Morris Care Limited

Corbrook Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 20 and 21 December 2016 and was unannounced.

Corbrook Park is a large manor House situated on the outskirts of Audlem. Within Corbrook Park there are two units, Corbrook Court and Cedar Court which provide nursing and dementia care. The home is registered to provide a service for up to a maximum of 80 people. During our inspection there were 69 people living at the home.

The last inspection took place on the 11 August 2015 and we found at that time that all the legal requirements were met.

During this inspection, we identified three breaches of the relevant legislation, in respect of safeguarding, good governance and consent. You can see what action we told the provider to take at the back of the full version of the report.

There was no registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A Manager had been appointed and was in the process of registration at the time of the inspection. The manager told us that he was focused on making improvements to the home and had identified areas where actions would be taken.

Staff knew the importance of keeping people safe, including being safe from abuse and harassment. We saw that the provider's safeguarding policy and procedure was available to staff. However we found that whilst the majority of safeguarding concerns had been reported to the local authority we identified some incidents which had not been appropriately reported. This meant that we couldn't be sure that people were fully protected.

Staff had received appropriate training to administer medicines and their competency was checked on a regular basis. However we found that there were some short falls in the recording and management of medicines. For example there were no protocols in place for "when required" medications and stocks of controlled drugs had not always been balanced as per the provider's policy. Not all of these issues had not been identified through the provider's quality assurance systems.

Prior to our inspection the local authority raised some concerns about the home's use of and recording around covert medicines. The provider had a policy in place which followed the principles of the MCA, but staff had not followed this policy robustly enough. During the inspection we found that the principles of the MCA had not always been followed in ensuring people's rights were protected. Actions were now being taken by the management team to address this.

We found that there were sufficient staff to meet the needs of people within the service. People told us that there had been a high turn over of staff and people found that they were not always familiar with the staff. The management team had focused on the recruitment of new staff and we saw that a significant number of staff had been employed and were undertaking induction training.

We saw that staff received a thorough induction and regular training was provided. All staff had been encouraged to develop their skills through the use of external qualifications.

We found that people's nutritional needs were being met. People's views on the quality of the food were mainly positive. Overall people told us that there was plenty of food available and they were able to choose from a menu.

People and their relatives told us that staff were kind and caring in their approach. People were treated with dignity and respect.

The management team were focused upon the development of people's care plans, they contained sufficient information to enable staff to meet people's needs but we found that these could be improved. People spoken with told us that they were given choices about the way their care was provided.

People looked well cared for and well presented. However, we found that had not always supported people with their oral hygiene.

There were varied activities going on and people could choose whether they wanted to take part. The home had two social life coordinators and we spoke with one of the coordinators, who we found to be very motivated and enthusiastic. There was a programme of events available, with a timetable on display in the home.

Staff told us that they had seen some improvements in the organisation of the service and were positive about the new manager. Staff told us that they received supervision and felt supported.

We found that the home had some systems in place to assess and monitor the quality of service that people received but systems to obtain feedback from people and residents were being developed. Quality assurance systems had not been robust enough to highlight the issues raised within this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found that whilst the majority of safeguarding concerns had been reported appropriately to the local authority, there were some incidents which had not been reported.

We found that there were some short falls in the management of medicines which had not been identified through the provider's internal monitoring system.

There had been a high turnover of staff, but there had been a recent focus on the recruitment of new staff. There were currently sufficient staff to meet the needs of people.

Appropriate risk assessments were in place to support people.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the MCA had not always been followed to ensure that people's rights were protected with regards to covert medicines. Action was not being taken to address this.

Staff had received a thorough induction and received regular training to ensure they had appropriate knowledge and skills.

People's nutritional needs were being met and people were happy with the food that was provided.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring.

Staff respected people's wishes and preferences and people were involved in decisions about their care and support.

We found that people were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The management team were focused on the development of people's care plans as aspects of the care plans needed to improve.

Staff were familiar with people's needs but this could be improved further specifically within the transitional care aspect of the service.

There were was a comprehensive and varied activities programme in place, including outings.

People and their relatives knew how to complain and felt able to raise any concerns about the service they received. Appropriate action was taken in response to complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a newly appointed manager, who was clear about his responsibilities and actions needed to make improvements.

