Care UK Community Partnerships Ltd

Darlington Court

Inspection report

The Leas off Station Road
Rustington
West Sussex
BN16 3SE

Tel: 01903850232
Website: www.darlingtoncourtrustington.co.uk

Date of inspection visit:
03 January 2019

Date of publication:
13 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 3 January 2019. Darlington Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Darlington Court is situated in Rustington in West Sussex and is one of a group of homes owned by a national provider. Darlington Court is registered to accommodate 61 people. At the time of the inspection there were 46 people accommodated in one adapted building, over two floors. Each person had their own room and ensuite bathroom. The home provided accommodation for older people, those living with dementia and people who required support with their nursing needs. People's needs included physical disabilities, diabetes and epilepsy.

At the first comprehensive inspection on 24 and 25 February 2015, the home was rated as Requires Improvement and breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 were found. At the next scheduled inspection on 24 May and 2 June 2016, the home had improved and was rated as Good'. At this inspection on 3 January 2019 the rating of the home changed to Requires Improvement. This is the second time the home has been rated as Requires Improvement. This was because there was mixed feedback from staff about the leadership and management of the home. Some staff told us that the registered manager was approachable and supportive. Other staff told us that they did not feel able to approach the registered manager if they encountered problems of concerns. This was fed back to the registered manager and regional director who told us they would discuss this with staff to further identify the issues and to help find a solution.

Quality assurance processes were not always effective. The provider's audits had identified some of the shortfalls that had been found as part of this inspection. Action had been taken to make changes, however this needed further improvement. This related to records not being sufficiently maintained as well as mental capacity assessments not being completed for specific decisions relating to people's care. Other shortfalls that were found as part of this inspection, however, had not been identified by the provider. These included ensuring that all people had access to appropriate pressure relieving equipment when required. In addition, the involvement of people and relatives in discussions about people's care was not documented to demonstrate this had taken place.

Assessments had been undertaken to determine people's needs to enable them to maintain their health. One person, had been assessed as being at a high-risk of developing pressure wounds. Although they had received appropriate support from community nurses when they had sustained a pressure area wound, they did not have access to appropriate pressure-relieving equipment to maintain their health. Staff were unable to provide an explanation of what setting the person's pressure relieving mattress should be set to. Guidance had not been provided to staff to inform their practice. This meant that staff could not assure themselves that the person was using a suitable piece of equipment to prevent further pressure damage.

When this was fed back to the registered manager, immediate action was taken and the mattress was replaced.

The home had a registered manager. A registered manager is a '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 home is run. Since the previous inspection on 24 May and 2 June 2016, the registered manager of the home had changed. The management team consisted of the registered manager who had been in post for one year, a clinical lead and two unit managers. A regional director regularly visited the home to conduct quality assurance audits and provide support to the management team and staff.

The provider's aims of creating a home-from-home environment were shared amongst the staff team and implemented in practice. People told us that they felt comfortable and at ease. People, their relatives and staff were involved in decisions related to the running of the home. They told us that their views and suggestions were listened to and respected and that they felt able to raise concerns about their care.

The provider and registered manager saw the importance of partnership working. They worked with the local authority and external healthcare professionals to ensure people received coordinated care. There was shared learning between the provider's other homes and regular meetings helped ensure that good practice was shared.

People told us that they felt safe. They were protected from abuse and discrimination. Sufficient numbers of skilled staff ensured people's physical and emotional needs were met.

Risks to people's safety were identified and mitigated. Infection control was maintained.

People's needs were assessed and reviewed. People received personalised care and were actively involved in discussions in relation to it.

People had access to medicines when they needed them. Medicines were managed safely. People received support from external healthcare professionals when required. People were complimentary about the effect that the care they had received had had on their health.

People could plan for their end of life care to help ensure their comfort was maintained and their wishes were respected.

Staff were kind and caring. People were supported sensitively and their privacy and dignity were maintained. Positive relationships had developed between people as well as with staff. Compassionate interactions were observed and staff took time to interact with people. Staff were mindful of supporting people in a way that met their needs. When people displayed signs of apparent anxiety, staff took time to listen to them and offered distraction techniques. People were calm and settled after their interactions with staff. Comments from people included, "I think they're marvellous" and "They are very good with me". A relative told us, "They have time for everybody. I've never heard staff here be unkind about anybody and you can have a laugh with them".

