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

Summary of findings

Overall summary

Youell Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Youell Court accommodates a maximum of 40 people in one adapted building across three floors. One floor provides specialist care to people who live with dementia. At the time of our inspection visit 28 people lived at the home and one person was staying at Youell Court on respite care. Of the 28 people, three were in hospital during our inspection visit.

This inspection took place on 31 January and 8 February 2018, and the first inspection visit was unannounced. The service was rated as 'requires improvement at our last inspection but there were no breaches of the Regulations. During this inspection visit we found two breaches of the regulations.

The home has 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 informed us they had not moved the home forward with improvements as much as they hoped they would. Since our last visit they had managed a number of staff performance issues which had led to an increase in staff vacancies. They had not had a stable and experienced management team in the home to support them. The provider had recently supported the registered manager by providing extra management cover to help them with their responsibilities. Some decisions taken by a member of the senior team at the home were not based on assessed need.

People who lived at the home felt well cared for and safe. But records related to their care did not always provide up to date and accurate information about their health and social care needs, or provide information to explain why some care practices had changed or been implemented. Staff were compassionate with people at the end of their life, but the home did not provide staff with training or procedures to help staff more fully understand how to support people's end of life care. We recommended the home seek further professional advice for this area of care.

There were enough staff on duty to meet people's needs, but deployment of staff was not always effective in making sure people's care needs were always met in a timely way. Communication between care staff and their seniors did not always ensure staff were aware of people's changing needs. The use of agency staff had reduced from 88 percent at our last visit, to 43 percent at this visit. The provider 'block booked' agency staff to support continuity of care.

People enjoyed their meals and changes to meal times had improved people's well-being. Some people

were provided with specific diets, but records did not explain why they had been placed on these diets and staff did not know. The registered manager had recently contacted the appropriate healthcare professionals to ask them to assess whether people needed to be on these diets.

Medicines were managed safely and staff recruitment procedures meant staff could not start work until all checks on their suitability had been carried out. Staff understood how to safeguard people from harm.

The premises and the equipment used to support people's needs were safe and well maintained. There had been further improvements in the décor of the units which housed the 'butterfly project' to support the needs of people who lived with dementia. The home was clean and staff knew their responsibilities to maintain cleanliness and reduce the risks of infection.

Staff had received training to help them keep people safe, and to help them work effectively with people who lived with dementia. Staff felt supported by the manager to carry out their roles and responsibilities.

People were treated with dignity and respect. Staff recognised the importance of maintaining people's independence and did their best to do so. People were asked their consent prior to any care task being delivered.

People's lives were enhanced by a range of activities. These included group activities and ones which linked more with people's individual interests and past lives. Relatives and people who used the service were provided with opportunities to share their views of the service, and complaints were managed in line with the provider's policy and procedure.

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 not always safe.

Care plans did not always contain updated information for staff to make sure they could manage the risks related to people's care. There were enough staff to meet people's needs, but deployment of staff was not always effective. Medicines were administered safely to people, and staff recruitment procedures supported the recruitment of suitable staff. Staff knew how to safeguard people from harm. The home was clean.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had the skills, knowledge and experience to support them in their roles, but staff had received training to provide them with a good understanding of dementia care and health and safety. People enjoyed the meals provided, but some people had regularly eaten meals prepared for them in a way they might not have needed. People were given good support to attend healthcare appointments or to receive healthcare within the home. The 'butterfly' project units had been further adapted and decorated to support people with dementia. Staff understood the importance of gaining people's consent before providing care.

Is the service caring?

Good

The service was caring.

People were treated by staff with dignity and respect. Staff supported people's right to privacy and encouraged people to remain as independent as they could. Staff were kind and considerate of people's needs and wants. Visitors were made welcome in the home.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Not all people who lived at the home had their care reviewed in a

timely way but staff were responsive on a daily basis to people's individual needs. There were a range of activities available for people who used the service. Complaints were managed according to the provider's policy and procedure. The provider did not have procedures and guidance to support staff in the provision of end of life care.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

The registered manager had experienced changes in the home's management team, and had faced some challenges with staff performance. Management of these issues had reduced the time available for the manager to undertake some of their other expected management functions. Communication between staff and the leadership team in the home had not always been effective, however staff felt supported by the registered manager. People and relatives thought the home was managed well.

