check that staff had provided care. A relative told us they sometimes found it difficult to be let into the home after 6pm when the office staff had left. This was confirmed by a visiting police officer, who had to go around to the back of the home after repeatedly ringing the door bell and not being let in.

People who were more independent told staff how they wanted their care to be provided on a daily basis and we saw staff respected these decisions.

The majority of people and relatives we spoke with, were complimentary of the caring and compassionate attitude of individual staff members. People told us, "Staff are as good as gold"; another said, "Staff are very good. They do anything for you." A relative told us, "It is excellent. If we ask staff any questions they are good at saying what is happening."

During each visit we found staff trying to do their best to support people in a caring way, and were friendly to those they supported. For example, we saw one member of staff come up to a person and gave them a hug and a kiss. The person in response said, "That's better," clearly having enjoyed the interaction with the staff member. Staff were overheard complimenting people. For example we heard one member of staff tell a person, "You're looking beautiful today." Another said, "I think blue suits you. I know it's your favourite colour."

We saw a person was showing signs of anxiety. A care worker approached them and said, "Tell me about your mum and dad. I love to hear the stories you tell me about them." The person relaxed and chatted to the care worker whilst they laughed and reminisced together.

All the staff we spoke with told us they wanted to provide good care to people. They knew the care they provided was not always good because there was not enough of them, and had informed the provider of their concerns. Staff told us they did not feel that the provider had been caring to them in their response. One care worker told us, "We would cling to each other to help us through." They told us they felt staff had left because of concerns about the care provided.

Our third visit to the home was when staffing levels had been increased. We came in the evening and saw staff sitting and talking with people, helping them to get ready for bed, and making sure they had drinks and snacks. There were staff available to support people's care needs in a timely way. The atmosphere was relaxed and pleasant. Staff told us they had the time to give people the showers they wanted, and to meet their needs.

Requires Improvement

Is the service responsive?

Our findings

Care and support records did not have up to date detailed information from the person's perspective about how they wanted to live their lives, what they liked and did not like doing, and how they wished to be supported. For example, one person was displaying behaviours which challenged others and had lost weight. Their behaviour had not been recorded in the care records. This meant we could not determine whether any analysis of their behaviour had been undertaken to help staff understand how better to meet their needs. They had a diagnosis of dementia, but this had not been recorded in the care records, and staff were unaware of this diagnosis. The GP had visited the home on request to check the person's behaviour and weight loss, but the advice from the visit had not been written in the care records.

The head of care was open with us about the poor care planning. They acknowledged care plans were not up to date and did not reflect people's needs. They told us they had delegated the responsibility to other staff, but had not the time to monitor whether staff had carried out their delegated responsibilities. They were hopeful that now the registered manager was back at work, they could focus on this task. Team leaders told us they did not have time to update care records, and care staff told us they did not have the time to read care plans. One care worker told us, "I simply don't get a minute. My priority is the residents. I don't have the time to read the care files." This meant staff relied on people having the capacity to tell them what their needs were, verbal staff feedback, or their visiting relations to inform them of any changes.

Activities were provided for people both within and external to the home. These included bingo, daily group chats, ball games and quizzes. People also had the option of using the hairdresser and having hand massages, and taking part in the Sunday Service. During the summer months there had been trips to the local canal and butterfly farm; and visiting singers had performed at the home. However, we did not see anything which demonstrated that people who lived at Youell Court had been consulted as to whether these were activities they were interested in, or wanted.

The chaplain of the home had been involved with providing activities to people, however at the time of our visit there was no one in this post. When the activity worker was not working, no activities took place. This was because staff did not have the time to provide additional activity support. For people with more complex needs and who could not, or did not want to undertake the activities on offer on the ground floor, there were limited opportunities for their interests to be supported on an individual basis. A relative told us, usually on arrival for a visit, their relation (a person who lived with dementia) appeared 'muddled.' They went on to tell us, that by talking with the person and going through the newspaper they seemed a lot better able to understand things by the time they finished their visit. This meant if the person had more stimulation, their mental health and capacity improved.

We were told a new chaplain would be working in the home soon. They had an interest in working with people with dementia, and it was hoped more individualised activities would take place once this person started work. One person we spoke with, was looking forward to their spiritual needs being supported by a Salvation Army chaplain.

Not all people who lived at the home knew there was an activity programme. We spoke with two people on the top floor. They told us there was no entertainment, and they would like to see activities taking place. The staff member told them there was an activity co-ordinator and entertainment, and both appeared surprised by this and said they did not know.