People had access to sufficient quantities of food and drink to maintain their nutrition and hydration. People told us that they enjoyed the food and that they were provided with choice.

People had access to an environment that met their needs. Communal areas, as well as private spaces,

enabled people to spend time on their own or with others.

People were not socially isolated. Planned group activities, as well as one-to-one interaction between people and staff, enabled people's social needs to be met. People were observed to be engaged. They were laughing, smiling and enjoying the interaction and stimulation that was provided.

People were encouraged to be independent. Some people could independently move around the home and chose how to spend their time. Records advised staff that some people enjoyed undertaking household chores and encouraged staff to involve people where possible.

People were involved in their care and in the running of the home. Concerns that had been raised had been listened to and dealt with. People and their relatives told us that they were happy with the care people received. They spoke fondly of the staff and of the registered manager and told us that they felt that the home was a nice place for people to live.

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 home was safe.

There were sufficient staff to ensure people's needs were met.

Staff understood the signs that might indicate people were at risk and they knew how to keep people safe.

Risks were assessed and measures taken to mitigate risks. Improvements were made when there had been learning from incidents.

Medicines were managed safely to ensure people's health was maintained.

Infection control was maintained.

Is the service effective?

Requires Improvement

The home was not consistently effective.

Staff had not always worked in accordance with the Mental Capacity Act 2005. They had not always ensured that people's capacity was assessed and that relevant people were involved in the decision-making process.

Staff had not always ensured that people had access to appropriate equipment to maintain their health.

Staff had the appropriate skills and experience to meet people's needs.

People had sufficient amounts of food and drink to maintain their nutrition and hydration.

Is the service caring?

Good

The home was caring.

People were supported by kind and caring staff. Staff knew people well and took time to interact with them.

People were respected and they led dignified lives. They could make their feelings known and these were listened to and acted upon.

People's skills and experiences were respected. They were supported to maintain their independence.

Is the service responsive?

Good

Person-centred care ensured that people's needs and preferences were known and respected. Care was tailored around people's needs.

People were supported to plan for their end of life care. Staff respected people's wishes if they had chosen not to discuss this.

People were provided with opportunities to comment or complain about the care they received.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Staff provided mixed feedback about the leadership and management of the home.

Quality assurance processes had not always identified shortfalls in the systems and procedures within the home.

Records were not always well-maintained to confirm staff's actions and the care people had received.

People, their relatives and staff were encouraged and able to be involved in the running of the home.

Partnership working helped provide shared learning and good practice.

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 home, and to provide a rating for the home under the Care Act 2014.

This unannounced inspection took place on 3 January 2019. 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. In this case the expert-by-experience had experience of older people's services.

Before this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the provider had sent us. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return (PIR). A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted and received feedback from the local authority.

During our inspection we spoke with seven people, five relatives, six members of staff, a visiting health care professional, the registered manager and the regional director. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and medicine administration records for 11 people, staff records, quality assurance audits, incident reports and records relating to the management of the home. 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. We observed the care and support people received as well as the lunchtime experience and the administration of medicines.

Good

Is the service safe?

Our findings

People remained safe. Comments from people included, "I feel I'm in a good, safe place and everyone seems friendly" and "There's nothing not to feel safe about".

People continued to be supported by staff who were suitable to work with them. Appropriate pre-employment checks had been made before staff started work. Their employment history and references were obtained. Registered nurses had valid registrations with the Nursing and Midwifery Council.

When devising the rotas the registered manager had considered staff's skills and levels of experience. New staff were allocated to work alongside existing staff to ensure that they were supported to have a good awareness of people's needs. Staff told us that they valued this and it provided them with someone who they could seek support and advice from. They told us that this ensured that they knew how to care for people according to their needs and preferences and to assure their safety.

There were sufficient staff to support people. The registered manager used the assessments of people's needs as a tool to help determine the required level of staffing. People told us that there were enough staff to meet their needs.

Staff had completed safeguarding adults training and knew the signs and symptoms that could indicate people were at risk of harm. Staff were aware of their responsibilities to safeguard people and told us what they would do if they had concerns about people's safety. People told us that they felt comfortable to speak to staff if they had concerns about their care. The allocation and deployment of staff meant that there was always staff within communal areas to ensure people were safe. Staff were mindful of potential situations that could occur when people displayed behaviours that challenged others. Additional staff were available to offer one-to-one support for people to meet changes in their needs. They provided distraction techniques and interacted with them to help occupy their time. When there were concerns about people's safety, appropriate referrals had been made to the local authority. Advice and guidance provided by the local authority had been listened to and complied with.

