Bluecroft Estates Limited

Wrenbury Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 1 and 4 March 2016 and was unannounced.

Wrenbury Nursing Home is located in the rural area of Wrenbury in Cheshire, which is close to the town of Nantwich. It provides accommodation and nursing care for up to 33 older people. There were 30 people living at the home when we visited. It is a two-storey building and people live on both floors. Access between floors is by stairs and a passenger lift.

At the time of our inspection there were two registered managers in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service told us that they felt safe and were cared for. People received their medicines in a way that protected them from harm. Staff understood their responsibility to keep people safe from abuse and harm. However, not all staff knew how to report a concern outside of their organisation. The registered manager ensured that immediate action was taken to address this issue.

Staff were not always deployed in way to meet people's individual needs in a timely manner. This occurred during the morning. People were sometimes left waiting in the dining room until staff were available to support them. The registered manager had already started to identify ways to address this concern.

The provider had carried out some refurbishment to the home and plans were being made for further improvements. The home was clean and the premises were safely maintained.

Staff received induction and training. A thorough and robust training programme had recently been implemented. Staff had regular supervision meetings and team meetings to effectively support them in their role.

Staff had an understanding of the Mental Capacity Act 2005, and where a person was being restricted or deprived of their liberty, applications had been appropriately made to the supervisory body under Deprivation of Liberty Safeguards.

People and relatives were very complimentary about the staff. Staff supported people in a kind and patient manner and it was evident that relationships between people and the staff had developed. People's privacy had not always been maintained because people's care records had not always been kept securely and could have been read by visitors. The registered manager addressed the security of the records immediately.

Records did not always provide an accurate reflection of the care that had been provided. The daily charts

were not always completed and were not completed at the time that the care was provided. Care plans were in place and had been regularly updated, the detail of personalised information varied but they reflected the support that people needed so that staff could understand how to care for the person appropriately. We saw that staff responded to people's changing needs and sought involvement from outside health professionals as required. The GP visited the home every week to review people's health needs on a regular basis.

The home employed an activities coordinator who had developed a programme of activities, one to one support was also provided. Entertainers and other visitors from the local community supported the home.

The home had two registered managers. People and relatives felt that the management team were approachable, communicated well and would respond to any concerns raised. Staff felt well supported.

Systems were in place to monitor the quality of the service. Audits were carried out on a regular basis and a monthly managers' report was completed. The provider carried out a monthly audit. The management had identified areas for on-going improvement prior to the inspection.

We identified two breaches of the relevant legislation in respect of person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

People felt safe and staff understood their responsibilities in protecting people from harm or abuse.

Staff were not always deployed in a way to meet people's individual needs.

People received their care from staff who had been through appropriate recruitment processes, to ensure they were suitable.

The environment was clean and the provider had plans to further improve the facilities.

People received their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective.

Staff were skilled and well trained. There was a thorough and appropriate induction process for all staff before they started work.

People had a choice of meals and staff were aware of people's likes and dislikes. People received support to maintain their nutritional needs.

Staff had an understanding of the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards were being applied appropriately to people within the home.

People were supported to maintain good health and had access to healthcare services.

Is the service caring?

Good

The service was caring.

We observed some positive and caring interactions between staff and the people who lived at the home. People and relatives

were complimentary about the staff and the support that they received.

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

Staff had good relationships with people and maintained their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place and gave a reflection of a person's care needs. They were reviewed on a regular basis.

There were gaps in the records of the care provided to people and did not always reflect the care that had been given.

There was an activities programme in place and people also received one to one support and activities.

People and relatives knew how to raise a complaint, a complaints procedure was in place and any complaints had been dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

The home had a friendly and welcoming atmosphere and the registered managers were approachable.

The registered managers had good knowledge and understanding of the needs of the people who lived at the home. People were asked for their views of the quality of the care and changes were made in response.

Staff felt supported and were able to raise any concerns with the registered managers.

The home had effective quality assurance systems in place to monitor and improve the quality of the care.