Staff told us that they felt well supported and that they could raise any concerns with the management team.

There were some systems in place to monitor the quality of the service but these needed to be developed further.

Corbrook Park

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 and 21 December 2016 and was unannounced. The inspection was carried out by two adult social care inspectors on the first day of the inspection and one adult social care inspector on the second day. The service were aware of our visit to conclude the inspection on the second day.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed this and other information we held about the service. We looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law.

We contacted the local authority before the inspection and they shared their current knowledge about the home. We checked to see whether a Health watch visit had taken place. Health watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. A recent visit had not taken place. We also spoke with two health and social care professionals to gather their views about the home.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with 13 people who lived at the home and five relatives/visitors, to seek their views. We spoke with 13 members of staff including three nurses, four care staff, the home manager, deputy manager and deputy clinical lead, the operations support manager, the social life coordinator and the maintenance person.

As most people living within the dementia unit at Corbrook Park were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of

observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of four people who lived at the home and inspected other documentation related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people in the communal areas.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt "safe" and had no worries or concerns. Their comments included; "Yes, I feel safe" and "They look after you at night." Relatives spoken with felt their family members were in a safe place. Their comments included "I feel reassured that mum is in good hands," and "If you want something they come within minutes."

The home was made up of two units, Corbrook Court and Cedar Court. Within Corbrook Court there were a number of beds commissioned by the local clinical commissioning group and local authority to provide transitional care from hospital, as well as respite care. There was a new manager in post who told us that there had been some recent reorganisation of staffing. Staff had also been seconded to work at Corbrook Park from other homes within the organisation and this included the introduction of the role of care quality leader. Staff spoken with told us that the home felt more organised in recent weeks and staff were working well together.

Discussions with staff identified that they knew the importance of keeping people safe, including being safe from abuse and harassment. We saw that the provider's safeguarding policy and procedure was available to staff. Staff told us and we saw from the records that they had been provided with safeguarding training. Discussions with staff demonstrated their understanding of the process involved and that they understood how to alert external organisations if necessary. We saw that appropriate contact numbers were available to staff on the notice board. One staff member said "Everyone knows how to report, it's covered in the Care Certificate."

We saw that where necessary some referrals had been made to the local authority to report safeguarding concerns by the management team. However, when we reviewed the records we found some incidents had occurred within the home over the past few months, which had not been referred to the local authority as safeguarding concerns. Following the inspection the operations support manager provided further information about the actions that had been taken with regards to these instances and was keen to demonstrate that any safeguarding concerns would be reported appropriately. We were of the view that at least two of these incidents should have been reported as safeguarding concerns. The new manager provided further information and indicated that they believed they had followed the correct procedures. We discussed this with the local authority who advised us the information provided indicated that safeguarding referrals should have been made to the local authority. This is to ensure that any safeguarding concerns are dealt with in an open and transparent way and to ensure that all appropriate action has been undertaken. We asked the manager to liaise with the local authority to ensure that all necessary referrals had been made.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

As part of our inspection we looked at whether medicines were being administered, stored and disposed of safely. We spoke with staff and made some observations whilst a nurse administered medications. We saw

that an up to date medicines policy was in place. Training records showed, and we were told, that the staff had received training in the administration of medicines. We could also see that the nurses' competency to administer medications safely was assessed on an annual basis. Medicines were stored safely in a locked clinical room and medicine trolleys were closed and locked when unattended in the home. The management team told us that a recent external medication audit had been undertaken, which had highlighted some actions around the need for air conditioning and the recording of room temperatures, which had now been addressed.

We looked at the medication administration records (MAR) for four people as well as checking their medicines. The provider had already identified that staff occasionally left gaps on the MARs, which meant that it was unclear whether medication been unavailable, omitted, not signed for or disposed of and the manager was monitoring this. The records which we reviewed had all been signed appropriately. However, we noted that medication instructions had been handwritten on one of the MARs and had not been signed or countersigned to confirm the recorded instructions were correct.