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 was partly prompted by concerns raised to us by three people who shared their experiences about the management of the home and the quality of care provided to some people.

The inspection visit took place on 31 January 2018 and 8 February 2018. Our first visit on 31 January 2018 was unannounced. During our visits to the home we spoke with five people who lived at Youell Court and six relatives. We spoke with 10 staff members including care staff, housekeeping, administration, maintenance, activity staff, the chaplain and management. We also spoke with three visiting healthcare professionals.

We spent time on each unit engaging with people and staff to see how care and support was delivered. We also looked at a range of records including, five care records, two staff records, training records, seven medicine records, health and safety records, continence records, staff communication books, incident and accident records, staff meeting and resident meeting minutes, quality assurance records and complaints records.

On 31 January 2018, 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. On 8 February 2018 the inspection team comprised of two inspectors.

Prior to our inspection visit we looked at statutory notifications sent to the CQC by the provider (statutory notifications provide information about important events which the provider is required to send to us by law), information received from the public via our 'share your experience' web form, and spoke with the local authority commissioners find out their views of the service. Commissioners are people who work to find appropriate care and support services for people and fund the care provided.

Requires Improvement

Is the service safe?

Our findings

This key question was rated as 'requires improvement' at our last inspection visit. The home continued to require improvements in this area. Whilst we found improvements were required, people told us they felt safe at the home. One person said, "I feel safe as there are good people here." Another said, "I feel safe here as I kept falling at home and was worried."

At our last inspection we checked whether staff understood and acted on risks associated with people's care needs. We found there were some areas where risks had not been recorded correctly or acted on. At this inspection visit we found again that some risks had not been addressed, and others had not been appropriately managed.

Those people at risk of skin damage were provided with pressure relieving mattresses which were designed to ensure air flowed through the mattress to reduce the pressure on people's skin. However, for the mattresses to be effective they needed to be set at the correct setting which was linked to the weight of the person. The registered manager was not aware of this responsibility and we saw none of the beds had been set according to people's weight. They said they would make sure mattress settings were set correctly and put checks in place to ensure they continued to be at the right setting.

Where people are unable to move independently, and this puts pressure on their skin, sometimes they are assessed as needing to be repositioned in bed by staff to reduce the risk of too much pressure being applied to one area of skin to prevent pressure sores. We found all people who were at risk of skin damage were on a regime of being turned in their bed every two hours, both day and night. Staff told us a senior member of staff told them a district nurse had advised them this was the procedure to follow, but we could not find notes from the district nurses with these instructions. We were concerned that all people with a risk of skin damage were being cared for the same and the care provided was not meeting their needs.

When we looked at some completed repositioning records, we found one person, on one night between midnight and 7am was repositioned six times. There was no reason given as to why the person was repositioned so much. Our concerns were that if this was initiated by staff, the person was not given the opportunity to sleep properly. Another person could reposition themselves, but staff were still repositioning the person every two hours. We asked staff why they were repositioning this person, but they said they did not know. After being made aware of this, the registered manager contacted the district nursing team and requested they visited to assess each person's individual needs.

This meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We checked the premises and equipment were safe for people's use. We saw fire alarms were regularly tested to ensure they worked. Staff had undertaken fire training, but not all staff new to the service had undergone a fire drill to make sure they knew what to do in the event of a fire. We were told this would be rectified soon, but the majority of staff on each shift had undertaken a drill, and all staff had received fire

training as part of their induction to the home. We looked to see whether there were personal emergency evacuation plans (PEEPs) to support staff and emergency services in knowing what levels of support people might need in the event of an emergency evacuation of the home. The PEEPs were kept in a grab file on the ground floor so they were easily accessible to emergency services. However we found there were still out of date PEEPs in people's care files. The registered manager told us they would be removed.

At our last two inspections we found the provider had to use a high number of agency staff (staff employed by an agency which provides staff to other services where there are either short or long term staff shortages) to cover the staff rota to ensure there were enough staff to provide care and support to people. During this visit we found the levels of agency staff, whilst reduced from our previous visit, were higher than the provider told us they had hoped them to be. One person said to us, "There is often agency staff on."