Wrenbury 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 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 1 and 4 March 2016 and was unannounced. The inspection was carried out by an adult social care inspector. As part of our planning we reviewed the information that we held about the home including statutory notifications received from the provider. These statutory notifications include important events and occurrences which the provider is required to send to us by law. We reviewed previous inspection reports and we contacted the local authority contract monitoring team to gather further information. We also reviewed the latest "enter and view visit" report carried out by Healthwatch. The registered manager had not received a Provider Information Return (PIR) before our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However this information was gathered during the inspection.

During the inspection we spoke with 11 people who lived at the home, four visitors and one visiting health professional. We also spoke with staff including the registered manager, the clinical lead, a nurse, four members of care staff, the activities coordinator, the auxiliary lead and the cook.

Throughout the inspection we made observations of the care and support provided to people, including how the staff interacted with the people and made a specific observation of the way that people were supported during one breakfast time. We completed a tour of the home and inspected bathrooms, toilets, communal area and some people's bedrooms with their permission. We examined a number of records relating to the day to day management of the service including three staff files, staff rotas, quality audits, meeting minutes, training records, supervision records, accidents /incidents records and maintenance records. We also inspected three care records of people living at the home, as well as numerous charts which recorded the care that people had received.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. Comments included "Yes I feel safe here" and "I'm quite content". Relatives who we spoke with were complimentary about the care provided and felt that their relatives received a safe service.

Most of the time the provider deployed sufficient staff to meet the needs of the people living at the home. However, we found during the morning time and particularly after breakfast people were sometimes left waiting for assistance, for example to go to the toilet or to move to another part of the building. At the time of our inspection we saw that a qualified nurse and six care staff were on duty between 8am and 2pm and one nurse and five carers were on duty between 2pm until 8pm. During the night one nurse and two carers were on duty. People we spoke with told us they thought there were enough staff to meet their needs. Someone said "I think there are plenty of staff" and a relative told us that the staff were all very "patient."

The registered manager showed us that they used a staffing dependency tool to help decide on the number of staff required. This combined information on care homes, including care hours and residents' dependency to help inform staffing levels in care homes. We saw from people's records that dependency assessments were carried out and updated on a monthly basis. We were told that the home was now fully staffed, apart from one domestic who was due to start soon. A number of staff had worked at the home for several years. The registered manager told us that they had recently introduced a new senior care role and two people had been recruited to this position. The reason for this was to help develop new systems and to provide increased leadership to the care staff.

For the majority of the day we found that people's needs were met by staff in a timely manner, however staff told us that the mornings were sometimes "rushed". One member of staff commented that mornings were "the busiest times" and that they had already raised this with the management. We saw from the staff meeting minutes that this concern had been raised and discussed. The registered manager told us that they had already planned to make some changes and had planned to make the start time earlier for two carers in the morning, who would start their shift one hour earlier at 7am, to provide increased support during this time.

We spent time in the dining room on both mornings of the inspection and observed the care being provided. We saw that some people were in the dining room when we arrived at 8am and were still in dining room at 10.20am, despite having finished their breakfast some time earlier. We saw that when one person asked for assistance to go to the toilet, a member of the auxiliary staff responded and said that they would ask a carer to assist, but the person waited over 15 minutes and we saw that they became a little agitated. We observed that there was little interaction between staff and people sat in the dining room during this period, as staff were busy assisting people elsewhere in building with their personal care needs.

Staff told us that they were organised to work in pairs, as several people required the assistance of two care staff. They were allocated a list of the people whom they were responsible for. They said that when they had "finished the list", having supported people with their personal care and breakfast, they would then move

people from the dining room into the lounge. This meant that people had to wait at times for their care needs to be met. At 10.45am we went into the lounge and saw that three people were sat in wheelchairs, as they were waiting for assistance to be transferred into an armchair using equipment, one person said that they were cold. We found that one person was seated in a wheelchair in the dining room and observed that she had been seated in the same position for over two hours, staff then assisted the person to move into the lounge. We looked at the person's records and saw that they had been assessed as being at high risk of developing pressure ulcers. The person's care plan stated that staff should be aware that in the day the person needed to be sat in their reclining chair so that she could change position; however we observed that this person had spent a significant period of time not in a reclining chair and the wheelchair did not have a pressure cushion in place. This meant that this person could have been at increased risk of developing pressure ulcers.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014). The care and treatment of service users did not meet their needs.