We did not see any guidelines for when any prescribed 'as required' medicines should be administered. Some people using the service were not able to verbally communicate if they needed an 'as required' medicine such as pain relief. Guidelines for nurses as to how people would communicate non-verbally their need for an 'as required' medication were required. The manager was aware that these guidelines should to be in place and told us that they were in the process of implementing these. We found that there were creams and ointments stored in people's bedrooms, which enabled staff to apply them more easily when undertaking personal care. However we looked at five separate creams and none of these had the date of opening recorded on the label. It is important to ensure that this date is recorded, so that they are not used outside of their expiry date.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation, these medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. However we saw that the provider's policy stated that the stock of any controlled drugs should be balanced on a weekly basis to ensure that there were no discrepancies. We found that this had not always occurred. We saw for example that one person's controlled drugs had not been balanced for over three weeks, so any potential discrepancies would not have been identified in a timely manner. However we checked and found that the balance was correct.

The management team told us they had undertaken an internal audit of medicines and advised us that this had highlighted that they were not where they should be with regards to medication administration, as a result of this actions had been distributed to nursing staff. However there were further short falls identified during this inspection which needed to be improved. They told us that medication audits were a work in progress and they were aiming for these to be undertaken on a monthly basis in future.

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

We also found that there were some short falls in the procedure for administering covert medication, this is discussed in more detail within the "effective" section of this report.

We reviewed staffing rotas and spoke to people living at the home. We also spoke with staff and made observations throughout the inspection. People spoken with did not express any significant concerns about the staffing levels at the service. People told us staff responded to their calls for assistance usually in a timely manner. They said "They come quite quickly, I've never had any trouble". However there were a few

comments which suggested that at times staff appeared rushed. One person told us "They are a bit slow at times." Relatives gave mixed views regarding the staffing levels at the service. Some relatives did not express any concerns about the staff levels whilst others thought it could be improved. One relative stated "Staffing has improved again, we went through a period of concern." Whilst we speaking with a person, they used their call bell and the staff responded very quickly. Staff spoken with told us that overall there were sufficient staff, one nurse said "There is enough staff, some days are busy, there's a lot of new staff to mentor," and "Things are getting better and more organised."

The manager demonstrated that staffing levels were based on people's dependency levels and any changes in dependency were considered to decide whether staffing levels needed to be adjusted. The manager told us that in recent weeks the numbers of care staff on each shift had been increased and the home was staffed above the levels indicated by the staffing tool. This was to take into account the size and layout of the building, as well as the number of new staff who had been recruited and were undertaking induction training. There were 34 people living within the Corbrook Court unit on the day of the inspection and we saw that there were 10 care staff on duty during the morning which decreased to eight later in the afternoon. There were also two nurses on duty. Within the Cedar Unit there were 31 people living within the unit. There were eight care staff on duty between the hours of 8am to 8pm, as well as two nurses. There was also ancillary staff and an activities coordinator on duty.

We found that some people living at the home were more concerned about the high turnover of staff. One person told us, "There's been a rapid change over of staff, some get to know you." The manager and operations support manager accepted that people had experienced care from a number of different nurses and staff in recent months. They told us that recruitment and staffing was their priority. The home had been through a period whereby it had been necessary to use agency staff to cover a significant amount of the shifts. These are staff who are employed by a separate organisation which provides staff to any service which requires them. People told us that agency staff were sometimes less knowledgeable than the permanent staff and that this had affected the consistency of the care. They said "They get agency staff, you have to tell them things yourself, like where things are and how some things should be done." We spoke with one health professional who told us that due to the frequent changes in nursing staff and use of agency staff they had found that this could impact on effective communication.

The manager told us that they aimed to use the same agency with regular agency staff, so that there was as much consistency and familiarity as possible. The service was actively recruiting and the managed advised that the use of agency staff had reduced significantly and he hoped that this would continue to reduce. The organisation was offering incentives to staff and the new manager told us some of the focus was on staff satisfaction. Staff confirmed that the situation was improving. There had been twenty new staff recruits over the previous month.