The provider had continued to block book agency staff to provide continuity of care to people who lived at the home. They told us the number of agency hours would soon significantly reduce as clearance checks had just been received for five prospective new staff who would soon be starting their induction to the home. The provider's use of agency staff had dropped from 88 percent at our previous inspection to 43 percent at this visit.

We looked to see if there continued to be enough staff on duty to meet people's needs. One person said, "Currently I think there is just about enough staff." Another said, "I feel safe when there is enough staff."

There were 29 people being supported at the home at the time of our inspection. Ten staff were on the duty rota to support their needs. The lay out of the home provided people with spacious corridors and bedrooms, with inner courtyards so everyone had access to open space. The first and second floors were split into two units with lounge/dining facilities within each unit. Whilst these were good facilities for people who lived at the home; they also meant a lot of physical space had to be covered by staff to get from one area of the home to another.

At our previous visit, staff told us they felt there were enough staff to meet people's needs. During this visit we were told there were not always enough staff available on the first floor to provide safe care. We were told there were five staff to support people on the first floor, where 13 people lived across two of the units. One of the staff was a team leader who had responsibility for all three floors. This meant they were routinely required to support staff on other floors with medicine administration, GP surgeries, and any other issues requiring leadership.

On both days of our inspection we saw the team leader was often called to support staff on the different floors. When the team leader was working on a different floor this meant there might not be enough staff to monitor people in communal areas if the other four staff were supporting people with higher dependency needs. One member of staff said, "We find it hard. If we are both with a person who needs two [staff] in a bedroom and another person comes out their room we get in trouble because there is no one to look after them." Another member of staff said, "I don't know what to do I can't split myself in two." During our visit we did not see any unsafe care. The provider informed us they used an 'evidence based' tool to determine staffing levels, and they 'overstaffed' in relation to this tool to compensate for the lay-out of the building.

We found there was no communication devices used to enable staff to contact the team leader quickly. Instead, staff had to leave what they were doing to go and find them. This could take time. We asked the registered manager if they had considered using other IT systems to make team leaders more accessible to staff. They said they had, but IT such as 'walki- talkies' had been considered incompatible with the 'butterfly project'. The butterfly approach is a person centred model of care which is a 'feelings based' approach

promoting a family environment. They said they would re-visit this again in an attempt to make improvements.

As well as concerns relating to people's safety staff also said that when the team leader was not available, they could not access people's care records or medicines because the team leaders carried the keys. One member of care staff said, "We're told you can access them anytime, but they are locked up." The registered manager told us they were looking at how they could support staff to have easier access to records, but at the same time maintain the security and confidentiality.

We looked at how the provider managed falls, incidents and accidents, and what action they took to reduce the risks of falls or incidents re-occurring. Records showed the registered manager completed a monthly falls analysis to establish any patterns or trends in relation to people's falls, and if trends were identified then action had been taken. For example, after analysing a person's falls in December 2017, the GP had been contacted and asked to refer one person to the falls team.

Accident and incident records were completed, although we found that some had limited information. Neither of these records had been analysed by the registered manager, and they were not sure if the provider undertook analysis. Team meeting minutes showed the registered manager had spoken with staff about the completion of records and had reminded staff of the importance that these were fully completed and accurate.

The provider's recruitment practices minimised risks to people's safety. The provider ensured, as far as possible, care workers of suitable character were employed by the home. 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, and records confirmed they had to wait for DBS checks and references to come through before they started working in the home.

We found other safety checks for gas, water and electricity had been undertaken either by the maintenance worker, or by external contractors who specialised in areas such as legionella, within the required and recommended timescales. External contractors had also checked the equipment used by people such as hoists, and lifts to make sure they were safe to use. We saw staff using equipment which supported people with moving safely. One person said, "I feel safe when I am hoisted."

We checked whether medicines were managed safely. Prior to our inspection visit the registered manager had contacted us to advise us of one medicine error. They had contacted the GP to check whether the error would adversely affect the person, and were told it would not.

