Care UK Community Partnerships Ltd

Darlington Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 24 May and 2 June 2016 and was unannounced.

Darlington Court provides nursing and residential care for people with a range of health needs, including physical frailty and dementia. It is registered for up to 61 people and at the time of our inspection, 31 people were living at the home. Darlington Court is a purpose built nursing home surrounded by landscaped gardens and patio areas. The home is divided into five units: Milton and Shelley on the ground floor provide residential care to older people and people living with dementia. On the second floor, three units: Byron, Elliott and Keats, provide nursing care. The majority of rooms are of single occupancy, with five double rooms. Each unit has communal areas comprising a sitting room and dining room with kitchenette.

A registered manager was in post. 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 last inspection took place on 24 and 25 February 2015. As a result of this inspection, we found the provider in breach of a number of regulations and asked them to submit an action plan on how they would address these breaches. An action plan was submitted by the provider which identified the steps that would be taken. At this inspection, we found that the provider and registered manager had taken appropriate action and required standards were now being met.

Sufficient numbers of suitable staff were employed to keep people safe and meet their needs. People risks had been identified and assessed and were reviewed monthly. Environmental risk assessments were also completed. Medicines were managed safely. Checks were made on new staff before they commenced employment. People said they felt safe living at Darlington Court.

Staff had been trained in a range of areas and received individual supervision as well as attending staff meetings. New staff underwent a period of induction and followed the Care Certificate, a universally recognised qualification. Staff had a good understanding of their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and put this into practice. People had sufficient to eat and drink and were supported by staff to maintain a healthy diet. They had access to a range of healthcare professionals and services. The ground floor at Darlington Court had recently undergone a period of refurbishment and all rooms had en-suite facilities.

People were looked after by kind and caring staff who knew them well. Staff were encouraged to sit and chat with a different person they did not know well in a daily event entitled, 'Tea at 3'. People were supported to express their views and to be involved in decisions about their care. They were treated with dignity and respect. Some care plans contained guidance about people's end of life wishes.

Handover meetings were organised between each change of staff shift which enabled information to be shared about people's care needs in an effective way. Before people were admitted to the home, a pre-assessment was completed which formed the basis of their individualised care plan. A range of planned activities was available to people. Complaints were managed in line with the provider's policy.

The home had undergone a period of change relating to the care provision and a change of registered manager since the last inspection. Systems were in place to measure the quality of care delivered and drive continuous improvement. Staff felt well supported by management and people and their relatives attended monthly meetings to feed back their views about the service. The registered manager was involved in various initiatives and worked in partnership with other agencies.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's risks had been identified and assessed and staff were trained to recognise and report any cases of potential abuse.

There were sufficient numbers of staff to support people safely and checks were made when new staff were recruited to the service.

Medicines were managed appropriately.

Is the service effective?

Good

The service was effective.

People received care from staff who where appropriately trained and supervised.

People had sufficient to eat and drink and had access to a range of healthcare professionals and services.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them well.

People were involved in decisions about their care and were treated with dignity and respect by staff.

Is the service responsive?

Good

The service was responsive.

Care plans provided staff with detailed information about people's care needs, their likes and dislikes.

A range of activities was planned for people.

Complaints were managed effectively in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

The service had undergone a period of change resulting in a change of care provision and management.

People and their relatives attended monthly meetings to feedback their views about the service.

Staff felt supported by the registered manager.

A robust system of audits was in place to monitor and measure the quality of care delivered.

The registered manager worked in partnership with other agencies.

Darlington 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 24 May and 2 June 2016 and was unannounced. An inspector and a nurse specialist undertook this inspection.

This inspection was carried out to check that breaches of legal requirements made as a result of the last inspection on 24 and 25 February 2015 had been met.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including 10 care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

On the day(s) of our inspection, we met with 10 people living at the service and spoke with one relative. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the regional operations manager, the registered manager, the customer relations manager, the deputy manager, two registered nurses, four care staff, housekeeper and assistant chef.

Good

Is the service safe?

