Care Quality Commission

Morris Care Limited

Corbrook Court Nursing Home

Inspection report

Corbrook Court, Audlem, CW3 0HF
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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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 22 and 30 January 2015 and was unannounced.

Corbrook Court Nursing Home is a large manor house which is situated on the outskirts of Audlem. The home provides day care and general nursing care and can accommodate up to 45 people. There were 29 people living in the home at the time of our inspection. The home's statement of purpose identified that the home was able to provide care for older and younger adults, as well as people with a disability and people who were living with dementia.

One of the conditions of registration for the home was that it must have a registered manager. At the time of our inspection there was no registered manager in place. 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'.

Summary of findings

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 provider told us that they had just started the process of registering the current manager.

At the last inspection on 11 July 2014 we asked the provider to take action to make improvements to arrangements for consent to care and treatment, the care and welfare of people who used the service and staffing levels. The provider sent us an action plan and said that they would comply with the relevant regulations by the end of October 2014.

At this inspection we found that the provider had taken some action around these areas including offering additional training and recruiting additional staff. However we also found that responses to call bells could be lengthy and people told us they had been left waiting to go to the toilet, which had caused them some discomfort. The registered provider had failed to take steps to ensure that the planning and delivery of care met the service user's individual needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is being followed up and we will report on any action when it is complete.

At this inspection we found that staff working in the service understood their obligations in respect of safeguarding people and that the registered provider took steps to make sure that they were suitable to work in the home. Staff were well trained including in their obligations towards people who might not be able to give consent to their own care.

Staff knew the people who lived in the home and the people who lived there told us that staff were caring and relatives confirmed this. Activities were available in the home for those who wished to participate in them and a series of audits meant that the standard of service in the home was monitored. However we did not always see action resulting from these audits. People were divided in their opinion of the standard of food in the home.

Summary of findings

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 because staff knew how to safeguard the people who lived in the home and most people living there and their relatives said they felt safe. The registered provider took proper precautions to make sure that the people who worked in the home were suitable for this kind of employment.

There were sufficient staff working in the home and the registered provider had increased the level of staffing since our last inspection to include stewards to assist at certain mealtimes. Although the home was not full the registered provider had maintained staffing levels.

Is the service effective?

Requires improvement

The service was not always effective. Opinions were divided on the quality of the food at the home and people had expressed dissatisfaction with this for some months. The manager was about to take steps to remedy this. People could make choices over meals and were provided with drinks.

Staff understood the need for people to consent to their care. Staff knew what to do if people were unable to make their own decisions because of illness and had received training in this. The home was observing the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring. Most people told us that they thought the staff were caring and we saw that they knew the people who lived in the home well and used this information to provide their care.

Staff treated people with dignity and respected their privacy. Relatives told us that they too experienced kindness from the staff in the home.

Is the service responsive?

Requires improvement

The service was not always responsive because people sometimes had to wait too long for their call bells to be answered.

There were activities on offer to people and a dedicated activities organiser was available to provide these either on a group or an individual basis.

Is the service well-led?

Requires improvement

The service was not always well-led because there had been no registered manager for some months and there was no registered manager at the time of our inspection. As well as being a condition of the home's registration this meant that the registered provider did not provide us with information we required before the inspection.

Summary of findings

There was a system of audits in the home which the manager used to monitor the quality of service provided. The registered provider also supplied performance information for the manager to use in this way. Complaints were responded to promptly and in a courteous manner.

Corbrook Court Nursing Home

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 was 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 22 January and was unannounced. The inspection team was made up of two adult social care inspectors, a specialist adviser, 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 people living with dementia. One inspector returned to complete the inspection on 30 January 2015.

Before the inspection, we asked the provider to complete 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 improvements they plan to make. The provider did not return the PIR and we took this into account when we made the judgements in this report.

We also reviewed the information already held by the Care Quality Commission in respect of this service. We contacted the local authority with responsibility for commissioning and safeguarding in the home who provided us with their latest reports. We contacted the local Healthwatch organisation but they did not have any observations to make. Healthwatch is the consumer champion for health and social care.