We looked at how the service responded to people's complaints. We saw information in communal areas informing people how they could complain, and how their complaint would be managed. There was also information about who they could contact if they were not satisfied with the outcome of their complaint. We saw the service had received four formal complaints in 2016 and these had been responded to according to the provider's complaint policy and procedure.

However, relatives told us they had informally complained to the head of care about concerns they had with regard to their relation's care. They told us they felt the head of care listened to their complaints but did not always follow through on the actions they said they would. For example, one relative told us they met with the head of care to express their concerns, but they never saw any of the agreed actions followed up by care staff. Another told us that the head of care was very nice and "Listens to what you say, but doesn't seem to do anything." A third relative told us they had complained to a team leader about the care received by their relation, they were told measures would be put in place to address them. The next week, the same issues were still present. The relative went straight to the head of care, who had not been made aware of the concerns they had raised.

We spoke with the head of care about relatives' concerns. They acknowledged they had not always followed up on concerns raised. This was because they felt they had been dealing with staff absences, and had to take on the work load of the registered manager during their periods of absence. We asked if a log was kept of informal concerns to be able to track whether there were identifiable themes for individuals or for the home. They said this was not the case, but thought it would be a good idea to keep a log of informal complaints and actions undertaken. There was no system for staff to inform the head of care of concerns raised about the quality of care provided to individuals.

In the early part of 2016, the management team had provided relatives and people with opportunities to provide feedback about specific aspects of the service. For example, in response to concerns raised about the frozen meals provided to the home; a tasting evening was arranged for family and friends. There had also been a meeting in July 2016 with relatives to discuss the implementation of a dementia care strategy for those people who lived with dementia. Whilst there had been meetings about specific issues, there had been limited meeting opportunities for people and their relatives to discuss more general issues about the home and any concerns they had.

The provider had started working with a nationally recognised organisation to improve the dementia care it provided to people. The project was in its infancy, however people who lived with dementia on the middle floor of the home, had been assessed to determine their capacity to engage in tasks, interact socially with others, and problem solve. However, a relative contacted us with concerns about the accuracy of the assessments, telling us that their knowledge of their relation's abilities were at odds with the home's assessments of these. The provider had also prior to our visit, acknowledged that to provide good dementia care, there needed to be additional staff in the unit and were in the process of recruiting staff. The organisation was scheduled to provide those staff who worked in the dementia care units with dementia training in September 2016.

On the day of our visit, some changes had been made to support the project. Staff no longer wore uniforms, and wore day clothes with home/vintage style aprons (pinnies), or night clothes if they were supporting

people to bed at night. This was to create a more homely atmosphere and help people with dementia link bedtime with night wear, and day time with day wear. Whilst this was positive in terms of creating a more homely environment, we found some relatives were confused by this. A relative told us, "We were told staff would wear name badges and aprons so you could identify them, but they don't. You don't know who is a visitor and who is a staff member, particularly with the number of agency staff they use." On the first day of our visit, some staff were not wearing aprons or wearing their name badges.

Inadequate

Is the service well-led?

Our findings

Since registration with the Care Quality Commission, the provider has not consistently been compliant with the regulations at this home. In 2012, under our previous method of inspecting, the home was not compliant in 'record keeping'; in December 2013 it was not compliant in the management of medicines and staffing (not enough to meet people' needs); and in June 2014, it was again not compliant in staffing and medicines. In November 2014, after the provider had closed the ground floor unit to ensure there were enough staff to meet people's needs, it was inspected again and rated as 'Good' in every area.

Since the inspection in November 2014, the then registered manager, and head of care, left their positions, both after periods of unplanned absences, leaving the home without continuity of management. A new management team was recruited towards the end of 2015. The registered manager told us the new management team came into the home at a time where staff morale was poor, there was a high level of staff sickness and absence, and records were in a poor state. This was echoed by staff who worked at the home during this period.

In August 2015, the home was inspected by Healthwatch Coventry. Healthwatch Coventry is a local independent champion for people who use health and social care services in the area). Their report was published at the end of October 2015. There were a number of recommendations from this report. One was to provide, 'More staff on each floor especially during the night shift and a review of staffing to ensure that staff are not left on their own on any floor at any time. This should also improve the opportunity for staff to have break'. The provider's response to this was, 'Staffing levels meet national guidance and dependency levels'. The provider told us they used the 'staffing tool' required by the Care Inspectorate in Scotland to determine staffing levels. They said it was a recognised tool for determining staffing levels and it had never shown that Youell Court was understaffed. We were concerned that whilst the staffing tool had not shown Youell Court as understaffed; from talking to people, staff, relatives and from our own observations it was clear that the tool did not ensure the needs of people at the home were met with adequate staffing.