Effective recruitment processes were in place. We reviewed three staff files which evidenced that recruitment procedures were followed and applicants were checked for their suitability, skills and experience. Suitability checks included a robust interview, checks for criminal histories and following up references prior to a job offer being made. In all the files we looked at we saw that either a Disclosure and Baring Service (DBS) check, or the authorisation number, which confirmed a check had been undertaken, was present. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions to try to prevent unsuitable people from working with children and vulnerable adults. Two references were also evidenced, in line with the provider`s policy. We looked at the dates on references and DBS checks and they confirmed that no new employee had started work before all the required security checks were completed

We checked the systems within the care home and found there was a system in place of recording and reporting incidents and accidents which were being reviewed by the manager who was aware of the risks within the service. Risk assessments were in place to support people. People were assessed where there were risks to their health and well-being. These were centred on the person's individual needs and provided staff with a description of identified risks. Risk assessments included actions for staff to mitigate the risks. For example we saw that one person had been identified as being at very high risk of falls. A risk plan included using a sensor mat in the bedroom so that staff could be alerted if the person was moving around or had fallen. A nurse informed us about the actions that had been taken and strategies used to reduce the risk of further falls. Records showed risk assessments were reviewed every month or sooner if needs changed or an accident occurred.

We saw that where necessary staff used appropriate equipment to support people with their moving and handling needs. During the inspection we sought further clarification from the manager regarding the use of hoists and equipment, because information gathered suggested that this may not always be the case, specifically with regards to one person. However, we were satisfied that staff were aware of this person's requirements and there was no evidence to suggest that the person was moved using an inappropriate technique. We saw that staff competencies around moving and handling were assessed on an annual basis.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building. The home employed one full time and one part time maintenance person. We spoke with one of the maintenance team, who demonstrated that routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. We reviewed records which demonstrated that external contractors carried out inspections and servicing of, for example, fire safety equipment and electrical installations. Arrangements were in place for equipment used at the home to be regularly checked and serviced, including the bed rails, hoists and specialist baths. This helped to ensure that people were kept safe.

The maintenance person was also responsible for ensuring that fire training and practice drills were undertaken. During the inspection the fire alarm sounded which turned out to be a false alarm, however staff responded to the alarm in a calm and organised manner.

We observed that all parts of the home were clean and hygienic and there were no unpleasant odours. Housekeeping staff were visible around the home. We saw that staff wore gloves and aprons to help reduce the risk and help the prevention of infection. We discussed infection control procedures with a member of staff who told us that they were the link person for infection control. They undertook audits in areas such as hand hygiene and the appropriate use of personal protective equipment.

Requires Improvement

Is the service effective?

Our findings

People living at the service told us "The food is very good " and "I like it here." A relative commented, "Staff seem competent."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Prior to our inspection the local authority raised some concerns about the home's use of and recording around covert medicines. This means medicines which are hidden in people's food or drink and given without their knowledge. The provider had a policy in place which followed the principles of the MCA, but staff had not followed this policy robustly enough. During the inspection we found that the principles of the MCA had not always been followed in ensuring people's rights were protected.

There were a number of people whose medicines were being administered covertly and the local authority had found that in some cases relatives had not been consulted with as part of best interest decision, as required. The necessary documentation was not always in place to evidence that the MCA had been appropriately followed. During our inspection we looked at one person's records where their medication was being administered covertly. We saw that a DoLS authorisation had been granted for the person to remain at the home to receive care and treatment. However, this deprivation was subject a number of conditions around the administration of covert medicines, including the need to record the names, dates and views of people consulted with. Care plans and records did not reflect the conditions attached to this deprivation of liberty safeguard. We discussed this with a nurse, who assured us that this would be addressed.

Since the local authority had raised their concerns with the provider, the management team had started to take action to make the required improvements regarding the process and documentation for the administration of covert medicines. We found that they had been working with a representative from the local authority to address the concerns that had been raised. They told us that they had requested support from the local GP to review people's medications and were currently awaiting this support. However we found that at present the provider was not compliant with the MCA and we were not assured that people were being deprived of their liberty lawfully.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent

Staff explained they understood the importance of ensuring that people agreed to the support they

provided. We saw staff supported people to make decisions for themselves about their care. For example, we saw people were offered the choice of where they wanted to eat their meals. They could choose to eat in their own rooms or in communal areas. Staff told us "Everyone has the capacity (to make choices) unless proven otherwise." People spoken with confirmed that staff always sought their consent and they were given choices about their care. For example, one person told us" I get up occasionally to sit in the chair, when I choose. "

We saw that assessments had been undertaken of people's capacity to make other decisions. Where people had been deprived of their liberty the registered manager had made appropriate applications to the local authority for a DoLS authorisation. There were 15 people with a current DoLS authorisation in place and a further 30 applications had been made to the supervisory body (local authority). A matrix had been implemented to ensure that information about DoLS applications and authorisations were appropriately recorded, and to ensure that any renewal applications were highlighted and applied for in a timely manner.