We saw that the registered manager kept a file in place relating to when safeguarding alerts and care concerns had been made to the local authority and notifications sent to CQC. We saw that the outcome of these were recorded and dealt with appropriately.

We found that the registered manager and staff understood their responsibility to keep people safe. Most of the staff were able to tell us about the provider's safeguarding policies and procedures and knew what to do if they suspected that a person was at risk of abuse. One member of staff said, "I would go straight to the manager". The staff we spoke with understood about the various types of abuse that could occur. Some staff were aware of the documentation which should be completed to report safeguarding concerns to the local authority. However not all of the staff knew who they should report concerns to outside of their organisation, three of the staff we spoke with were uncertain. We discussed this with the registered manager and on the second day of the inspection we saw that staff had been given access to a one minute guide about safeguarding and the correct forms had been placed in the staff room so that all staff could access them easily.

We reviewed three staff files which evidenced that satisfactory 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. We saw records that showed arrangements were in place to monitor staff performance and carry out formal disciplinary procedures if required. In all the files we looked at we saw that either a Disclosure and Barring Service (DBS) check, or the authorisation number, which confirmed a check had been undertaken, was present. These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. 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. Two references were also seen on each file, in line with the provider`s policy. Application forms and interview checklists were seen. Staff were issued with a staff handbook and induction programmes were implemented when staff commenced employment.

People's medicines were managed safely. Qualified nursing staff administered medicines and we saw that a medication policy was available, which staff had read and signed to confirm. Medicines were kept safely in a lockable trolley within a locked room. Controlled drugs currently prescribed to people living in the home were stored in a special cabinet. Controlled drugs are prescribed medicines that are controlled under the Misuse of Drugs Act 1971. They require specific storage, recording and administration procedures. There were appropriate arrangements to store medicines within their recommended temperature ranges and the

expiry dates of medicines were checked. We saw that a homely remedies policy was in place. Homely remedies are another name for non-prescription medicines which can be used in a care home care for the short term management of minor conditions. There were care plans in place for people who were prescribed medicines such as painkillers and creams which were to be used "when required", to inform staff when these medicines should be used.

We spoke to the nurse and observed her administering medication during the morning. She was able to demonstrate an understanding of all aspects of medication management. We looked at the administration and recording of medicines. We looked at a sample of eight medicines and checked them against the Medication Administration Records (MARs). The administration of medicines included the administration of creams as part of people's personal care. We saw evidence which indicated that medicines had been administered and recorded correctly.

We looked at the ways the home managed risks to people. We saw individual risk management plans were in place to keep people safe. In most cases actions needed to minimise risks to people's safety had been identified. However, in the case of the person we saw seated in the wheelchair, although there was a plan in place, staff weren't carrying it out to mitigate risks. We saw that risk assessments were carried out when people were at risk of falling, where the risks of falls had been identified for one person, a falls sensor mat had been provided to alert staff so that they were able to respond as quickly as possible to reduce any possible risk.

There was a procedure in place to monitor accidents and incidents. We saw that the registered manager kept a log of any accidents which had occurred on a monthly basis. The registered manager told us that risk assessments would be updated following any incidents as required. However, we found that there was no detailed analysis of these in order to identify themes and trends. It is important to review this information in order to highlight any improvements that can be made.

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. On the first day of the inspection building work was being carried out and changes were being made to the laundry to meet infection control standards. We noted that some areas appeared cluttered and untidy, boxes and other items were seen in corridors around the building. The registered manager told us that this was partly due to the building work being carried out and also because items had been removed from a room being used by the hairdresser. We found that this had improved on the second day of the inspection. There was a sign on one of the store room doors on the first floor which warned people to be careful because the door was not on its hinges. The registered manager told us that this was due for repair.