Our findings

At the inspection in February 2015, we found the provider was in breach of a Regulation associated with staffing. We asked the provider to take action because there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. Two registered nurses were on duty between 8am and 8pm, with one registered nurse on duty during the evening between 8pm and 8am. Care staff were allocated to different parts of the home according to the needs of people they were looking after. Six care staff worked on the first floor and a team leader and one additional member of care staff worked on the ground floor. At night, in addition to the registered nurse, three care staff worked on the first floor and a team leader on the ground floor. The occupancy at the time of our inspection was 25 people on the first floor and six people on the ground floor. Staffing rotas were checked and confirmed these staffing levels were in place. Staffing levels were assessed based on people's care needs and a dependency tool was used. The registered manager told us that occasionally agency staff, usually registered nurses, were required to maintain safe staffing levels. Where possible, the same agency staff were used, who knew people well and how their needs should be met. One member of staff felt that staffing levels were sufficient and that staff worked as a team, saying, "Very good, very helpful staff, everyone helps each other". Other staff, when asked, said they were happy with the staffing levels and were pleased to be at the stage when using agency staff was going to be reduced. A recent recruitment drive to employ new staff had been successful.

At the inspection in February 2015, we found the provider was in breach of a Regulation associated with safe care and treatment. We asked the provider to take action because care and treatment was not provided in a safe way for people and their risks of receiving care and treatment had not been adequately assessed. Medicines were not managed safely. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

People's risks had been identified and assessed and systems were in place to mitigate the risks. We looked at two care plans in detail and met with the people these care plans related to. For example, one care plan showed the person had been assessed regarding bed rails, fluid intake and output. The provider used a range of tools to assist with assessments such as Waterlow (a tool for assessing people's risks of developing pressure areas) and the Malnutrition Universal Screening Tool (MUST) which assessed people's risk of malnourishment. The provider had a policy that the GP should be notified if people lost two kilogrammes or more in weight in any month. This person's care plan showed that they received care in bed, had received dental care and eye tests. We met this person who looked comfortable and oriented with their surroundings. They received aromatherapy treatment weekly as they were known to suffer from anxiety and this was a good use of complementary therapy.

Another care plan showed the person required nursing care relating to pressure areas. They had been assessed using Waterlow and had an airflow mattress. Their fluid intake and output was recorded hourly, as were other residents. This person had a long-standing history of varicose ulcers and was under the care of a Tissue Viability Nurse. We observed their leg being photographed and redressed by nursing staff. Photographing pressure areas is good practice to monitor the rate of healing. The leg was clean and there were no concerns. In addition, a chiropodist was attending to address problems with this person's feet.

People's risk of falls had been assessed and bed rails and sensor mats were in use where required. Where falls had occurred, care staff were vigilant and undertook regular checks of people immediately following the falls, to ensure no long-lasting harm had been sustained. Risk assessments were in place for moving and handling and for people going out into the community. One person was at risk of becoming lost in the community and the accompanying assessment stated, 'Competent staff to accompany, use wheelchair'.

Environmental risk assessments had been completed and there were systems in place for the evacuation of people in the event of an emergency. The environment was light and clean with wide corridors for wheelchair access. We did note, however, that bathrooms in some units had been used to store hoists and other moving and handling equipment. We asked staff about this and they told us that storage space was limited, but that hoists were moved out when people needed to use the bathroom. Two bathrooms were locked and out of commission as Legionella bacteria had been discovered in the water supply. Tests were being undertaken and the water was continually monitored; it was hoped to have the bathrooms back in operation as soon as tests were clear. We observed domestic staff on duty at various times of day and that the home was clean. One person referred to the home and said, "It's very good and it's regularly cleaned. You get a regular bath. I have a bath every week, sometimes I have more. Whoever's on duty, I can just ask".

Medicines were ordered, stored, administered and disposed of safely and stock levels were not excessive. We observed a registered nurse administering medicines at lunchtime. Medicines were administered from trolleys which were locked between each medicine being given to people. A pharmacy provided printed Medication Administration Records (MAR) for each person and medicines were administered from colour coded blister packs. The pharmacy conducted their own unannounced drug audits every three to four months and the provider also undertook an internal audit. The temperature of the room used for storage of medicines was recorded, as was the refrigerator used to store specific medicines; all temperatures were within safe limits. We checked the stock levels of some drugs and these tallied. Registered nurses administered medicines in line with guidelines and their competency was checked.