During our visit to Youell Court we checked the medicine administration records of seven people. We also asked people if they received their medicines as prescribed. A person told us, "They never forget to give me my medication." We found the records accurately reflected the medicines given to each person. Where people were prescribed medicines to be given 'as required', there was information for staff explaining why the medicine had been prescribed and, if the person could not communicate their need, what signs and symptoms might mean they required this medicine.

Stronger medicines were stored safely and in line with the legislation. Stocks of stronger medicines matched the records kept of the number of medicines administered. Medicines which required lower temperatures to remain effective were safely stored in a medicine fridge.

Staff had undertaken training to administer medicines, and the provider had systems to check staff understood their responsibilities and were competent to support people in administering their medicines. Staff had also received training to help them understand how to safeguard people from harm.

Staff we spoke with shared their knowledge of the different types of abuse people could experience and their responsibilities to report any concerns. One said, "If I saw anything at all, a bruise or I saw someone shouted at a resident I would go straight to the manager. [Registered manager] would deal with it." The staff member told us the provider had a confidential 'hot line' they could use if they thought their concerns had not been dealt with.

Prior to out inspection we had received information that a person at the home was being restrained (restraint is anything which restricts a person's freedom of movement). We sent this information to the local authority safeguarding team for them to investigate. At the time of our inspection visit we had not received the outcome of the investigation. During our visit we asked staff what they would do if they saw a person being restrained. Staff told us they had a non- restraint policy and they would report this to the registered manager. Staff told us they had never seen this happen in the home.

We looked at how well people were protected by the prevention and control of infection. We saw all areas of the home were clean and there were sufficient housekeeping staff to meet people's needs. Staff understood the importance of using disposable gloves and aprons when providing personal care as this reduced the risk of infection being passed from one person to another by staff. They told us they had undertaken training in infection control.

Whilst all areas of the home used by people were clean we heard a person collecting clinical waste explain to a team leader they had found full 'catheter bags' in the clinical waste bin (a urinary catheter is a tube which drains urine from the bladder and collects it into a drainage bag). These should not have been placed in the bin without being emptied first. In response the team leader said they would speak with staff to ensure it did not happen again.

Requires Improvement

Is the service effective?

Our findings

This key question was rated as 'good' at our last inspection visit. During this visit we found improvements were required.

The registered manager told us they had been made aware that the training records for moving people safely, which we saw at our previous inspection, were not an accurate reflection of the training staff had received. They had subsequently made sure all staff had received further training on how to move people safely to make sure staff understood good moving people practice.

Staff told us they had received the training required to support them in providing safe and effective care to people who lived at the home, and this was confirmed by the training records we saw. However, we found that there had been issues with the skills, knowledge and experience of staff in senior positions which had led to some wrong and inappropriate decision being made. The registered manager was aware of some of this prior to our inspection visit and had been managing them according to their policies and procedures, but more issues came to light as our inspection progressed. The registered manager informed us they would deal with the issues we found.

Staff new to the home told us they had received a good induction to the home which helped them understand how the home worked, and the needs of people who lived there. Staff told us they had worked alongside more experienced staff for between two to three weeks before being working on their own. They said this gave them time to learn about people's needs and preferences.

New staff had 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.

At our last inspection visit, the home was moving towards gaining accreditation with a specialist dementia care organisation to become a 'Butterfly' home. The home had not yet been accredited but hoped for accreditation before the summer of 2018.

The home's chaplain had become an accredited trainer to provide training to staff on the butterfly project, and they told us all staff apart from those who had recently been recruited, had received this training to support them in their knowledge and skills in working with people who lived with dementia. A member of staff told us, "The 'butterfly' training is useful, I enjoy the dementia training."

The majority of people who lived at Youell Court lived with dementia. The training provided to staff supported them in providing effective outcomes for people with dementia. To further support effective care; where appropriate, technology had been used to improve outcomes. For example a relative told us their relation was registered blind and there had been an increase in them falling. The home was now using a 'pressure mat' which sounded an alarm to staff if the person stood on it. This meant staff could check the person was safe and reduce the risk of them falling over.