We saw that there was a lockable gate at the bottom of the stairs to prevent the risk of some people using the stairs without assistance. There was a sign next to the gate to remind people that it should be kept locked at all times. However when we arrived we found that this gate was unlocked and on two subsequent occasions found that the gate was unlocked.

Systems were in place to check the safety of the premises and equipment. The home had recently employed a maintenance person and we saw from the records that he completed various daily, weekly and monthly checks to check the safety of the premises. We saw that the home had a fire safety policy and procedure in place, with each person having a personal evacuation plan which showed the support that they would need in the event of a fire. Staff had received appropriate fire safety training and regular fire drills were carried out. A home emergency plan was also in place in the event of an emergency which required an evacuation

of the home; the manager was able to demonstrate the actions that would be taken.

Good

Is the service effective?

Our findings

People told us they were supported by staff who were skilled and knowledgeable about their needs. One person said that they had "no complaints" and another told us that the home had "very good staff."

Staff received training, supervision and appraisal of their work so they had the skills and knowledge to look after people effectively. The registered manager maintained a spreadsheet record of staff training in courses considered mandatory to provide effective care and recorded when staff had completed these. This allowed the registered manager to monitor this training and to check when it needed to be updated. We saw that staff had received training in areas such as, manual handling, safeguarding, health and safety, dementia care and diabetes.

The registered manager told us that they had decided to focus on training over upcoming months and had employed an external training company to carry out regular training with staff. We saw that a thorough programme of training had been developed with ten training dates arranged for March and April 2016. Some of these training sessions included topics such as infection control, person centred care, managing challenging behaviour and privacy & dignity. Staff told us that they were provided with appropriate training to support them in their roles. They said, "we work as a team" and "we get enough training". Staff who worked during the night also told us that they had access to regular training. We saw that individual staff members had been identified to "champion" specific areas of the care provision, such as diabetes or weight loss.

Newly appointed staff received an induction training programme to prepare them for work at the home. We saw that this was comprehensive and covered a number of areas. Staff confirmed they completed an induction period. A new member of staff told us that they had received a five week period of induction which had included the shadowing of colleagues to gain an understanding of the role. Staff also told us that they had read people's care plans to understand their needs. Staff had enrolled for the Care Certificate which is a nationally recognised qualification from Skills for Care. This Certificate covers 15 standards of health and social care and is a work based award achieved through assessment and training. We saw that one member of staff had completed this certificate. The activities coordinator told us that the management had supported her to enrol for a qualification specific to her role, as well as completing the Care Certificate.

Staff spoken with told us that they received regular one to one supervision meetings which allowed them to discuss their work, training and future plans with their line manager. Supervisions were provided by the registered manager, clinical lead and auxiliary lead dependent upon staff roles. Staff said they found the supervision sessions to be supportive. Records of staff supervision and annual appraisals of their work were maintained. We saw that the registered manager kept a spreadsheet to record when staff had received supervision and when the next session was due.

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

make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager kept a record of those people who had a DoLS authorisation in place. We saw that four people living at the home had an authorisation in place and a further 13 applications had been made to the supervising body (local authority) for best interest assessments to be completed. The dates that these authorisations were due to expire were recorded so that the home could reapply for a further authorisation in a timely manner.

We spoke with staff who told us that they had received training in MCA and DoLS. They had an understanding that certain decisions made, need to be made in a person's best interests. A member of staff was able to tell us that there were four people living at the home who were subject to a DoLS authorisation. The activity coordinator commented that she supported one of these people to regularly have a walk outside to reduce any restrictions on them as much as possible. We saw that where decisions had been made for people in their best interests these were recorded on people's care records. For example we saw that all relevant people had been appropriately involved in a decision about the way a person's medication should be administered. However, we could not always find the relevant capacity assessment to go with these best interest decisions. Some capacity assessments had been completed, but the provider needed to ensure that assessments were recorded for each specific decision as required by the MCA.