Safe recruitment practices were in place. Before new staff commenced employment, checks were undertaken with the Disclosure and Barring Service, to ensure they were safe to work in care. Staff completed an application form, their employment history was checked and at least two references obtained. Registered nurses were validated in line with the requirements of the Nursing and Midwifery Council.

People told us they felt safe living at Darlington Court. One person confirmed this by saying, "Yes, definitely". Another person told us, "Yes, I feel quite safe. I've got no complaints at all. I would hate to leave here". Staff had been trained to recognise the signs of potential abuse and knew what action to take. Training records confirmed that staff had been trained in safeguarding adults at risk.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. One person told us, "Everything about this place is good. I don't have a bad word to say". We spoke with a new member of staff who told us about their induction where they shadowed experienced staff for two weeks before working more independently. They told us, "The staff, the leads and the manager have been really good". They went on to describe the training they had undertaken recently in moving and handling, diabetes, wound care and on the provider's computer system. New staff were required to follow the Care Certificate covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The registered manager told us they were thinking of using the components of the Care Certificate to enable existing staff to update their training.

The training plan showed that staff were required to complete mandatory training in the following areas: dementia awareness, fire, food safety, health and safety, infection control, mental capacity, moving and handling and safeguarding. Additional training was also provided on topics such as basic life support, care planning, diabetes, end of life care, first aid at work and medication awareness. The majority of training was on-line training, but first aid and moving and handling were delivered by a trainer in person. A registered nurse talked about the training they had received and added, "Then we also go to other Care UK homes and I've been to three now. I've done wound care and basic life support. We also had the community matron for admissions avoidance come and she's opened up a whole load of new training". Nursing staff could also access training provided by a local hospice.

We asked the registered manager how often staff received supervision. They told us that the plan was for staff to have four appraisals a year, which related to meeting defined objectives and supervision meetings in-between. Staff had not received regular supervisions in the past and the registered manager recognised this and had identified this as an area for improvement. Where supervisions had taken place, staff competency was reviewed and they were asked for their reflection and feedback, what had gone well, not so well and what could be done differently. Issues were then identified which required attention and would be discussed at the next meeting. Observational supervisions were completed for staff by their supervisors. These supervisions included areas the supervisor observed the staff member completing, such as, posture of residents, social interaction, presentation and food, personal hygiene/dignity, offering choices, environment, staff language and body language and documentation. Positive aspects of the observation were recorded and any improvements that might be required were identified.

Regular bi-monthly staff meetings were held which were also group supervisions, with separate meetings for care staff, team leaders and registered nurses. The last team meeting was held in May 2016 and minutes confirmed this. Daily handover meetings were held for heads of departments and these were minuted. On the second day of our inspection, items discussed included care, maintenance, marketing, catering, admissions, discharges and deaths. Staff were updated on an event to be held during Care Week which involved setting up a stall in the superstore located close to the home. A member of staff said, "I would say

we have a fantastic team. We are a very caring, supportive team. As a consequence, our residents and relatives respond in such a lovely way".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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). 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.

Staff had a good understanding of the requirements of the MCA and associated legislation under DoLS. One member of staff described this as, "Whether a person can make their own decisions and what is in their best interests. People should have their choices and preferences". A registered nurse said, "You need to assume the resident has capacity and even our residents with dementia, they can still have a right to choose. Sometimes we have to consider best interests and choices that are best for them". People's capacity to make decisions had been assessed and this was documented. Where people had been assessed as lacking capacity, applications had been made to the local authority under DoLS and were yet to be authorised.

People had sufficient to eat, drink and maintain a balanced diet. We asked people for their feedback about meals and menu choices. One person said, "Quite good I'd say and a good choice. I wouldn't complain about the food, definitely not". Another person told us, "If I don't like something, they'll make something for me". A third person felt, "Food's excellent. We have a good chef. You can request anything. You have a menu every day so you can get what you like". Menu cards were printed and placed on each dining table during the day. On the second day of our inspection, the menu on offer at lunch was home-made soup, sandwich selection, sausage roll and plum tomatoes followed by sticky toffee pudding or lemon sorbet, jelly, yogurt or fresh fruit. Dinner was a choice from salmon fishcakes or Boeuf Bourguignon with seasonal vegetables and new potatoes, with a dessert choice of rhubarb and orange crumble or chocolate ice-cream.