We found that staff spoken with were knowledgeable and had the appropriate skills to carry out their roles effectively. New staff completed an induction which was based on the Care Certificate. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. Staff spoken with told us that they had completed an induction and this had included working alongside more experienced staff, until they were confident and competent to work unsupervised. We saw from the records that new staff had the support of a mentor. The operations support manager explained that induction training was currently being adapted so that new staff would undertake initial training off site. Staff currently undertook an initial three day induction and were then expected to complete the Care Certificate within 12 weeks.

All the staff spoken with confirmed that they had received regular training. They told us "The training is very good". Training records were held electronically and were monitored by the organisation. These showed staff had access to a wide range of training which included: moving and handling, fire training, mental capacity and deprivation of liberty, dementia awareness and health and safety. We saw that some people were overdue with some aspects of their training, the administrator was able to provide details about the reasons for this and we saw that appropriate training had been booked. Training in the areas of MCA and safeguarding had been arranged for January 2017.

All staff had been encouraged to develop their skills through the use of external qualifications such as Diplomas in Health and Social Care. A member of staff said about the organisation "Staff development is really good, they encourage everyone to do diplomas."

Some of the people we spoke with commented that communication with some members of staff was difficult, as English was not always their first language. One person told us "I have difficulties in understanding some staff." The manager informed us that there had been some recruitment of staff from overseas and their language and communication skills were assessed as part of the recruitment process. The manager was aware that some people had raised concerns about communication and staff were therefore paired with English speaking staff to support and monitor. The organisation offered support to staff members to develop their language skills and the manager advised us that this issue would be monitored.

The home had a supervision policy which required staff to receive regular supervision. The policy stated that anything less than two months ceased to be regular. The manager provided records of supervision meetings held with staff over the past 12 months. We saw that there were some gaps and not all staff had received supervision as frequently as required by the policy. However, staff spoken with told us that they did receive

supervision meetings and supervision discussions also took place on an ad hoc basis. For example, one member of staff told us that the operations support manager had carried out general supervisions of staff when specific incidents had arisen. The new manager told us that he would be focusing on regular supervisions for all staff, which would be booked in over the next 12 months.

We found that people's nutritional needs were being met. People's views on the quality of the food were mainly positive. Overall people told us that there was plenty of food available and they were able to choose from a menu. We saw that drinks were available to those people who remained in their bedrooms throughout the day. During the afternoon we saw that staff offered a drinks trolley and people were also offered cakes and biscuits. Comments included " You get enough to eat and drink, they bring you a tray," and "The food is alright, you get a choice."

Staff had good knowledge of people's individual support needs and preferences around food and drink. We spoke with a carer who had a clear understanding of the support that people required, she knew for example that one person had specific guidance in place which had been provided by a speech and language therapist. During the inspection we observed that a person did not like their meal when it arrived, a carer was kind in response and ensured that an alternative was provided. We were told that some people had specific preferences and alcohol was available at an individual's request. One person commented that they liked yoghurt and said they were able to have it "every day."

Records demonstrated that people's nutritional and hydration needs were recorded. There was evidence that staff were monitoring those people who were at risk of losing weight and the people at risk were weighed on a regular basis. The management team had oversight of these people through a monthly audit, which ensured that all appropriate actions had been taken.

Meal times were a pleasant experience for people. There were clean table cloths and tables were laid out with napkins and cutlery, with soft music playing in the background. Drinks of squash and water were available for people. We undertook a SOFI (Short Observational Framework Inspection) during lunchtime within the Cedar Unit. We observed that people received the appropriate level of support from staff. During this time we saw that carers were available at all times and provided sensitive support to people. We saw that one person didn't like the choice of soup, the nurse noticed and offered an alternative.

Records showed health and social care professionals including GPs, speech and language therapists and dieticians visited the home to provide advice and support as was required for people. The local GP practice undertook a weekly visit to the home. Health and social care professionals said that staff were available to support them on their visits and staff at the home knew people well. However they also told us that changes in staffing and the use of agency staff sometimes meant that communication was not always as good as it could be. They felt permanent staff had a good understanding of how to meet people's needs.