Medicines continued to be managed in a safe way. Registered nurses and trained staff administered medicines and had clear and appropriate guidance to inform their practice. People told us that they had access to medicines when they needed them. Staff gained people's consent before supporting them. They were asked if they required certain types of 'as and when required' medicines. Their right to refuse medicines was respected. People had access to regular GP visits where their medicines were reviewed and discussed. Audits ensured that medicines continued to be managed safely. Information about people's health and the medicines that were prescribed, was readily available should people transfer to other settings, such as when they were admitted to hospital. This helped to ensure that people's care was consistent.

Risks to people's safety had been considered and people were safe. Staff worked alongside people and their relatives when devising care plans and risk assessments. These identified people's specific nursing and care

needs. For example, wound care and malnutrition. Accidents and incidents that had occurred had been recorded, monitored and analysed to identify trends. One person, had experienced several falls. Staff had identified this and taken action to mitigate risks. The person had also seen their GP and a referral to the falls prevention team had been made. Lessons were learned and information from the analysis of accidents was used to inform staff's practice. For example, risk assessments and care plans were updated to reflect the change in people's needs following an accident or incident.

Equipment was regularly checked to ensure people's safety. Infection control was maintained and the home was clean. Staff used personal protective equipment when supporting people with their personal care needs. They disposed of waste appropriately to minimise the risk of cross-contamination. Staff had access to food hygiene courses to ensure that they demonstrated safe practice when supporting people with their nutrition and hydration.

Requires Improvement

Is the service effective?

Our findings

At the previous comprehensive inspection on 24 May and 2 June 2016, the Effective Key Question was rated as 'Good'. However, at this inspection on 3 January 2019, we found areas of practice that needed improvement.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

Records showed that when people had a condition that had the potential to affect their decision-making ability, staff had assessed their capacity to consent to living at the home. However, staff had not ensured that this process was followed for all specific decisions relating to people's care. For example, records showed that staff had asked some people's relatives to sign consent forms, which had been sent by the GP surgery, for people to have the influenza immunisation. The registered manager had not considered assessing people's capacity prior to doing this. Some relatives who had been asked to give their consent, did not always have the legal authority to be the sole-decision maker in relation to decisions about people's healthcare. Audits conducted by the provider had identified that capacity assessments had not always been conducted for specific decisions related to people's care. Action had been taken to improve this and staff had been provided with additional learning and development to improve their knowledge. Our findings were fed back to the registered manager who said that they would act to ensure this was remedied. This is an area of practice in need of improvement.

When DoLS had been authorised by the local authority, staff worked in accordance with any conditions that were associated to them. For example, one person's DoLS condition advised staff to ensure the person had access to activities and stimulation that was meaningful to them. Daily records showed that the person had been regularly supported to partake in activities and interaction to occupy their time.

Assessments were conducted to identify risks to people's health, but risks were not always effectively managed. One person, who lived on the residential floor, was assessed as being at high-risk of pressure damage and had sustained a wound. Appropriate and timely treatment was provided by community nurses and the person's condition had improved. However, appropriate action in response to the findings of the assessments, had not been taken. The person used a pressure relieving mattress to minimise the risk of pressure damage. The mattress had been set yet records did not inform staff of the appropriate setting that the mattress should be set at to ensure that it was appropriate for the person's weight. We asked staff how they checked if the mattress was on the correct setting and they could not tell us. This meant that the

person may not have been using the correct pressure relieving mattress to aid healing. The risk of further pressure damage was not minimised. When this was fed back to the registered manager, immediate action was taken. The person's mattress was changed to a mattress that had appropriate guidance to inform staff's practice. This enabled the person to use a mattress that was suitable for their weight and build and therefore minimised the risk of further pressure damage.

People and relatives continued to have confidence in staff's abilities. A relative told us, "Oh gosh, yes. They are very helpful, polite and experienced. They are all very, very good with my relative and their needs". Staff were supported and encouraged to undertake courses that the provider felt were essential to their roles. This included courses that were specific to people's individual needs, such as supporting people who were living with diabetes and dementia care. Staff told us that this had helped them to understand what people may be experiencing and enabled them to support them in a considerate and appropriate way. Interactions between people and staff demonstrated that staff were mindful of how best to engage with people who were living with dementia. Registered nurses had access to learning and development to enable them to maintain their clinical skills. Links with external healthcare professionals enabled staff to have access to current good practice and to develop within their roles.