We spoke with the assistant chef who explained that menus followed a three weekly cycle. They told us, "The main meal tends to be evening, but people can choose if they want it at lunchtime". Special diets were catered for such as for people with Coeliac's disease (gluten intolerance), vegetarians and for people who had been assessed as requiring liquidised or soft diets. Where people had been assessed as at risk of malnourishment or who had lost weight, foods with higher calories were used. The assistant chef said, "I make soup with cream. I put lots of cheese into cauliflower cheese". The provider had recently organised an event at Darlington Court which was open to the public, entitled, 'Eating as we age'. Various types of food were on offer and information provided on food groups that were beneficial to people as they aged.

We observed people eating their lunch in the dining room. Where needed, staff were assisting people to eat their meal. People were asked if they wanted salt and pepper and whether they would like to wear a protector to keep their clothes clean. Lunchtime was a relaxing experience and the food looked appetising. Tables were attractively laid with cloths and serviettes. Menu cards also showed photos of the food on offer, so people who had difficulty reading, could easily recognise the different food choices available.

People had access to a range of healthcare services and professionals and care records documented this. One person told us about a recent visit from their optician. A GP visited every Tuesday from a local practice in Rustington. Other visits could be arranged on request. If people's prescriptions were in need of replacing,

then a fax request would be made to the surgery. There were links with the Tissue Viability Nurse based in Chichester who was contacted for advice and guidance on the management of wounds and pressure areas. The Speech and Language Therapist (SALT) assessed people at risk of dysphagia (swallowing difficulties) or dysphasia (communication difficulties). Where assessed as required, people had liquids thickened to aid swallowing and prevent the risk of choking.

The ground floor of Darlington Court had recently been completely refurbished to a high standard and all rooms had en-suite facilities. On one side, a seaside theme had been introduced with pictures of the seaside, driftwood and other items relating to the sea used to decorate the corridors The other side had a countryside theme. People's bedroom doors had been decorated and fitted out to look like front doors, with door knockers and numbers. In the Keats unit on the first floor, people had memory boxes on their bedroom doors containing items of importance to them. People also had their photos on their doors with their name displayed beneath. One person told us, "It's nicely furnished and I'm very happy here". On the first floor, we observed magazines placed on occasional tables for people to have a look at. 'Rummage boxes' were also available and contained a variety of items that might be of interest to people living with dementia. However, many people might not have been aware of these boxes or the meaning behind them. Items from these boxes would probably be noticed and picked up by people if they were left around communal areas of the home, rather than kept in boxes.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. One person said, "I get on well with them and they get on well with me. They're very co-operative". Another person referred to staff and said, "They're very helpful, extremely helpful really". A third person thought that staff were, "Excellent, they'll do anything for you". We observed that staff were kind and caring with people. For example, we observed a member of care staff was extremely patient with one person as they tried to persuade them to pick their feet up, so that the foot plates on their wheelchair could be deployed. The person appeared very reluctant to move their legs, but the staff member stayed with them until eventually the person changed their mind and lifted their feet from the floor. The staff member spoke to the person in a gentle, warm and kindly way throughout.

The provider had recently introduced an activity 'Tea at 3' which involved any member of staff taking time out to sit with a resident they did not know and have a chat with them. Staff were observed to leave what they were doing and sit with people for approximately 10 minutes and socialise with them. These 'Tea at 3' sessions had been implemented as a way for staff, who may not necessarily have been involved in directly caring for people, to get to know residents. It also afforded residents who may not have had any relatives or friends to visit, an opportunity to engage socially.