There were 29 people living in the home on the day of our inspection. On the first day we were told that several of the people who lived in the home were suffering from infections. In order to avoid unnecessary cross-infection relatives had been asked to limit their visits to the home and the people living in the home were spending more time in their individual rooms. The manager was content for us to continue with our inspection but this limited some of our observations such as joining in with communal meal times, activities and the number of visitors we could talk with. We were able to make further enquiries on the second day of our inspection when the risk of cross-infection was no longer a concern and the home was operating on the usual basis.

Over the course of the inspection we spoke with fourteen people using the service and visited them in their bedrooms with their consent. We spoke with five of their relatives and friends or other visitors including one relative by telephone. We looked at five care files and other documentation such as medicines records. We talked with nine staff and looked at three staff files as well as other management records. We also met and spoke with the manager as well as the chief operating officer and the clinical governance officer for the company which operates the home. We spent one lunch time with the people who lived in 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.

Good

Is the service safe?

Our findings

Most people we spoke with said that they felt safe living at Corbrook Court Nursing Home. They told us ""I'm safe and happy here, I don't want to go anywhere else", "Safe? Of course I feel safe" and a third person told us that they thought the staff were very kind. All six relatives we spoke with agreed their family member was safe.

When we visited Corbrook Court in July 2014 we found that the home did not have sufficient staffing. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The home sent us an action plan as a result of which we saw that a dependency tool had been introduced which allowed staffing requirements to be determined by the level of needs required by each person. We saw evidence that this tool was in use during this inspection visit.

During the current inspection the manager told us that current staffing levels were set at two nurses and seven care staff in the day. In addition one person was receiving one-to-one staffing because of their needs. This role was shared throughout the staff group to avoid it always falling on the same person. The home now also employed two stewards whose role was to serve the breakfast and lunchtime meals to the people who lived in the home. An activities organiser also worked in the home during the week. Staff told us that they felt the reintroduction of the steward role had assisted the staffing situation.

These staff were supplemented by the head cook and kitchen and domestic staff as well as the manager. We confirmed that this was the level of staffing during our inspection and confirmed the staffing levels against the rotas for the last four weeks. We were told that at night staffing levels were either one or two nurses with two carers although we saw from the rotas that it was not uncommon for there to be only one nurse on duty with the carers.

Relatives we spoke with were divided as to whether there were sufficient staff and told us about delays in providing care to their relatives. Staff told us that they thought there were enough staff for the current reduced number of people living in the home. They told us that they thought that although staffing had not been directly adjusted during the period of under occupation that the registered provider was compensating for this by not bringing in extra staff to cover staff sickness absence or leave. We saw records that confirmed that the level of staffing in the home had not been reduced despite recent reductions in the number of people living in the home.

Staff had a good understanding of safeguarding. They were able to describe the sorts of abuse to which people living in the home might be vulnerable. Some of the staff had worked in the home for a number of years but none could remember any incidents where they had felt people were not safe. Staff said they had no concerns and knew what to do if they did have. One told us "If I thought anyone wasn't happy or wasn't safe I'd go straight to the manager" and other staff we spoke with confirmed that they would also report anything of this nature in this way.

Staff told us that they had received training in safeguarding and we saw that the registered provider's own records showed that this had been completed across the whole staff group. We saw that staff had completed workbook training in safeguarding and how to respond to potential abuse or neglect. This included how to whistle blow.

We saw that care files contained a series of assessments relating to various risks such as falls, weight loss, moving and handling and skin integrity. These assessments had been reviewed at regular intervals and we saw that the reviews were up to date. This meant that care could be provided in such a way as to avoid these risks as far as possible. The registered provider told us that there were some people In the home who used bed rails and lap belts. The provider had included risk assessments for the use of these and we saw that they had been regularly and recently reviewed.

We saw evidence of a robust recruitment process including references and identity checks, The registered provider referred to the Disclosure and Barring Service so that any criminal convictions relating to staff would be declared. The provider had checked that nursing staff were registered with the appropriate professional body. These arrangements helped to ensure people's safety because the provider could make sure that the people who worked in the home were suitable to do so.