The registered manager told us that she had recently written out to relatives to ask for confirmation about whether they held a lasting power of attorney for their relative living at the home and if they did to ask for a copy, for the home's records.

We found that people's views on the food were varied. Some people told us that the food was good and there was sufficient choice. Comments included "the food is pretty good" and "the food is nice". We saw records from a residents' meeting where someone had commented "I like the food most days and like how they do me cheese on toast every night". However, two people thought that the food could be better. Comments included "the food is nothing to write home about" and "the food is alright."

We spoke with the cook, who told us that people's views were sought on a weekly basis regarding the food provided. She told us that the menus were due to be changed shortly. People had a choice of three options at lunchtime. People were asked in the evening for their lunch choices for the following day, however changes could be made and alternatives were available if people did not want the choices on offer. We found that the cook was knowledgeable about people's individual nutritional needs, including that one person required a reduced fat diet. The cook also had information about people's personal likes and dislikes around food. The cook told us that all puddings were made from scratch and meals were served with a mix of fresh and frozen vegetables. During our inspection we saw that the lunch looked appetising and people told us that they were enjoying it.

We saw that menus were displayed on the tables in the dining room. A senior staff member had started to develop a picture menu, so that people with dementia needs would be able to understand and express a choice more effectively. We observed that the majority of people ate their meals in the dining room, but some people preferred to eat their meals in the lounge or in their bedrooms and the staff respected their

wishes.

During our inspection we observed breakfast time in the dining room, people were having cereals, toast and cooked breakfasts. We saw that staff assisted a person into the dining room and told the cook that they would like "the full works". We saw that the person then enjoyed a full cooked breakfast. Staff understood the support that people required with their meals and drinks. A member of staff told us that it was important that the people with diabetes had their breakfast in a timely manner. Another member of staff was clear about the people who required their drinks to be thickened and who required assistance with their meals.

Most of the staff supported people with their meals in an effective manner. We observed a staff member assisting someone with their breakfast and saw that they asked whether the person would like to wear an apron to maintain their dignity. They chatted to the person in a pleasant manner and supported the person at their own pace. However when we initially arrived we saw that another member of staff was standing whilst assisting a person with their meal which did not demonstrate an unrushed caring manner. We pointed this out to the registered manager who told us that she would address this.

We also found on the first day of our inspection that two people were not assisted to come down for breakfast until 11.15am. We noted that lunch was served at 1pm, which meant that for some people the timing of the meals was not well spaced out. This was not because it was the preference of the people. We spoke with one of their relatives who told us that their relative usually had their breakfast earlier and it was unusual that day. The registered manager confirmed that it was not a usual day and that the staff were "running behind", for a number of reasons. On the second day of the inspection we saw that breakfasts were completed at a much earlier time.

People were offered drinks and snacks throughout the day. Staff offered drinks from a trolley during the morning and afternoon; we saw that staff also made drinks at the request of people. Snacks such as biscuits, crisps and fruit were available. We found that a person who was nursed in bed had a number of drinks available on their table including juice and tea.

Records viewed 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. People were weighed on a monthly basis and a malnutrition screening tool was completed monthly to assess whether people were at risk of weight loss. The registered manager reviewed people's weights on a monthly basis to identify whether any actions were required. We saw that where a risk had been identified, referrals were made to the GP and people were sometimes prescribed food supplements.

However, we also found that where charts had been put in place to record a person's fluid intake these had not always been completed fully or at the time that drinks had been taken. We looked at some charts which had been archived and saw that people's fluid intake had not always been totalled up at the end of each day, this meant that it was not always easy to identify whether the person had taken sufficient fluids. Staff told us that they monitored the charts and the senior care staff would inform the nurse if they had any concerns about a person's food or fluid intake. We found that people's food and fluid intake was being monitored but sometimes the records did not always reflect this.

Wrenbury Nursing Home had been awarded a food safety rating of four in their latest food safety inspection carried out by Environmental Health, this meant that their hygiene standards were rated as good.