People were supported to express their views and to be involved in making decisions about their care. We saw evidence that people were involved in commenting on their care plans and had signed them to this effect. One person confirmed they felt free to express their wishes and had contributed to their care plan. Another person told us, "I don't ask for a lot. I'm not a very demanding person" when asked about how they were involved in decisions about their care. Where people were unable to communicate effectively, staff could tell what people wanted and how they were feeling, because they knew them well. A member of care staff explained, "Through their eyes, expressions and faces, I know how they're feeling. It's rewarding and challenging. I love it". People's spiritual beliefs were acknowledged and a contact list of priests and ministers was on display in one of the offices. These people could be contacted if required and visits arranged for residents if they wished. A weekly religious service was also held at the home.

We asked people if staff treated them with dignity and respect. One person told us, "Oh yes, very much so. They always knock on the door". We asked a member of staff how they respected people's privacy and they said, "Exactly as if I was looking after my mum and dad. Try and let people have as much independence and choice as possible – be kind". We observed that staff treated people in a respectful way throughout our inspection. For example, knocking on people's doors and checking with them it was all right to enter. The atmosphere in the home was calm and quiet and we saw that staff treated people and any visitors with dignity and respect. It was clear that staff knew everyone very well.

Some care records contained 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms which were completed when it had been assessed by a healthcare professional that people's quality of life would be diminished if resuscitation was attempted in the event they stopped breathing. These forms had been completed appropriately and showed that people and/or their families were involved in the decision. A

registered nurse told us about some training they had completed on end of life care and that local funeral directors had organised an outing for staff to the local crematorium to gain an understanding of what happened to people's bodies after death.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Handover meetings were held each day at 8am and 8pm when staff came on or off shift. Handover sheets documented brief details about each resident, moving and handling equipment they required, diet and whether they had a DNACPR form in place. Handover sheets also recorded that charts relating to people's care needs had been completed, such as for behaviour, elimination, turn charts (used when people were at risk of developing pressure areas), fluid charts, personal care and activities.

Before people were admitted to the home, pre-admission assessments were carried out. These included an assessment relating to people's communication, diagnosis, food likes and dislikes, MUST, continence, eating and drinking and risk of falls. A registered nurse explained the importance of these pre-admission assessments and how they formed the basis of people's care plans. Where required, any specialised equipment could also be put in place before the person came to live at the home. The registered nurse told us, "When the resident is here, you can then do an individualised care plan". Care plans included detailed advice and guidance to staff about people's care needs and how they needed to be supported. Information was provided on areas such as sleeping, breathing, communication, personal care, nutrition, mobility, and moving and handling. Other assessments included information about bathing, dressing, walking, continence, cognition, appearance and social life, as well as any sensory impairments, medications and medical history.

Each month, every person living at the home was identified as 'Resident of the Day'. This meant that once a month, everything about the individual was reviewed. This included a review of their care plan, where the person and their relatives were invited to contribute. Care plan reviews included reviews of risk assessments and any activities the person had participated in. Staff from the home, including the chef, housekeeping and activities co-ordinator, were also invited to the review meetings so people and/or their relatives could feed back their views on all aspects of their care and life at the home.

Daily records completed by staff recorded various checks in areas such as personal hygiene and continence, pressure relief, food and fluid intake and any activities or appointments. Staff signed to say what time the check had been completed and the location where the check had taken place, for example, whether in the person's bedroom or in a communal area. These daily records were kept in bags which people had with them all day. They provided an easily accessible record for staff to see how people were and were a good communication aid. These daily records even included when staff had joined people for the 'Tea at 3' activity. Relatives could also see at a glance what their family member had been doing and how they had been cared for by staff and were encouraged to write any information on the daily records. The registered manager described the process as a holistic approach to care and said that other healthcare professionals such as chiropodists or district nurses also recorded information on these daily records. The registered manager said, "Everyone's involved in the whole process".

During our inspection, we observed that some people spent long periods of time sitting in wheelchairs. We discussed this issue with the registered manager who assured us that some people preferred to spend time

sitting in wheelchairs, rather than being transferred to an armchair for example. Other people had wheelchairs that were specially adapted to support their posture or were reclining specialist chairs suitable for people with muscular problems or other special needs.