We talked with one person who managed their own medicines who told us how staff supported them to do this. They told us "(Staff) went through all my medicine with me and it's stored in the cupboard, they are going to sort out my repeats (prescriptions)". The medicine was stored in a

Good

Is the service safe?

locked compartment in the person's room. Another person told us they needed special injections and that "They said they're going to do it here for me". Another person confirmed that they were satisfied with the arrangements for receiving their medicines. The home's medicines policy had been updated immediately before our inspection.

We looked at the arrangements for administering and storing medicines in the home where people did not do this for themselves. On each floor we saw that medicines were stored in a locked trolley designed for this purpose. The trolleys were in turn secured to the wall. Although the trolleys were not kept in a separate room the temperature they were stored at was recorded and fell within the correct range for this. We saw a central medicines refrigerator which was operating within the correct temperature range. Medicines that are not stored at the correct temperature may lose their efficacy. The refrigerator was kept in a locked central medicines' room which also contained the controlled drugs storage cabinet. We checked that this conformed to the legal requirement for the storage of such drugs and that appropriate arrangements were in place for their administration and to account for them.

On the day of our visit we saw that medicines were administered by nursing staff and saw evidence that they undertook a self- assessment of their competence annually and were observed by the clinical lead. We were told of arrangements to ensure that staff could easily make requests for fresh stocks of medicines and reconcile deliveries with what had been prescribed for people. We saw nursing staff administering the medicines by referring to the medicine administration record (MAR) and then taking them to the person in their room.

We saw that there had been five medication gaps (where someone had not been given the medicine they were due) in the last month. We saw that the MAR sheets were audited and any resulting changes recorded. The manager used a decision-making tool for dealing with medicines errors which included reporting appropriate instances to the local safeguarding team. We saw a note of action taken in response to medicines errors which included providing additional supervision to staff on an individual or group basis.

We looked around the home and saw that it was clean and that communal areas, bedrooms and bathrooms were tidy and uncluttered. We saw that there were well-equipped sluice rooms on each floor. We saw that there was a good selection of cleaning materials available in these rooms. However, although the signs on the doors of these rooms indicated that they should be closed to reduce the risk of cross-infection we found that two were left open for long periods during our inspection.

We saw that there was a well-equipped laundry and that people's clothes were labelled and kept separate so that they did not get mixed up. We saw that personal protective equipment (gloves, aprons, etc.) was available to staff at various points in the home where staff could easily access it. The home had a programme of deep cleaning rooms in turn and three were recorded as having been completed in the last month.

The manager showed us how arrangements for helping people to leave the building in an emergency were assessed and recorded within care plans and then translated into a colour coded system within the home so that staff would know the correct action to take in event such as of fire. During our inspection the fire alarm was triggered and we saw that staff followed appropriate procedures whilst the source of this was identified. We saw that there had been a recent fire risk assessment of the home within the three months prior to our inspection.

Requires improvement

Is the service effective?

Our findings

People we spoke with were not always complimentary about the food at the home. One person told us the food was "OK - sometimes but not always." Another described the food as "Abysmal as it's sometimes cold or dried up after being kept warm." A third person told us "They feed you too much, I've had to stop eating the puddings I was putting on too much weight" and a fourth said "The food is terrible. Not cooked properly. But you do get a choice". On the other hand one person told us, "The food is good. It tastes lovely" and another said "The food is good". One relative told us "Food's pretty good as far as I know". We saw that the standard of food had been identified as an issue in the last satisfaction survey carried out by the home and which pre-dated the current manager's arrival. The manager told us that satisfaction with catering would feature in a forthcoming customer survey of people's views.

When we visited Corbrook Court in July 2014 we found that the home did not have suitable arrangements in place for obtaining and acting in accordance with the consent of the people who live there. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The home sent us an action plan in which the manager told us that she would arrange training for staff in this area and would ensure closer monitoring of care plans to make sure that this was happening. The training provider confirmed that this training had taken place. We saw that the registered provider had undertaken mental capacity assessments in a number of circumstances.

Staff told us that the registered provider gave them training according to their role. This included induction training which was arranged by the registered provider at a separate location. We saw in staff files that new staff had received a comprehensive induction programme including orientation, review of policies, mandatory training, overview of care planning and the opportunity to shadow more experienced staff. We saw that an Induction checklist was completed to ensure all elements were covered. We also saw that probationary period training records were in use and were signed off to confirm that this training had been completed at four, eight and twelve week intervals.