Staff told us that they continued to feel well-supported. They had access to regular supervisions and appraisals that enabled them to discuss their roles and reflect on their practice. Feedback was provided to staff during these times and they were supported to consider additional learning and development opportunities. Registered nurses had access to clinical supervision from a clinical lead who observed their practice and offered support and guidance when required.

People continued to be supported to maintain their health. Staff were responsive when there were changes to people's health. Timely referrals to external healthcare professionals ensured that people were provided with appropriate treatment and coordinated care. People had access to a weekly GP visit as well as additional visits should they be required. Regular meetings with the GP surgery took place to ensure that there was a coordinated approach to people's care. Procedures such as prescribing medicines and the dispensing of prescriptions were discussed to ensure these processes ran smoothly. An external healthcare professional told us that staff were proactive about people's care and that they were assured by staff's practice. They told us, "They talk to the diabetic nurse at the surgery. They manage people's diabetes very well. They keep an eye on weight loss. They have a hard job and they do it very well".

Communal areas provided people with opportunities to engage and interact with others. People had access to their own rooms so they could spend time alone or entertaining their family and visitors. The provider acknowledged the importance of creating a welcoming environment and had made efforts to maintain and improve the home. Redecoration had taken place and was in the process of being completed. Memory boxes which displayed photographs of people or items that were important to them were displayed on some people's bedroom doors to support them to orientate and recognise their rooms. People had access to the garden and told us that they spent time outside in the warmer weather. A travel-themed area within one of the communal lounges had been decorated with postcards and flags to remind people of holidays that they had enjoyed.

Staff continued to ensure that people had access to sufficient food and drink that met their needs and preferences. Most people were complimentary about the food. One person told us, "It's excellent, the way it's done, it's excellent food. It's cooked to perfection". When people were living with dementia efforts were made to promote choice. Staff showed people a choice of meals which had been served on plates. This visual prompt enabled people to understand what was available and supported them to make an informed choice. When required, people had access to soft diets. People had access to drinks and snacks outside of

mealtimes to ensure they had sufficient amounts to eat and drink. People could choose where to eat their meals and this was respected. When people required support to eat and drink, staff were sensitive to their needs. Staff reminded people of their food choice, explained what they were doing and ensured that people were supported at their preferred pace. For people who chose to eat in the main dining room, a sociable and relaxed atmosphere was created. People enjoyed shared conversations with people sitting at their table. Audits were conducted where the registered manager observed meal times to ensure that people's experiences were pleasant and met their needs.

Good

Is the service caring?

Our findings

Staff had a caring attitude and approach and people were supported with kindness. People and their relatives told us that people were fond of the staff. Comments from people included, "They never rush you" and "I think they're marvellous". A relative told us, "They have time for everybody. I've never heard staff here be unkind about anybody and you can have a laugh with them". Positive comments were provided by a visiting healthcare professional, who told us, "They're marvellous. They are incredibly good and caring and they know people and their families well".
A warm, friendly and welcoming atmosphere ensured that people felt at ease and at home. Staff cared about people and their experiences. People's diversity was acknowledged and practice was adapted to ensure that people were treated in an inclusive way. People's religion was respected and people had access to multi-faith religious leaders if they wished to practise their faith.

Information about people's life history had been gathered. This included information about their employment and family-life. This supported staff to know people well and to gain an insight into people's lives before they had moved into the home. One person told us "They know I was in the forces and lived abroad for years, some of them will talk about that".

Staff took time to sit with people and engage in conversation with them. One person had displayed signs of apparent anxiety and had displayed behaviours that challenged others. Staff took time to interact with the person, explaining their actions and providing choice so that the person felt in-control and cared for. This interaction calmed the person and they were observed to be less-anxious and disorientated as a result. One person was asked how staff treated them with compassion and kindness, they told us, "I feel pleased they are kind enough to listen and to sort me out, when I need it".