We looked around the home and found the environment to be conductive to the needs of the people who lived there. People had been encouraged to bring in personal items from home, many rooms were personalised and some people had telephones in their bedrooms. The manager told us that a refurbishment within the Corbrook Court unit was being planned. He also informed us that the environment within the Cedar unit had been designed using guidance from the University of Stirling, Dementia Services Development Centre to provide a quality environment for patients living with the experience of dementia. We saw that coloured paint had been used to enable people to easily identify toilets and bathrooms. People's names were written clearly on their doors and there were tactile pictures within the corridors. There was an enclosed garden so people could enjoy some time outside during the warmer months. The home also had extensive grounds which were well maintained.

Good

Is the service caring?

Our findings

People told us that they were happy with the care that they received and told us that staff treated them in a caring manner. People commented "It's a very friendly home" and "Staff are amazing, really good." A relative told is "I can visit anytime and feel welcome."

We spent time talking to people and observed interactions between staff and people during our inspection. Staff supported people in a kind and caring manner. We saw that staff had built relationships and had good rapport with the people who lived at the home. One person commented that the staff seemed. "kind and caring." We heard staff chatting with people in a friendly and respectful manner. One relative was very complimentary about the support her relative had received at Corbrook Park. She explained that her relative had recently been in hospital and staff had shown great concern when she returned to the home. The relative felt that they demonstrated a caring approach and had told her "we'll look after her," which made her feel reassured. We saw that the home had received a number of thank you cards and letters about the care that people had received.

We saw in people's care records that information was held around people's likes, such as whether a person preferred to remain in bed. People's care records also contained a "This is me" document, which provided background information about people's life histories including things that were important to them. This enabled staff to have a good understanding of the person when providing care and support to them. However as discussed in the safe section of this report, some people told us that relationships with staff had been affected by the usage of agency staff and that these staff did not always have detailed knowledge about people's care needs.

Staff told us that in recent weeks they believed there had been improvements in the general organisation of the home and that the focus was on person centred care. One staff member told us that staff were more focused on promoting independence and the importance of giving people choices. We saw that people were supported and involved in planning and making decisions about their care Staff spoken with understood how to provide care, people were given choices and staff were aware of people's personal preferences. We saw an example of this when we were speaking with a person in their bedroom and the door was closed. A member of staff politely came to check that the person was alright as she knew that this person sometimes felt anxious when her door was closed. People also told us that they could choose whether they would like a shower or a bath.

We found that people were given information in a way that they were able to understand. For example, we saw that a member of staff offered a person living with dementia, a choice for breakfast, the person found it difficult to understand the choices available. Therefore, the staff member was kind and patient, she brought the food options available to show the person and supported the person to understand the choices available.

Relatives told us that they were made to feel welcome and that they could visit at any time. We found that most of the staff ensured that people's dignity and privacy were maintained. People were treated with

respect. We observed that staff knocked on people's bedroom doors before entering and ensured that doors were closed when carrying out personal care, to maintain people's dignity. People spoken with told us that they were treated in a manner that maintained their dignity

Requires Improvement

Is the service responsive?

Our findings

People who used the service and relatives told us, "They look after me very well," and "They do everything they can." One relative commented that their relative had recently returned from hospital and said they felt "Much better for being here."

The management team explained that they were focused upon the development of people's care plans. They told us that the local authority quality assurance team had identified some areas for improvement with regards to the standard of the care plan records. We saw that audits were being undertaken on a regular basis by the management team, these had identified that further work was required to ensure that care plans were person centred and reflected people's needs. We saw from one person's care records that a speech and language therapy (SALT) assessment had been undertaken, which provided advice to staff about the person's swallowing needs. Whilst staff spoken with were aware of these requirements, we noted that the person's care plan around eating and drinking did not contain this detailed advice. There was a letter which included this advice within the person's records and we noted that there were instructions in the person's bedrooms. However, we consider that this information should also have been included within the care plan to ensure that any unfamiliar staff had access to this information.

The new manager explained that care plans were being reviewed and re-written in collaboration with people using the service, their relatives and staff members. They were developing a named nurse system, whereby nurses would be allocated specific people living at the home, to enable them to build closer relationships. The manager hoped that this would also support the development of the care plans for these people and their relatives. The manager was clear about the need to provide people with personalised care and staff spoken with told us that they had seen improvements in this aspect of the care.