Significant changes had been made to the décor in the two units which made up the Butterfly dementia project. The walls and doors were painted in different colours to help people identify where they were. Hallways were brightly decorated and pictures and photographs filled the walls. Items of interest hung from handrails which people could stop and touch as they walked by. Themed areas had been created which provided people with many varied object which they could pick up, touch and feel to stimulate their senses. For example, one area was themed around 'wash day'. There was an iron and ironing board, items of clothing draped over a clothes horse and a wash board was placed on the floor which people could pick up and move.

New carpet had been laid in the lounge areas and we heard staff ask people how they would like the furniture to be arranged. Lounges were light, homely and colourful. Individual boxes, in the hallway, housed items of interest to the particular individuals which staff said they used to promote discussion with people. Memories boxes were located outside people's bedrooms to assist people to identify their room.

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 found staff had a basic understanding of the Mental Capacity Act and had completed training to support their understanding. Staff knew the importance of making sure people gave or implied consent before any care act was undertaken to support them. A person told us, "They don't make you do things, they suggest." A member of staff told us, "It is really important to ask people. You should never assume or immediately make a decision. You need to give people time." We saw care staff seek people's consent throughout our visit. For example, one care worker was heard asking a person if they would like to go to bed for an 'afternoon nap'. The person said they would like this to happen and they were provided with assistance to go to their room.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that not all the required applications to the supervisory body had been made at the time of our first inspection visit. When we checked at our second visit, seven applications had been completed and were ready for submission, and were going to be submitted that day. The registered manager acknowledged this meant some people had been unlawfully deprived of their liberty.

People mostly 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 and snacks throughout the day without leaving people unsupported. One person said, "The food here is brilliant, we have a choice and you have more than you want. I also have loads of fluids." During our visit we often saw staff asking people if they wanted a hot or cold drink or snack. Another person said, "The staff are friendly and offer us refreshments."

We saw one staff member supported a person with dementia to make a choice about what they would like to eat for breakfast. To aid their memory, they showed the person two plates, one with scrambled egg and the other with a fried egg. The person pointed to the scrambled egg. Once the staff member had prepared

the person's breakfast they sat by the person and encouraged and assisted them to eat.

Since our last visit, the home had made changes to meal times. The main meal of the day was now served in the late afternoon, and a smaller hot meal or snack was served at lunchtime. The registered manager felt this had improved people's sleeping patterns, and was working well. A person told us, "They changed the time of the main meal to later in the afternoon, I am never hungry."

We had concerns where people did not eat well, or had been identified as needing a special diet. The registered manager told us they had recently sent referrals to the speech and language team (SALT) for them to assess people who received a pureed diet. This was because they did not know why some people received these diets because people's records did not inform them.

On the second day of our visit the SALT team were visiting the home. They told us they used to get referrals from the home but then they 'dropped off', the last one being over a year ago. They said people's care records provided them with no information about why the changes to people's diets had occurred. They found inconsistency in people's food regimes. For example, people received pureed diets usually because of concerns that they could not swallow and might choke; but some people on these diets were also having cornflakes and toast for breakfast which could lead to them choking. The SALT team concluded those people did not require a pureed diet.

The home had assessments to ensure that those who were at risk of not getting enough food or drink were monitored and action taken to support them in eating or drinking as well as they could. However, we could not be sure by looking at the records in some instances, that people received the food and drink they needed. This was because the completion of the food and fluid charts did not give us confidence that staff sufficiently supported the person to drink as well as they could. Their risk assessments in relation to nutritional intake (MUST) had not been completed for a few months. The registered manager assured us the person had received good care, but acknowledged the records did not reflect this.

The service weighed people who were at risk of malnutrition. We found one very ill person had been weighed four times in the space of one week. We saw that the person's weight had dropped significantly from one month previously, however, there was nothing in their care notes to indicate what action had been taken with regard to the weight drop; and why the person had been weighed a further three more times so soon after each other. The registered manager was unable to explain why, but said they would investigate this.