In November 2015, we received a concern from a relative about the quality of care provided at the home, and concerns about the forthcoming opening of the ground floor unit. We contacted the provider and asked if they could investigate these concerns as part of their formal complaints procedure. The provider gave us assurance they would do this, but told us that staffing was not an issue, and staff were getting familiar with a new management team who had higher expectations of them.

During this inspection visit we looked at staff meeting minutes. We saw one dated 15 November 2016. In these minutes the Director referred to the complaint we received and said, "The CQC keep all complaints and they will eventually come in on a mission. They will not stop till they find loads of things wrong and there could be enforcement and they could shut Youell Court." The minutes showed that staff were concerned about the levels of staffing and staff morale, and the Director of Operations did not agree with staff concerns. Whilst the Director told staff they did not want them to 'cover things up',the minutes of the meeting suggested that senior management felt staffing levels were sufficient to meet people's needs, and staff were wrong to think otherwise. We were concerned at the message given to staff in these minutes. The

provider told us the minutes were taken out of context. They told us there were only 27 people who lived in the home, and at the time the staff group were struggling with adapting more flexibly to the needs of the home and the people who lived there.

The new management team did not provide the management cover and improvements expected. This was because the current registered manager had periods of planned and unplanned leave due to ill health, leaving the current head of care with extra management responsibilities to fulfil. The head of care told us that prior to the manager recently returning to work, they had not, had time to fulfil the extra duties along with their own duties. This was because the increasing difficulties in recruiting and retaining staff meant they often had to work as a care worker to cover the shift.
The provider had notified us of the registered manager's absence and told us they had provided management support. This mainly consisted of senior management visiting the home, but no additional 'hands on' management cover.

Despite staffing and management issues, the provider opened the ground floor in March 2016, increasing the number of people who required staff support. This gave the home's management team more issues to deal with, and a need to recruit more staff to meet people's needs. This was at a time when there were already concerns identified.

The provider did not give the home proper oversight to ensure people were cared for safely, and staff were managed appropriately. There were monitoring visits by the provider's senior management team, and audits were carried out. However these audits identified where the home was not meeting the provider's own quality standards, but there was little analysis to understand why many of the areas checked, did not meet their standards and what support or action the provider or management team should take to improve quality.

Staff told us they did not find some of the senior management team supportive. A staff member told us they did not feel they could speak out because the response would be, 'Do you want us to close the place down.' Staff told us that a number of their colleagues had left, or went on sick leave because of the pressure of working with less staff than was needed to provide safe care. The provider told us they had no knowledge of this being said and did not believe a member of the senior management team had implied this. They also told us there were other reasons why some staff had left the home which could not be disclosed to other staff members.

Staff had not been supported enough to do their care work safely and effectively. There had not been enough individual and team meetings for staff to share their thoughts and concerns and to receive guidance in their care provision. Team leaders and care managers had not received enough support to ensure care records and risk assessments were up to date and provided staff with an accurate account of people's needs and risks. They had not been supported to have the time to receive the training important to carry out their duties safely and effectively.

This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they found the new management team more supportive than the previous team. Those who had worked with the previous management team told us they had felt frightened to raise their concerns and did not feel valued or listened to. A relative told us they had spoken with the previous head of care and they found the person 'defensive'. All staff we spoke with felt the new management team were approachable and listened to them. One staff member told us that they had previously been concerned to speak out, but felt

the registered manager was, "More open door." They said, "I know the registered manager wants to sort everything out. She is approachable if you want to discuss things." Another told us that under the previous management they felt their, "Lives were a misery" but felt that the new registered manager "Does sort things out."

The provider had instigated an initiative with a national company to improve dementia care in the home. Whilst we consider this a very positive move, as the company is highly respected in the field of dementia care; we were concerned that this was being considered at a time when the fundamentals of care were not in place at the home.

The registered manager understood the responsibilities and requirements of their registration. They notified us of any issues concerning individuals who lived in the home, and any other events which impacted on the lives of people who lived at Youell Court.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 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. Where people's capacity had diminished or fluctuated, there was no assessment to determine what decisions, they could make for themselves, and when decisions needed to be made in their best interest. Medicines were not always managed or administered safely. Concerns raised by relatives were not always acted on, or recorded for the provider to check for trends.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care records were not always fit for purpose. They did not contain up to date information about people's care needs, and did not always contain references to discussions with people or their relatives, or healthcare professionals advice. The provider's system of governance did not provide sufficient assessment and monitoring of risks to mitigate the risks to the health, safety and welfare of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff on each floor

during the day and night to support people's needs safely. Staff had not received the necessary training, support and supervision to enable them to carry out their duties safely and effectively.