A range of activities was organised by two part-time activities co-ordinators and a weekly activities programme was given to each person living at the home. In the week of our inspection, the following activities were available: 'Sit, Fit and Sing', wheelchair exercises (could also be armchair exercises for people who had mobility) and 'residents' choices' or 'one to ones'. The programme was vague on detail as to what specific activity was on offer. On the second day of our inspection, wheelchair exercises were on offer to people in the dining room. We observed that these exercises also involved people being encouraged to kick a giant beachball, catch a giant pompom and shake koosh balls, which were sensory, tactile balls that lit up when shaken. Eleven residents were present in the dining room during this activity and they were encouraged to join in by the activities co-ordinator and care staff. The majority of people appeared to engage positively with the activity and were smiling and laughing. Each activity was offered in short bursts which encouraged people to concentrate for brief periods of time without being too exhausting. One person told us, "There's a bit of a choice of what you want to do" and added, "Staff would take me shopping if I wanted to go". Another person told us, "I'm usually in great demand for Scrabble!" There were limited opportunities for people to go out into the community, unless they were taken by family or friends. A notice on an upstairs board stated that outings scheduled were: 'July – visit to Mewsbrook Park, Littlehampton, September – Visit to Arundel, December – Xmas visit to Haskins or Wyevale Garden Centre'. When asked, people felt there were enough activities to engage with and that they could also go out into the garden with staff when they wanted to.

Complaints were listened to and managed in line with the provider's policy. One person said, "I very rarely complain to anyone. If I did, I think I'd know who to go to". Another person told us they had never had cause to complain and that they were very happy. The provider's complaints policy stated that complaints would be acknowledged within three working days, investigated and responded to within 20 days. We saw five complaints that had been recorded in 2016. All the complaints had been investigated and managed to the satisfaction of the complainant. Two had resulted in notifications being sent to the Commission and appropriate follow-up action had been taken by the provider.

Good

Is the service well-led?

Our findings

At the inspection in February 2015, we found the provider was in breach of a Regulation associated with good governance. We asked the provider to take action because systems or processes had not been established or operated effectively to drive continuous improvement. Following the inspection, the provider sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

Substantial changes and improvements had been implemented with a change of registered manager since the last inspection. A range of audits was in place that measured and monitored the quality of care delivered. Checks were made in relation to the care that people received each day which included environmental checks and review of their Medication Administration Record (MAR) charts. Audits were completed with regard to people's mealtime experiences and nutrition. Accidents and incidents were analysed and any emerging trends or patterns were identified and steps taken to prevent possible reoccurrence. Reports were completed by night staff to show that security checks around the home and other checks on the premises were completed.

Monthly residents and relatives' meetings were organised. The last meeting was held in May 2016 and minutes recorded the items that were discussed which related to various maintenance projects at the home, events, relatives signing care plans and fundraising. Darlington Court has a Facebook page which is accessible to the public and advertises various events and meetings that were planned.

People spoke positively about their experience of living at the home. One person said, "It's quite a good place with a lovely garden. The people are nice". Another person said, "Great. It's better than the last home I was in". A number of compliments had been received and recorded. A relative had written, 'Words cannot convey the thanks we send to you for all the love and care that [named family member] received. We always knew he was in safe hands from his first day there. Also thanks for the love and care that were given to me and our family'.

Staff felt supported by the registered manager and said she was extremely approachable. The home had undergone a series of changes within the last year which had impacted on the staff and their work. A registered nurse told us, "There's nothing I would change now. We have made a lot of changes, mixing mentally frail with physically frail [people] and it has worked. If there's something I felt needed changing I could discuss with [named registered manager] and it would be done". A member of care staff said, "It's very well managed now and I think this is the best it's been run. Obviously there's changes and you have to adapt. Any suggestions are listened to". The registered manager acknowledged that the service had undergone a period of change recently. They told us, "It's a changing culture because of the changes last year. We're still evolving as a service. It's a culture of progress, learning, honesty and development. Change has brought about an awareness and understanding and the staff have come through".

Notifications had been sent to the Commission in line with registration requirements. The ratings of the last inspection were displayed prominently in the reception area and on the provider's website.

The registered manager was involved in various projects and worked in partnership with other agencies such as NHS Coastal West Sussex Clinical Commissioning Group to redesign a new care pathway model with health and social care professionals. The registered manager met with other managers of care homes every three months where the brief was to promote better relationships within the care industry and share good practice.