Care records showed people had access to healthcare professionals when required. However, they did not always show the outcomes of visits made. For example one person's care record informed that a district nurse would be visiting on a certain date to follow up on a person's discharge from hospital. There was no record of whether the visit occurred, and if so, the outcome of the visit. During our inspection we saw people supported by the visiting GP and community nurses. The provider told us the district nurses recorded their visits in their own nursing files which were located in the person's bedroom. We advised the provider that the home's staff should record the date of the visit and any advice given by nursing staff . One community nurse told us they had no concerns about the care provided to people as staff did what they asked them to do. They did however say they sometimes had problems getting into the building.

Access to the building had been identified as an issue prior to our inspection visit. We received a safeguarding notification from the ambulance service, as they had tried unsuccessfully and via a variety of means to alert staff they wanted to enter the building. A healthcare professional who was visiting the home at the time of our visit told us they too had experienced difficulties in alerting staff when they wanted to

enter the building. The registered manager told us they had taken steps to remedy this so nobody should be left waiting a long time for the door to be opened.

Good

Is the service caring?

Our findings

This key question was rated as 'good' at our last inspection visit. The service continues to be caring.

We asked people what they thought of the staff who cared for them. One person said, "There are some exceptional caring staff," and another said, "I feel that the staff sit and listen to me."

Relatives were also pleased with the engagement staff had with their family members. One said, "The staff here are very good, they have a caring attitude and understand what is important to mum." Another told us that they had been unhappy with staff previously but they now felt the staff group paid their family member 'a lot more attention' and the quality of care was 'much better.'

We spent a lot of time over the two days we visited the home, noticing how staff engaged with people. All engagement with people was kind and caring.

On our first visit, we arrived at the home just before 8am. We found the home was peaceful with some people out of bed, but many still in bed asleep. We walked past people's bedrooms. One bedroom had the door shut but we could hear staff in the person's room talking with them. The person was clearly not happy with the idea of receiving personal care, but staff gained the person's consent and used distraction techniques to help limit any signs of agitation.

During both days we visited the home we saw staff were attentive to people's needs. For example we noticed a person had not drunk their cup of tea. The member of staff knelt by the person and reminded them their drink was on the table. The staff member said, "I think it's gone a bit cold. Would you like me to make a fresh cup?" The person smiled. The staff member returned with the freshly made drink and sat by the person giving encouragement until they had finished the drink.

Where appropriate, staff enjoyed a laugh and a joke with people. Two people were icing cakes and they and the staff member were laughing about how well the cakes were being iced. One person said, "You should have checked we were capable of doing it - we need a professional tool."

We heard one staff member say to the staff coming on duty, "You must go and see [person] in the hairdressers. She looks beautiful and has a big smile on her face." One by one staff went to the hairdressers and paid person compliments. "You look stunning." "You look amazing." One staff member was her to say, "That's made my day. It's so good to see [person] looking so happy." During the day as people came back from the hairdresser, staff were heard complementing them.

All the staff we spoke with enjoyed their work. One said they would be happy for their own relative to stay at Youell Court. They went on to say, "I love coming here – sometimes you don't like to come to work, but I haven't had it here." Another said, "I find it lovely here, different to my old job, we get the time to spend 'one to one' with the residents. Most of the time staff are with people." A person told us, "The staff never grumble, they seem happy in their work."

During the day we found staff respected people's privacy and dignity. For example, we saw a care worker knelt by the side of a person and discreetly asked if they needed the bathroom. Throughout the day we saw staff take people to their bedrooms to provide personal care behind closed doors. A member of staff said, "The normal habit here is door shut and curtains closed. Dignity is something I strongly believe in."

The home continued to be welcoming to visitors. A visiting relative told us, "The staff are respectful and kind, they offer me drinks or food when I come visit." We saw friends and relatives visited people at different times of the day and evening. They also took part in the activities at the home.

Requires Improvement

Is the service responsive?

Our findings

This key question was rated as 'good' at our last inspection visit. During this visit we found improvements were required.

At our last inspection we found care plans had improved because there was more information about 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.