We reviewed four care records and found that they provided sufficient detail to enable staff to know how to meet the people's care and support needs in a way that they preferred. They had been updated on a monthly basis. The manager advised us that care plan reviews including people and their relatives should take place at least annually but that these had not always taken place as frequently as required. The new manager planned to ensure that these reviews were now undertaken on a regular basis.

People spoken with told us that they were given choices about the way their care was provided. One person said that staff were very responsive to his needs. He told us that the staff had taken him out in his wheelchair and that he "Only had to ask" and they would respond. Another person commented "You can do what you like." Some staff told us that they had found that there had been an improvement in approach and staff were encouraging people to be as independent as possible. One staff member said "We're told on day one of induction- this is their home."

We saw that staff maintained daily records to evidence that support had been provided to people. For example staff recorded when people had been supported with a wash or other personal care. People looked well cared for and well presented. However, we were unable to evidence that four people who we spoke with had been supported with their oral hygiene on the day of the inspection. We reviewed three personal

care charts and saw there were no signatures to indicate whether people's teeth or dentures had been cleaned. On closer inspection we found their toothbrushes were very dry and appeared to not have been recently used. We discussed this with the management team.

Staff confirmed that they had read people's care plans and nursing staff told us that they were kept up to date with any changes to people's care through a daily handover meeting. We saw records from these daily handover meetings, which demonstrated that nurses discussed any changes to people's needs. However, care staff told us that they were not included in these meetings. A nurse explained that the senior carer would be involved in the handover and would provide information to the rest of the care staff. A carer told us that there was a communication sheet which they would read and use to pass any significant information to the nurse. This was particularly important for people using the transitional care and respite beds, as people were admitted and discharged on a regular basis.

During our inspection we observed that a person who was receiving respite care, requested support to access the commode, the staff member was caring in approach but said that she would need to clarify the person's care needs, as she has not met her before and she was unsure about the person's mobility needs. The carer had relieved a colleague for a rest break and whilst not familiar with the resident and their range of individual needs and associated care plans, followed clear processes when seeking clarity to ensure the person was supported in accordance with their moving and handling risk assessment in individual care plan. However, the carer and another carer, who was also unfamiliar with this person's needs, told us that they had not been part of the handover meeting that day and had not received all handover information. We discussed this with the new manager, who told us that he had already identified the need to ensure that handovers included all relevant staff and would be addressing this. We discussed this with the new manager, who told us that he had already identified the need to ensure that handovers included all relevant staff and would be addressing this.

There were varied activities going on and people could choose whether they wanted to take part. The home had two social life coordinators and we spoke with one of the coordinators, who we found to be very motivated and enthusiastic. There was a programme of events available, with a timetable on display in the home. A "Corbrook Park Chronicle" was also produced on a monthly basis which gave information about the activities taking place that month, people were given copies of the Chronicle and they were available in people's bedrooms. Activities included quizzes, sing a long, films, walks around the garden and reminiscence. There were also regular entertainers to the home and we could see that outings had been arranged to the local area.

People's individual needs were also met if they preferred to stay in their bedrooms. The coordinator explained that she spent time with people in their bedrooms, for example playing games or having a chat over a cup of tea. One person told us how helpful the coordinator had been in accessing suitable books to read. We spoke with one person who had spent the majority of time in bed and who told us that they felt lonely. When we discussed this with the coordinator she was aware of this person and told us that they had recently had a period of illness but had improved and had just started to take part in some of the activities. We also saw that staff had recently recorded in the person's care plan that staff should now assist this person to get out of bed and spend time in the lounge area so, "she can enjoy more social life."

One relative commented that the social life coordinator "Works miracles" and another relative told us that she was "Very good "and had "arranged a lot of things." Staff spoken with were also very complimentary about the social activities available for people, they commented, "Of all the homes I've worked in this has the best social life coordinator." People's spiritual needs were also considered. We saw from the programme that holy communion and church services were held on a monthly basis at the home.

People said that they felt able to raise any concerns with staff. The provider had a complaints procedure in place, which was on display in the reception at the home. We saw that there was a system in place for logging any complaints, these were documented with any actions taken to resolve them. We saw that there had been 16 complaints in the past 12 months, which had been fully investigated and appropriate responses were provided.