Records maintained showed staff sought advice from the doctor and made requests for specialists when they believed this to be necessary in order to meet people's needs. We saw that people had access to their

GP, district nurses and other specialists such as chiropody when this was required. In one example we saw that the home had contacted the GP on a regular basis to ensure that the person received appropriate support. The local GP visited the home on a weekly basis. We spoke with the visiting GP who told us that they would review people's health needs as required, they found the home to be supportive and felt that the arrangement in place worked well in supporting people's health needs.

The environment was clean and largely well furnished. However some furnishings such as chairs looked tired and worn and in need of replacement; the registered manager told us that some replacement chairs were on order. We noticed that there were no small tables available for people seated in the back lounge which meant that people had nowhere to place drinks or other items. We highlighted this to the registered manager who told us that tables were available and she would look into this.

Some areas of the home had been refurbished. The downstairs bathroom and toilet areas had been refitted and decorated; they were clean and modern. The registered manager told us that there were plans for further improvements such as decorating in the lounges and some bedrooms were due to be re-carpeted. The building had two linked lounges and a dining room on the ground floor. The registered manager told us that they had been considering ways to adapt the environment further. Apart from people's bedrooms, there were no other rooms available for people who wanted a quiet or more private space. Group activities tended to be carried out in the dining room. The registered manager told us that they were interested in taking part in a project called Namaste which aimed to offer meaningful activities for people with advanced dementia. This approach required a quiet room with low lighting and the provider was considering ways to accommodate this. We were told that planning permission had been agreed for an extension to the building.

Good

Is the service caring?

Our findings

We found that the environment at Wrenbury Nursing home was relaxed and friendly. People and relatives told us that staff provided kind and compassionate care. Comments included "They treat me smashing" and "the carers are very nice and pleasant." A relative told us that they thought that the staff were "marvellous" and said "I can't speak highly enough of them".

Care plan records were kept in lockable cabinets in a corridor next to the main desk, as well as in the manager's office. However during the inspection we found that folders containing people's care records about the care that they had received were kept outside people's bedroom doors in corridors. We noticed that one person's folder was kept outside their bedroom door on the floor in the main downstairs corridor, this corridor was used by all visitors to access the rest of the building and meant that this person's personal information was not kept securely. During the afternoon on the first day of the inspection we also saw that eight folders containing care records had been placed on two chairs in the lounge, at the time there were no staff in the vicinity and this information could potentially have been read by any visitors to the home. We informed the registered manager who took immediate action, on the second day of the inspection we saw that folders had been placed in people's bedrooms and were no longer left in public areas.

We found staff maintained people's privacy and confidentiality. One of the senior staff members told us that the management team had focused on this area to ensure that staff were mindful about not discussing private information in communal areas.The registered manager informed us that the provider had recently updated their policies around confidentiality and provided us with a copy following the inspection.

We observed that interactions between staff and people were positive and staff treated people with dignity and respect. This was demonstrated through the way staff spoke and supported people. We observed that staff knocked on people's bedrooms doors before entering and spoke to people in a friendly and respectful manner.

We did however find, that during the morning people were sometimes kept waiting for their care needs to be met. (As discussed further in the safe section of this report).

We saw that there were a number of signs that had been displayed in people's bedrooms. These mainly highlighted information about the person's care needs and provided a prompt to staff. We discussed these with the registered manager who agreed that these signs did not maintain people's dignity and were unnecessary, as the information should be included in people's care plan records. The registered manager took immediate action and the signs had been removed by the second day of the inspection. We saw from the training programme that training had been planned in the next few weeks for staff on the subject of privacy and dignity.

Throughout the inspection we saw that there were numerous visitors to the home and there were no restrictions on visitors. Relatives told us that they were made to feel welcome. One visitor told us that "it's a very friendly atmosphere and everyone gets on well here". They explained that they were able to visit their

relative on a daily basis and were involved in aspects of their relative's care, at their request. This meant that people were supported to maintain relationships with people who were important to them.