However, during this visit we found care plans contained information which was not up to date, or conflicted with what was happening in practice. A care worker told us, "Care plans aren't up to scratch. They need to have the changes updated. Reviews have not always happened when they should. We are working on it." Given the high levels of agency staff which the home had used and the increasing number of new staff it was important the care records were accurate for staff to respond to people's needs well. For example, one person's summary discharge from hospital referred to a chronic condition the person had. This important information was not in the care plan section for 'Essential information' and could not be found anywhere else in their record. The same person's care record was looked at by a senior manager at the home in May 2017 and they had recorded that it needed updating, but nothing had happened since.

Another person had required a lot of medical intervention over a three month period. Whilst it was good to see that staff had contacted different health care professionals; by looking at records only, it was difficult to know what this was in response to. Records therefore did not give an accurate reflection of how the home responded to the person and the need for the response.

Care staff told us the provider's head of care usually updated the care plans. We were aware the head of care had left the organisation and temporarily another member of staff had acted up as head of care.

During our visit we saw staff responded well to a person who had fallen. The emergency call alarm was pressed and staff arrived quickly. We saw the person had cut their head and was very distressed. Staff called for an ambulance, and whilst they waited for the ambulance to arrive they applied pressure to the wound. They sat on the floor with the person, holding their hand and gave verbal re-assurance. Another member of staff covered the person with a blanket to keep them warm. Staff started to sing and encouraged the person to join in. The person joined in and became more relaxed as a result. Staff later told us the person loved to sing and they used this to help the person if they were ever upset.

During our visit we found people had sufficient group and individual activities to interest them. Doll therapy was used for people who lived with dementia, and we saw some people received great comfort from this. Staff understood that the dolls had become a living being to some of the people who lived at the home and respected this. For example, two staff assisted a person to move using a hoist. The person was sat in a chair holding a therapy doll. Sone staff member said, "Can I take your baby and place her on this chair, just while we help you. I promise I will be careful." On being given consent, the staff member took the doll and placed

it on the chair. Whilst the person was moving, staff reassured them the doll was fine and as soon as the move was completed, the doll was gently returned to the person.

We saw one member of staff playing the guitar in the lounge. The staff member asked people what they would like them to play. People clapped and sang and smiled. At one point the staff member began to sing in Italian. People did not appear to know the tune they were playing. Then the staff member moved and sat by a person whose first language was Italian. At first the person did not respond, and then suddenly they smiled and began to sing very loudly. Everyone in the room clapped. This generated a discussion about the different languages people and staff could speak and countries they had visited.

Care staff on the two units for people with dementia wore a belt with pouches similar to a tool belt, which they could store different items in to use as activities for people. One care worker said, "I have lots of things in my belt, like Velcro and buttons. When I sit with the resident I use them to start conversations."

Staff appeared to know the personal histories of people and tried to make sure activities supported their history and reminiscence. For example, one person had previously been a 'brown owl' in the brownie and guide movement. Outside their room the staff had a mannequin with a brownie uniform used at the time the person had been involved with the brownies.

The chaplain at the home supported people with their spiritual needs and also supported people to find spiritual leaders of different faiths when or if required. The chaplain also enjoyed supporting people with different individual and daily activities. A person told us, "I take part in activities, if you want to go out they will take you." A new activity worker had started at the home. They had only recently taken on the role and were being supported to lead on new projects.

At our last inspection 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 of the LGBT (Lesbian, gay, bi-sexual and transgender) community. They told us people from the LGBT community 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. We asked at this inspection what action had been taken to promote inclusivity. The chaplain said due to other challenges in the home, they had not been able to move forward with this.

Complaints made to the service were responded to according to the provider's policy and procedure.
We found 11 complaints had been raised between May 2017 and November 2017. A letter had been sent to each complainant to confirm receipt of the complaint and to explain the complaint procedure. Outcome letters were then sent on completion of the investigation. When necessary, written apologies had been made to the complainant. We also found four compliments had been logged between November 2017 and our inspection visits. One relative had thanked the registered manager for re-arranging the staff rota to enable staff to attend their family member's funeral. Another thanked the home for the care provided by staff and was very positive about the way their family member had been looked after.

We looked at how people were supported at the end of their life to have a comfortable, dignified and pain free death. We asked staff what the procedure was if people were moving towards the end of their life. Staff told us they liked to sit with people and make sure people were not on their own at the end of life, but did not know if there was a procedure to work within.