There was a suggestions box located within the reception area, where people and relatives could provide comments about the service. We saw that there had been some previous residents and relatives meetings but the frequency of these had reduced in recent months. People we spoke with told us that their views were not always sought, for example with regards to the choice and quality of the food. Relatives told us that there had been no recent meetings, but were also aware that the new manager had arranged some dates for meetings in the future. The new manager told us that he had an open door policy and was keen to hear about people's experience of the care.

Requires Improvement

Is the service well-led?

Our findings

People told us that the management team were supportive. They said "This is a brilliant place to work" and "Everyone is pulling together as a team."

At this inspection, a newly appointed manager had taken up post in November 2016. They were not yet registered with The Care Quality Commission. The new manager told us that he intended to make an application to register as soon as possible. The operations support manager had been providing day to day support to the service, in the absence of a registered manager over the past few weeks and months.

Periodic monitoring of the standard of care provided to people funded via the local authority was also undertaken by Cheshire East's Council contract monitoring team. This was an external monitoring process to ensure the service meets its contractual obligations to the council. We contacted the contract monitoring team prior to our inspection and they told us that the service remained subject to an improvement plan, but they had made some improvements from when this was implemented.

The new manager told us that he was focused on the development of the service, especially with regards to the recruitment and retention of staff. We saw that a number of new staff had commenced employment at the home in recent weeks and the use of agency staff had reduced, although the recruitment of nursing staff was still required. The manager understood his responsibilities and was supported by a wider team of staff, including two deputy managers. He was available throughout the inspection and engaged positively with the inspection process. We saw that a number of changes had been made and new systems had started to be implemented, prior to the new manager coming into post. The manager was able to tell us about the areas that needed further improvement and was clear about the actions which were needed to achieve this. The management team had already identified some areas where improvements were required prior to the arrival of the new manager.

Staff spoken with told us that they had seen some improvements in the organisation of the service more recently and were positive about the new manager. One staff member said "There's been massive improvements." Staff described the manager as approachable and visible around the home. They explained that the new manager would address any issues straight away and told us they felt supported.

We saw that the manager held a daily meeting with the management team to discuss updates, especially with regards to the transitional care. Nursing staff confirmed that a weekly "heads of department" meeting had also been introduced. Although we found that there had been no recent wider staff meetings, we saw that the new manager had made arrangements for staff meetings to take place throughout 2017. The manager emphasised that good communication with staff was vital and had been encouraging staff to talk to him about any issues or concerns they may have. Staff confirmed that they felt that they could raise any issues with the management team.

Some people living at the home were aware there was a new manager in post, however all of those spoken with, told us that they had not yet met him. One person commented that they would have expected to have

been introduced to him by now. We shared this with the manager. The manager told us that he had been undertaking induction training so far, but that he would now make it a priority to meet with all of the residents.

The home had some systems in place to assess and monitor the quality of service that people received. We saw evidence that a monthly "quality indicators" report was produced, which reported on areas including infections, safeguarding, wounds, nutrition, serious incidents. The manager told us that they were undertaking regular care plans audits and had identified some actions to improve these. Health and safety audits and infection control audits were also carried out on a regular basis. The manager acknowledged that there was further work which was required to implement further audits, such as a regular audit of medication.

We asked whether any surveys had been undertaken to enable people to provide feedback about the service. The management team told us that their approach to gaining this feedback was being developed. There was a performance review which was undertaken weekly and discussed within the weekly meeting. This involved a discussion with a person living at the home and review of their documentation, such as call bell response times. Gathering feedback was an area which needed to be developed further, as people and relatives spoken with told us that they had not been asked about their views of the service. We saw that there were two residents and relatives meetings arranged so far for 2017, to give people an opportunity to contribute to the development of the service.

It was noted at the time of our inspection the provider had failed to have robust systems in place to recognise and address the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which are detailed in the safe and effective section of this report. The provider did not meet all the standards set out in the regulations.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity to make informed decisions or give consent, staff had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that robust procedures and processes were implemented to make sure that people are protected. Some safeguarding incidents had not been reported through local procedures. Safeguarding must have the right level of scrutiny and oversight.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems and processes to ensure that they assessed and monitored their service.