We checked the records of mandatory training to make sure that the provider was keeping staff up to date. Around 90% or more of staff were recorded as having completed aspects such as moving and handling and fire training. Where a lower completion rate was recorded the manager told us that this was because of the recent recruitment to 14 staff vacancies and there had not been time for all the new staff to be trained. The manager told us that she was introducing staff with specialist responsibilities for infection control and moving and handling who would be able to deliver and update this training on a local basis.

We spoke with staff who confirmed that there was an ongoing training programme. Examples of training they had recently undertaken or were about to complete included refresher moving and handling training. We saw in staff files that a range of training was available to them including mandatory modules, dementia awareness and national vocational qualifications at levels two and three. Staff had also received training in duty of care and responding to challenging behaviour. We spoke to the training provider who was working in the home. They told us following our last inspection they had delivered bespoke training for staff around the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), safeguarding, and moving and handling of adults.

The Mental Capacity Act 2005 and DoLS arrangements provide for the protection of people who are no longer able to make a decision for themselves usually because of an illness such as dementia. The local authority told us that the home had recently made 12 DoLS applications which they were currently waiting to assess. We sampled the paperwork for three of these applications and saw that the home was now undertaking appropriate mental capacity assessments to support them. This meant that the registered provider followed the requirements of DoLS. The local authority had not yet determined these applications and no one else living in the home was subject to DoLS.

We also saw evidence of other "best interest" decisions. These are decisions taken on behalf of people who do not have capacity to make a specific decision by people who have sufficient knowledge of the person to do this. These decisions included matters relating to covert medicines, health and safety and maintaining personal hygiene. They were each accompanied by a mental capacity assessment which staff in the home had undertaken.

All of the staff we spoke with told us that they had received training in the Mental Capacity Act 2005 and DoLS and this was confirmed by the registered provider's training records. We spoke with the training provider who told us that the

Is the service effective?

home was unusual in their experience because they included all (rather than only selected) staff in this training. We found that staff had a good understanding of issues of consent and had an appreciation of the DoLS arrangements. The registered provider had therefore properly trained and prepared staff in this respect. Policies relating to the Mental Capacity Act 2005 and DoLS had been updated immediately before our inspection.

However, four files contained confusing paperwork around the matter of capacity and consent. In two instances there was no evidence that consent to various care matters had been given as the form for this was blank. There was no mental capacity assessment present or any other explanation as to why the consent form had not been signed by the person concerned. In two other instances consent had been given by a relative on behalf of the person using the service but it was not clear why they rather than the person had done so. One person had been assessed more recently as having the capacity to make important decisions themself. We brought these to the attention of the manager.

The manager told us that the latter instance reflected that capacity could fluctuate in time and according to the decision being taken. The manager told us she would introduce a record showing that each person's capacity was reviewed periodically to take account of these fluctuations.

We saw that the registered provider had arrangements for helping staff to record and respond safely to behaviour which was unusual or unexpected .However we saw that one person's care file contained notes recounting behaviour which a member of staff had found challenging in this way. The recorded behaviour appeared isolated to two occasions but we did not see any evidence of any attempt to explain or understand it. Other staff told us that although they knew this person was unhappy they did not find their behaviour challenging. We asked the manager to review these records with staff so that some analysis could be provided to them about whether this behaviour had occurred exactly in the way recorded and if so how staff might anticipate it in the future.

We saw that the home employed stewards to provide drinks and meals to the people who lived there. We saw that choices were made available However we asked people if they got enough to drink and one person told us, "We don't always get (mid-morning) drinks because there is not enough staff. Sometimes they say, "we're too busy, and there are only two of us on duty" (in that particular area of the home).

On checking the records of fluids in people's bedrooms we found fluids were recorded as having been drunk. We saw though that when drinks were served there was sometimes a delay between them being handed out and care staff being able to support the person drinking. After staff had popped in and out of the same rooms throughout the day, there were sometimes three unfinished drinks lined up. Assistance with drinking one had not always been completed before another was presented.

On the second day of our inspection we spent time with people in the main dining room during lunchtime. We saw that the meal being served was in accordance with the menu for the day including alternative choices. We did not sample the meal but saw that portion sizes were appropriate.