People and their relatives were very positive about the way that the staff provided support. Someone told us that "staff are nice and caring." A relative told us that their relative was well supported at the home and said "they love it here". We found that positive caring relationships had been developed between people and staff. The registered manager and staff were very knowledgeable about people's care needs and demonstrated a caring manner towards the people living at the home. One person told us that they had recently suffered a bereavement and had appreciated the support that they had received from the staff. The person said that the activities coordinator in particular had been "so kind" and had provided excellent support during this time.

We saw that people were involved in the way that their care and support was provided and staff also supported people to maintain their independence. We spoke to one person whilst they were preparing to go for their breakfast. They told us that they were able to get up in the morning when they felt ready. They said that the staff helped them but that they didn't need any assistance to go to bed and they "preferred that". This demonstrated that staff supported people to maintain their independence and respected people's choices about their care and treatment.

The activities coordinator told us that she had been gathering information about people's life histories through talking to people and their relatives. We saw that she had started to implement one page profiles for each person so that staff had an better understanding of people's backgrounds and the things that were important to them.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that staff at the home were responsive to their needs. Comments included "I go to bed when I like between 8pm and 8.30pm, other people go later." and "It's alright, it's a good home". Someone else told us that they were looked after in a way that they wanted to be looked after and were "very comfortable".

We found that staff knew the importance of providing people with choice and respecting those choices. Staff told us that people were able to choose when they would like to get up and go to bed. We saw in a person's care plan that their personal preferences had been recorded and they liked "to go to bed between 9 and 10 o'clock". We observed that staff asked people where they would like to sit and what they would like to eat. We also observed a handover meeting with staff, where it was evident that staff were knowledgeable about people's likes and preferences. For example staff discussed that one person preferred to accept support from a male carer and that someone had gone to bed at an earlier than usual time, as they were feeling unwell and wanted to be comfortable.

Care plans were in place for all of the people living at the home. They contained pre- admission assessments and plans of care which outlined abilities, identified needs, risks and action required by staff. Records had been kept under regular review. Care plans included a section on the life histories of people.

We saw that there was a variation in the level of detail recorded in the care plans. Some of the care plans contained detailed person centred information relating to the person's likes and dislikes, ranging from what they would like to eat, what time they would like to go to bed and social activities, whilst others did not contain as much detail. However, overall the care plans provided sufficient detail to enable the staff to meet the people's care needs effectively.

We found that daily care charts were not always completed and so did not reflect the care given. A number of charts reviewed during the first morning of the inspection remained blank and no information had been recorded. This was also the same on the second day. Therefore we could not evidence that all appropriate care had been provided. We spoke with a person who was nursed in bed and required positional changes. We viewed their records at 12.30pm and there was no record that any positional changes had been carried out during the morning. We spoke to a member of care staff who told us that they had just assisted the person to move position and they had previously assisted them at 9am, however the charts had not been completed contemporaneously. The staff member said that they were about to complete the charts for care that had been carried out earlier that morning.

We also found that this was the case for other charts including food and fluid intake, as well as catheter care. As the charts were not completed at the time that the care was given this could lead to confusion and inaccuracies.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) because an accurate, complete and contemporaneous record was not kept in respect of each service user.

Staff told us that they were kept up to date about people's care needs because a twice daily handover meeting took place. The purpose of the twice daily handover meeting was to review the care and support provided over the previous 24 hours and to share knowledge and developments. The discussions were focused on people's care needs. We observed one handover and saw that the staff discussed a fall that a person had experienced the previous day, as well as an issue with a person's medication administration. Any further actions required were then identified. This meant that staff had a good understanding of people's support needs and how to respond to them.

People told us that there were activities going on. A relative commented that the entertainment was lovely and said there was "always something different". The home had an activities coordinator who was employed for 25 hours per week. She organised group activities and also supported people on a one to one basis. We observed the activities coordinator spending time with someone who was nursed in bed, as well as organising Easter crafts with four other people. There was a notice board in the reception area of the home which displayed a programme of activities for the month. We spoke with the activities coordinator who told us that activities such as baking, balloon volleyball, music time and reminiscence were carried out. There were plans for people to visit the gardens of a local hall in the warmer months.