We looked at the care record of one person who had recently died, and another who had been assessed as

moving towards the end of life. The records did not provide information to support staff in knowing how the person would like to live their last few hours or days. For example, what music they might like played, and who they would want to be with them. Staff did not fully understand how end of life care might need to be managed differently to more generalised care, for example in the management of pain and of risks to the person.

The registered manager and chaplain acknowledged staff had not received training in this area. The chaplain told us they were going to discuss this at the next care manager meeting towards the end of February 2018.

It is recommended that the provider seek further guidance from specialist bodies about the management of end of life care.

Requires Improvement

Is the service well-led?

Our findings

This key question was rated as 'requires improvement' at our last inspection visit. We found the home continued to require improvements in this area.

At our previous inspection the home was managed by an interim manager, who had not been in post for long but who had gained the confidence of staff. Since then, the interim manager had been recruited to the role of manager and was registered with the Care Quality Commission in July 2017.

Since our last inspection the registered manager had faced a number of staff performance issues at the home. This had resulted in staff vacancies and changes within their management team. Vacancies within the management structure had led to staff being temporarily promoted to management roles, with varying degrees of success. During our inspection visit we had some concerns with decisions taken by a member of staff who was in a senior position at the time the decisions had been taken. The registered manager said they were not aware of these concerns and would address these issues with the staff member. We were later informed the provider had investigated these concerns under their policies and procedures and the staff member no longer worked at the home.

The provider had supported the registered manager. The regional manager visited regularly and more recently arranged for a manager of a different location to provide some further managerial support to Youell Court. This was because they had identified during their visits there were areas of management which the registered manager needed additional support to address. This included ensuring care plans were up to date and contained the right information to ensure the safety of people. At the time of our inspection visit, the care records continued to not provide an accurate and complete record for each person, and did not effectively monitor and mitigate the risks related to the health, safety and welfare of people.

This meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

We looked at communication between management and staff. The registered manager and staff told us that communication between the levels of management needed to improve, particularly when informing about changes to people's needs. This was particularly so in relation to the staff 'handover' meeting at shift change.

Staff explained they completed a 'handover' sheet at the end of their shift, for collection by the team leaders. Staff said this information should then be used at the handover meeting to update staff coming onto their shift. However, staff said they felt this was not effective because often the handover sheets were not collected or team leaders simply told them at the handover meeting to read the handover sheet. Staff said this meant sometimes information was missed.

A relative told us whilst there was a lot of improvement in the home, "Communication sometimes fails when you tell a team leader – as it doesn't always get through." The registered manager said they were trying

different way to improve communication.

Team meetings had been held for both day and night staff. The minutes of these demonstrated both the registered manager and care staff wanted to make sure that care provided was safe, effective and compassionate.

Staff we spoke with told us they felt supported by the registered manager. One said, "It is definitely led well, she is a brilliant manager, she is really supportive." Another said, "There used to be a lot of negativity but not much now. [Registered Manager] has worked wonders, and the staff have a lot of respect for her.

Staff also told us they enjoyed working at Youell Court. One said, "It's really nice and friendly. Other staff are friendly, we're one big family, we have the odd squabble but it is okay."

Whilst we found some areas which required improvement, people and relatives were happy with the leadership and management of the home. One person said, "I am happy the way the home is run. They are all very good". Another said, "There is more openness now, and visibility." People and relatives also explained they had the opportunity to share their views about the home in relatives and resident meetings. One person told us, "There are monthly meetings, they always put notices up." A relative said, "There are family and resident's meetings and people are asked their opinions."

The provider has a legal requirement to inform the public of the home's inspection rating. The provider's website informed the public Youell Court had, at the time of their last inspection, been rated as overall 'requires improvement' and a poster with the inspection rating was displayed in the reception area of the home. The registered manager had also ensured they sent the CQC statutory notifications informing us of events which impacted on the well-being of people who lived at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not been reviewed regularly to ensure staff delivered care which met people's changing needs. Staff had been instructed to take some actions to reduce risks which were not based on individual assessed need.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating the care of each person did not provide an accurate record of all decisions taken in relation to their care and treatment. Information was not always up to date and accurate.