We saw that food preferences were recorded on the care plans, communicated to kitchen staff and that these were reflected in the meals which were sent to the different units by the kitchen.

We talked with the head cook and saw that the menu was organised on a four-weekly basis. The cook told us that they canvassed the people who lived in the home for their preferences and developed the menu on this basis with seasonal adjustments so that, for example, salads were available in the summer months. They told us that there was always a choice of alternative to the main meal shown on the menu and we heard staff asking people who lived in the home about their preferences in this respect. The kitchen had received a five star food hygiene rating from the local environmental health authority.

The manager told us that they had taken advice from the local infection control service provided by the Clinical Commissioning Group. The manager told us that the GP was monitoring the current outbreak of infection and also visited very week. We saw evidence that people received care from the continence advisory service, chiropodist, audiologist, physiotherapist, mental health nurses, dentist, speech and language therapists and opticians. The

Requires improvement

Is the service effective?

appointments and visits recorded in care plans indicated that here was a multi professional approach to providing care and a nursing diary in each unit helped to make sure that appointments were kept.

Good

Is the service caring?

Our findings

Most of the people we spoke with were complimentary about the staff. They told us "Staff are kind" and "Staff treat me with respect, I can have a laugh with them." One person felt that staff care was compromised by staffing levels when they told us "They're kind and caring, just not enough of them. Staff are working too hard" and "Some (staff) rush through what they have to do and don't have time for you." Another person echoed this when they said "On the whole the care staff are good there's just the odd one that is not as much." Other comments included "The staff are very kind. Smashing", "Corbrook Court is great" and "I think it is great here".

Other people praised staff and one said "It's nice to be looked after" and that "Carers pop in to see if you're alright". However one person told us ""Some staff treat me as a baby, the way they talk to me" and another told us that when they were bathed by staff they were unhappy with the way they had done this. We were aware that this person was not happy with a number of aspects of their stay in the home. We discussed their specific concerns with the manager and were satisfied that she was trying to respond to these.

Two relatives told us how caring they had found staff to be whilst their relative was seriously ill. One told us "They let me stay and brought me food and drinks". Another told us that they thought the home was "very caring". Other relatives spoke of how caring and sensitive they felt staff had been just before their relative's death (a few days earlier). We saw that the home made arrangements if relatives wished to stay overnight with their loved ones when they were very poorly. We saw that other family members and others were able to visit people who lived in the home and (apart from during the infection outbreak when this was discouraged) were able to visit at any time and when it suited them.

During our inspection we saw that staff treated people who lived in the home with dignity. We saw that they were patient, friendly, supportive, and used people's names when they addressed them. We saw that personal care was provided in people's own rooms with the door closed. We saw that staff maintained people's privacy by knocking on their bedroom doors before entering. Staff used a "nurse in attendance" sign on the bedroom door when they administered personal care so that other people and staff would not intrude. This helped to protect privacy and dignity. We also saw staff being respectful and caring to a family whose loved one lived in the home and who was very poorly.

When we talked with staff it was clear that they had a detailed knowledge of the people who lived in the home and used this to establish friendly relationships with them. On a number of occasions we saw staff chatting to people and sharing experiences with them. We saw staff respond appropriately to friendly banter from some people. This had the effect of introducing an appropriate level of familiarity into the personal care relationship and allowed people to participate as equals rather than just as recipients of care.

It was evident that supervisory care staff used this knowledge to support more junior staff and new employees. We saw that they sought to explain the differences between the people who lived in the home and provided relevant information about them so that these staff would become more confident in providing personal care.

We saw that when we were present during one lunchtime staff were attentive to people, interacted appropriately with them and where required encouraged them to eat their meal. People chatted to both the people they were sitting with and to people on other tables. Where people required assistance with eating their meal the stewards called for care staff as it was not part of their role to do this. In one instance this led to a delay meaning that the person concerned could not eat at the same time as the other people sitting at their table but otherwise the dining experience appeared to be a communal and enjoyable one.