People were treated with dignity and their privacy was maintained. When people required assistance with their personal care needs, staff were discreet and mindful of supporting people in a sensitive manner. Staff knocked on people's doors and waited for a response before entering people's rooms. One person told us that when staff assisted them with their personal care needs, they, "Put a towel over my midriff and close the curtains". Personal information about people's care needs was stored in locked cabinets and offices or on computers that were password protected to ensure that their confidentiality was maintained.

Positive relationships had developed between people as well as with staff. People enjoyed conversations with one another whist sitting with each other over lunch or within the communal lounge when watching a film. People could have visitors and relatives at any time and told us that their guests were made to feel welcome. Comments from relatives included, "Oh, yes. Absolutely. They are like a family to me now" and "Yes. Definitely. You always get tea".

People were involved in decisions that affected their lives and the care that was provided. They were involved in discussions about their care so that when their care needs were reviewed they reflected the person's current needs and preferences. As part of some people's DoLS authorisations they had access to paid representatives who could support them to ensure their needs were communicated and their rights

promoted. People could also have access to advocacy services if they required assistance to make their needs known. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

People and their relatives told us that they were provided with information to meet their needs. A relative told us, "We asked for advice and the manager put it well about dementia and helped us understand better". Another relative told us, "I asked about continuing healthcare and the manager gave me some information. They've supported me and my family".

People were encouraged and able to remain independent. People could independently mobilise around the home and were able to choose how they spent their time. Records for some people informed staff that the person enjoyed assisting with household chores and to encourage this to ensure that the person's independence and skills remained.

Good

Is the service responsive?

Our findings

People's holistic needs were assessed before they moved into the home and on an on-going basis. People told us that staff had taken time to find out information about them such as their preferences and their needs. A relative told us, "They came in and assessed my relative and we all said what we thought they'd need". Another relative told us, "They did a booklet describing the sort of person my relative is and what they like and what they like on TV".

People and their relatives were actively involved in continued discussions about people's care. Regular reviews ensured that the guidance provided to staff in people's care plans, was current and reflected people's needs and preferences. Staff focused on the 'whole' person, ensuring that not only were people's physical needs assessed and met, but that their social and emotional needs were too. When people required support with their mental health, staff ensured that they liaised with external healthcare professionals.

People's individuality was recognised and prompted. People could wear clothes of their choice. Some people preferred to dress smartly whereas others liked more casual clothes. Some people wore jewellery. People could furnish their rooms to meet their preferences and had sometimes brought in items from their own homes to create a homelier atmosphere and to help make them feel more at ease. This helped to maintain people's identity.

Staff knew people well, they took time to get to know the person and what their lives were like before they moved into the home. Dedicated lifestyle leads ensured that all people were supported to take part in pass times that they enjoyed. A relative told us, "My relative does the skittles. Last week it was the sprout peeling competition. There's always residents' parties. There's singing and children come in. There's bell ringing. There's always someone coming in, two or three times a week". Activities and stimulation helped occupy people's time. Observations showed people enjoying conversations with one another. One person, who was living with dementia, enjoyed looking at a newspaper with a member of staff. They reminisced about the articles within them. Others enjoyed a cinema afternoon where they watched a film of their choice and had drinks and snacks. Some people, due to their health condition or preferences, spent time in their rooms. The registered manager ensured that people were not socially isolated. People had access to televisions or music and had visits from staff or visitors. One person told us, "Yes, I take part in the activities, in the skittles, the singing and the exercise". Another person who preferred their own company, told us, "There is a lady who sings pop songs. I went to that, but generally I stay in bed. TV is my salvation; I watch from early morning to midnight".

People were provided with a call bell so that they could call for assistance from staff. For people who were unable to use a call bell, due to their capacity and understanding, regular checks were undertaken to ensure people's safety when they were in their rooms.

Staff ensured people's communication needs had been identified at the initial assessment and formed part of their care plans. These documented the best way to communicate with people. Information for people and their relatives, if required, could be created in such a way to meet their needs and in accessible formats

to help them understand the care available to them. A relative told us, "Staff make every effort for my relative to communicate. They pick up things from their eyes and any movements they can make when they are moving them. They have got to know them very, very well and to anticipate their needs".

Residents' and relatives' meetings as well as surveys provided opportunities for people and their relatives to share their opinions. People told us and records confirmed, that people could speak freely and air their views. People told us that they were happy with the care they received. People and their relatives told us that they would feel comfortable raising concerns. When people or their relatives had done this, records showed that the provider had taken appropriate and timely action to deal with these. A relative told us, "I have brought things up and they have been sorted, no problem".