We saw that the home provided respite or short stay care to people. This kind of care can support people to continue to live in the community and give their families a break from some caring responsibilities thus promoting independence. We saw that the home promoted this in other ways and that a person who used to live in the home had recently left after a year to resume more independent living. We saw comments from this person's relative addressed to the home which said "Under your care my father's condition has improved to the extent that he can now return to his home". We also saw that where appropriate, plans had been made around people's wishes for end of life care.

Requires improvement

Is the service responsive?

Our findings

When we visited Corbrook Court in July 2014 the registered provider was not taking proper steps to ensure that people living in the home were protected against the risk of receiving inappropriate care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During this inspection we asked people who lived in the home if they received help and assistance promptly when they used the call bell system. They told us they sometimes had to wait too long for a member of staff to respond to their call. This caused them particular discomfort when they needed assistance with going to the toilet. Two people said it was worse in the evenings or at night or when staff were on a break. One person said "They don't always answer the bell or it doesn't work" another told us they had to wait and "I know it was a while - about twenty five minutes because I had the television on". A third person told us "They didn't respond to the buzzer quickly enough (when I needed to go the toilet) so I wet myself". Other comments included "They can take some time to come to the call when they are busy" and "They can be a long time answering the call bells".

One relative commented on the availability of staff when they said, "Staff – most seem fine but there's not as many of them as there should be" and another expressed concern that the manager divided her time between two sites adding, "The manager always says there's enough staff but the staff say there isn't". However one person who lived in the home told us that they did not have any issues with responses to the call bells.

We saw that people were able to express preferences and staff would respond to these. One person preferred to spend the day in their nightwear and slept in a reclining chair. This was noted in the care plan and their wishes were met. We saw another person approach a member of staff with a specific request relating to how they wished to take their medication and we saw that the staff responded to and agreed with the request.

However we saw another person was sitting in their chair in their night clothes at 10.40 am. This person told us they were waiting for staff to help them wash and get dressed. Their hands and legs were bare and they felt cold. We found this person's room was draughty and they said they had told one of the staff "But nothing's happened yet." This person was not attended to until after 11.30 am. Another person told us that they preferred to have a bath in the morning rather than the afternoon but was told that staff were "too busy". This person also said that they would like more frequent baths but "staff are too busy".

Following our last inspection the manager sent us an action plan detailing how they were going to ensure the people's needs were met in a timely way. We saw that the manager had undertaken a number of these actions particularly around care planning and recording individual preferences and risks.

The registered provider also undertook to fully review the call bell system and its effectiveness because at the time of the last inspection we had identified delays when responding to people. At this inspection we were told that the coverage of this system throughout the building had recently been improved. We saw that the system displayed either the room number or the name of the person who was calling and also recorded the response to this on a database. Care supervisors could call for assistance from other parts of the building using a two-way radio.

We asked the manager to provide us with a sample of records from the database so that we could check response times. We looked at the records for five of the bedrooms. In each case we found that response times were usually under five minutes and sometimes within a minute. However the records also showed that on occasions each of these people had had to wait for more than 20 minutes for their call to be answered. The records also recorded some response times in excess of half an hour. This would be too long for someone to wait if they had an urgent personal care need.

When we asked staff about this they confirmed that they were aware that response times could sometimes be too long. They said that whilst staffing levels had been improved overall there were still instances where they could not attend people promptly because they were already providing care to someone. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

We raised the matter of call bell response times with the manager and her management team who agreed to look at ways in which they could better monitor performance in this area in order to identify the causes of delays and implement solutions.

People living in the home expressed different views on activities. One person told us "All there is to do is eat". Another person said "I like line dancing and know I'm not as active as I was but they could do something like that with better music, not just the chair exercises". Another person said "I've not got much choice. There's not much to do - I rely on (my relative) to take me out".

We were told that some people did not wish to leave their rooms so preferred to stay in their bedrooms. Three of the people we spoke with confirmed that this was their preference one saying "There are activities but I prefer not to join in". We saw that the activities coordinator also provided one to one sessions in people's bedrooms.

Although we were told that the home did not specialise in the care of people who were living with dementia some of the people living there suffered from this condition. The home included providing care for people with dementia in its Statement of Purpose. We were told that the home had access to a nurse with a postgraduate qualification in dementia. However we did not see any specific adjustments such as to the environment or activities to support these people during our inspection.

The manager told us that she did not consider this was required because people had lived in the home for some time and so were very familiar with its physical layout. However we were told that the home would look at whether there might be opportunities to tailor some activities more specifically to these people's needs.

On the first day of our inspection all communal activities were suspended due to the risk of cross infection. We saw that a copy of the daily newspaper was available in one of the communal areas. However since the communal areas were not in use at the time this did not appear to have been offered to anyone in their own room and so it remained unread.

We talked with the member of staff who was employed as activities organiser and found that they were enthusiastic about their role. We saw that there was a news sheet showing a timetable of activities. This included a regular coffee morning, movement to music sessions, reminiscence discussions, a film presentation, and arts and crafts as well as a supper club.

Recent records of activities reflected the current situation in the home but we saw that a log was kept of the people's activities and this included the period before this. We saw that some people had seen a fireworks display, participated in gardening, attended a performance by a musician and a showing of a recent film which had been used to promote discussion. On the afternoon of our second visit communal activities had resumed and we saw that for those people who wished to attend there had been a book reading (by a person who lived in the home) before a music and movement session.

People told us about a military band which played at Christmas and said that sometimes they were entertained by singers. Church services were included in the schedule. We were told that the home did not have its own minibus for excursions but had to make use of a shared vehicle on a few days of the year. However one person said "The activity list gets on my nerves. It's the same here every day".

We looked at the care plans which the registered provider kept. Each file included admission details, a dependency chart and a list of medicines. The dependency chart was used to determine overall staffing levels and was evaluated monthly to produce an index figure. If this increased by more than a certain amount a review was required with a greater increase being brought to the attention of the manager. However on one of the charts we looked at the scores had not been totalled so it would have been difficult to use this information on that occasion. Care plans described people's likes and dislikes and how these might influence their routine.

Daily task sheets were completed by staff and kept in a record which was kept in the person's bedroom. This record also contained an activity chart completed by the activities coordinator and a copy of "This is me" which included details of people's previous life including a family tree, special events etc. An events log was seen to be completed every few days and we saw that care plans also had evaluations completed every few days.

We saw that the care plans were reviewed monthly at a minimum and we saw signed and dated evidence of this in care records. We saw completed food and fluid charts in

Requires improvement

Is the service responsive?

the files in people's rooms. There were monthly risk assessments related to moving and handling, risk of falls and mobility. Care plans were documented clearly and staff could easily access information about the care and support care required. We saw that there were monthly evaluations of each care plan.

We saw from the communication records within these files that the home took steps to make sure that people's families were kept informed and where possible involved in their relative's care. However we did not see any explicit opportunities where these views and those of the person living in the home could be recorded. The manager told us that she proposed to introduce such a system in the next few months.

We saw the widespread use of airflow mattresses and cushions to reduce the likelihood of pressure sores. We saw a pressure mattress monitoring sheet (to check the mattress was functioning correctly) with clear instructions that these checks should be done twice daily. We noted however that in a number of instances the record showed that the mattresses had only been checked once in a week and sometimes there were unexplained gaps.

We saw that there was a complaints procedure and that this made available to people in a guide to living in the home which we found in people's bedrooms. One person confirmed there were residents' meetings saying "But nothing ever gets done". None of the people who lived in the home or their relatives said they had recently received survey forms or questionnaires about the service.

Requires improvement

Is the service well-led?

Our findings

The registered provider submitted a Statement of Purpose in September 2012. We saw that the Statement was displayed in the home's reception and outlined the home's objectives in terms of people's rights and the quality of care. The Statement of Purpose outlined the underlying principles according to which the home would be managed and recognised the importance of the role of registered manager.

The registered provider is required to have a registered manager in place at the home. The last registered manager recorded by the Care Quality Commission (CQC) had left in April 2014. At the time the registered provider had told us that it intended to make changes to the registration of another home which it manages on the same site as Corbrook Court Nursing Home but CQC records show that this did not take place. At the time of our last inspection we advised the new manager of Corbrook Court Nursing Home that her urgent registration with the CQC was needed.