People were provided with the opportunity to plan for their end of life care. Staff respected people's wishes if they did not want to discuss this aspect of their life. Some people had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. Feedback from relatives about the level of care and compassion people had received at the end of their lives was positive. Thank you cards showed that relatives had commended staff's caring nature.

Requires Improvement

Is the service well-led?

Our findings

At the previous comprehensive inspection on 24 May and 2 June 2016, the Well-led Key Question was rated as 'Good'. However, at this inspection on 3 January 2019, we found areas of practice that needed improvement.

The provider's aim is to provide a 'home-from-home'. Comments from people and their relatives demonstrated that this was implemented in practice. They told us that that people were content and comfortable and that their needs were met. People told us about the difference the care they had received had made to their lives. They told us, "Looking after my general welfare" and "They look after me". A relative told us, "It's made their life easier". Another relative told us, "They're happy; they were depressed at home. They are very happy and brighter here". However, despite these positive comments, we found areas of practice that needed improvement.

The registered manager, regional director and external healthcare services undertook quality audits. These helped to ensure that systems and processes were effective and met people's needs. Themed audits, such as safeguarding adults, were conducted to enable particular processes to be focused on. The provider asked staff questions to assess their skills and levels of understanding. The audits that had been completed had found some of the shortfalls that were found as part of this inspection. This included records not being completed sufficiently. This related to repositioning records and the application of topical creams to document the support people had received. Because these records were not complete we did not know if people had received the appropriate support or if staff had failed to document their actions. Another area that had been identified as part of the provider's audits, related to the completion of mental capacity assessments for specific decisions related to people's care. In response to identifying this the provider had ensured that staff had access to additional learning and development to improve their knowledge. Although these issues had been identified through the audits, staff had not made sufficient changes and these areas of practice needed further improvement.

Audits had not always identified other shortfalls that were found as part of the inspection. This included ensuring that all people had access to appropriate pressure relieving equipment when required. In addition, the involvement of people and relatives in discussions about people's care was not documented to demonstrate that this had taken place. Ensuring that audits identify and address all shortfalls, is an area of practice that needs improvement.

There was mixed feedback from staff about the leadership and management of the home. Some staff told us that they felt well-supported, whereas others told us that they did not feel supported by the registered manager. They told us that the registered manager was unapproachable and that they did not have confidence that actions would be taken if issues were raised. One member of staff told us, "A lot of staff don't really go to [the registered manager] as they are unapproachable. They are not on the floor enough to know what the residents' needs are". Another member of staff told us that the registered manager did not like to be contacted when they were on-call and therefore staff were reluctant to contact them if there were problems. This mixed feedback was fed back to the registered manager and regional director who explained

that a staff meeting was planned and that they would use this as an opportunity to explore staff's feelings in greater detail to determine how improvements could be made.

Staff and people were involved in the running of the home and in decisions that related to it. Staff surveys had been sent to gain staff's feedback. The results had been discussed at a staff meeting and staff had been asked to undertake a Stop, Start and Continue exercise to determine what practices they needed to stop as well as what practices they needed to start or continue. Regular residents' and relatives' meetings ensured that people and relatives could air their views and discuss any ideas or suggestions. Records showed that people had discussed the type of entertainment that they would enjoy. Regular surveys were sent to gain further feedback and positive responses has been received.

Since the previous inspection on 24 May and 2 June 2016, the registered manager had changed. The registered manager had been in post for one year. The management team consisted of the registered manager, a clinical lead and two unit managers. A regional director regularly visited the home to conduct quality assurance audits and provide support to the management team.

People and their relatives were complimentary about the leadership and management of the home. When asked if the home was well-managed, a relative told us, "Yes. It's a combination of everything, it works from the top down". Another relative told us, "They seem to maintain a happy atmosphere".

The registered manager was aware of their responsibilities to notify us of certain incidents and events that had occurred within the home. This enabled us to have an awareness and oversight of these to ensure that appropriate actions had been taken. Feedback from people and a relative, as well as records, showed that staff were aware of their responsibilities to comply with the Duty of Candour CQC Regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'.

There were links with external healthcare professionals and local authorities to ensure that people received a coordinated approach to their care and that staff learned from other sources of expertise. The registered manager attended regular meetings with other registered managers of the provider's other services. This enabled shared learning and supported the development of good practice.