The current manager of the home told us she divided her time between both homes on the site but at the time of this inspection the CQC had not received an application for her to register as manager in respect of Corbrook Court Nursing Home. Consequently there had not been a registered manager at the home for most of 2014 and for the whole period since the last inspection. The registered provider assured as that they had commenced the process of registering the manager just prior to our inspection. We checked our registration records and confirmed that an application had been received.

We saw that the manager had implemented her own system of quality audit. The areas covered by this audit included information and involvement, personalised care treatment and support, the lived experience, safeguarding, staffing and training, the environment, and quality and management. We looked at the last six months of these audits and saw that they included observations of the care being provided in the home as well as sampling of different records on each occasion.

We noted however that on the most recent occasion the audit had confirmed that a copy of the latest CQC inspection report was available in the home's reception whereas the copy on display was for the previous inspection. We were told that some relatives were aware of this discrepancy. This meant that other visitors to the home or members of the public enquiring as to the care provided there might not have known of the most up to date CQC findings from the last inspection. The Secretary of State intends to introduce regulations requiring that in the future registered providers must display the results of their latest inspection to the public.

We saw that the results of a survey of people who lived in the home were displayed in the manager's office. Some issues identified as requiring attention were the same as we found during the inspection. For example there were a number of comments relating to the food and dining arrangements in the home. Staff availability and response to call bells was rated as only "fair". Both these and other items were identified as being investigated but although the survey was dated Spring 2014 we could see no evidence that progress had been made since this.

We saw that there were a number of other audits maintained. These were generally samples of records. They included audits of medicines records and we saw that these included rigorous challenges to staff about their practices so that they could review and adjust these. The registered provider also produced quality indicators. These included quality of care, quality of life, quality of management and quality of environment. We saw also that reports of accidents and incidents were maintained and that each one included a note of the action which might be taken to avoid a repetition so that there could be learning from these.

The registered provider is required to notify the CQC of certain events in certain circumstances. We checked our records of the notifications made to us and were satisfied that the registered provider was reporting appropriately.

When we spoke to staff some said they felt well supported and that the organisation was transparent, open to change and new ideas. Staff felt positive that despite the lower number of people living in the home at the time of this inspection the registered provider had not laid any staff off or reduced their hours. Another member of staff told us that they had told the manager they didn't have enough staff and agency staff were brought in immediately. A third member of staff told us that they had had reason to report a matter to the manager that day and felt confident that it would be dealt with.

Requires improvement

Is the service well-led?

It was clear however that support for the change in management style introduced by the current manager was not unanimous amongst the staff group. In general though there was agreement amongst staff that they had been through a difficult period and things in the home were improving. The management style was described by staff as accessible, pragmatic, problem-solving and solution-oriented.

Staff told us that they received supervision which is a meeting held between a member of staff and their manager so that both parties can discuss any matters of importance as well as making plans for the future such as for training. We saw that supervision was offered monthly and the manager had recorded 42 supervision sessions completed in the previous month.

When we looked at the records we saw that the form of supervision was variable. Sometimes there were individual sessions but some supervision was conducted in groups of around eight people. Sometimes the agenda was influenced by the staff themselves but a number of meetings were used principally as management meetings to communicate with them.

Appraisals were being re-evaluated and all staff had been sent a pre appraisal questionnaire in the last month. We were told that the intention was that the clinical lead and manager would undertake everyone's appraisals over the coming months and then other team leaders would be trained to do this in due course.

We saw that there were records of meetings at which the people who lived in the home were invited to express their views about how it was run. One of these meetings had been scheduled for the evening before the second day of our inspection and the manager confirmed that this had gone ahead although only person had attended with her. The records showed that the meetings had been held regularly over the past few months. We also saw that there were records of regular meetings of staff as well. The manager told us that she aimed for all these meetings to take place monthly.

We looked at the register of complaints. There had been 15 complaints in the last year and all had been responded to within the registered provider's deadline of 28 days. We sampled the replies which had been provided to complainants and saw that the registered provider sought to understand the complainant's point of view and provide an explanation of why the circumstances leading to the complaint had occurred and any action being taken to respond to this. We saw evidence from their replies that some complainants appreciated this kind, detailed and careful response.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not appropriate, did not meet their needs or reflect their preferences.

The enforcement action we took:
We have served a warning notice to be met by 1 May 2015.