People from the local community also visited the home, people from a local centre had visited to carry out sensory exercises and entertainers were arranged on a monthly basis. The activities coordinator was keen to organise activities that people wanted and had spent time talking to people about their life stories and was in the process of completing one page profiles for each person. She was also knowledgeable about people's spiritual needs and we saw that she supported one person with a regular bible reading.

People said that they felt able to raise any concerns with staff. Someone told us that "I could tell the managers if I'm not happy about anything". The provider had a complaints procedure in place, which was on display in the reception at the home. We saw that the manager had a system for logging any complaints, which were documented with any actions taken to resolve them. We saw that the provider had received three complaints during 2015 and these had been dealt with in a thorough and robust manner. Compliments were also recorded and we saw that a compliment had been received which commented that they had found the staff to be kind and caring.

Good

Is the service well-led?

Our findings

We found that the service was well –led. People said "I think the managers are good. I would go to whoever is in charge with a complaint." and "The manager is always bobbing about and is very good at responding to any concerns". A relative told us that the registered manager was "excellent" as she was good at getting in touch and kept them informed.

Staff were very positive about the management team and told us that they felt well supported. One member of staff told us "the management is fantastic" and "we can go to the managers with any problems".

The home had two registered managers who shared the management responsibility. One of the registered managers provided the majority of the leadership within the home, whilst the other registered manager provided clinical support and worked mainly in the evenings or at weekends. During the inspection we liaised with the registered manager on duty, we also spoke with the second manager over the telephone.

We saw that a Statement of Purpose was on display in the reception area and a Service User Guide available for people who wanted to know about Wrenbury Nursing Home and the way that the care was provided. The home had appropriate policies and procedures in place including safeguarding, duty of candour, deprivation of liberty safeguards and Mental Capacity Act amongst others. We saw that these had all been recently reviewed and updated.

We found that the registered managers were very well organised. All information requested during the inspection was readily available. The registered manager on duty was able to discuss her vision for the home and plans for on-going improvements. She engaged well with the inspection process and responded positively to any suggestions regarding possible improvements to the quality of care.

People and staff told us that the registered managers were approachable. Staff said that they felt able to raise any concerns and that these would be acted upon. We saw that team meetings were held quarterly and the records of the most recent meeting held in January 2016 demonstrated that a range of topics were discussed, including whistleblowing. The minutes also demonstrated and staff confirmed that the registered managers addressed any practice issues with the staff and their focus was upon providing quality care. Health and safety meetings were also held on a quarterly basis.

The registered manager routinely observed the care being provided and carried out a daily walk round of the home to check that everything was in order. We saw that night visits had been carried out on a monthly basis to ensure that the night staff had regular contact with the registered manager and to monitor the quality of the service during the night. We observed that handovers took place at the time of staff shift changes to ensure important information about people's care and support was known to the oncoming staff team. The management team therefore ensured that staff understood what was expected of them and were addressing areas for improvement.

There was a system in place to gain views from people and relatives on their experience of care provided.

The latest questionnaires were sent to relatives in February 2016. The responses were all positive and people felt that the care provided was good. Compliments included "I feel that the leadership sets a consistent standard of individual personal care which promotes commitment and kindness to each resident." and "Watching Dad's reaction to members of staff gives us a fair view of their care and respect to him".

Questionnaires had also been sent out to people living at the home and to staff during August 2015, these did not raise any concerns. One member of staff stated "I am very happy here."

We saw from the records that meetings were held on a monthly basis with people living at the home; these were chaired by the activities coordinator and overseen by the registered manager and gave people the opportunity to make any suggestions or comments about the care provision.

Quality assurance systems were in place to regularly review the quality of the service provided. There was an audit schedule for aspects of care such as medicines, care plans and infection control. An audit of care plans was completed monthly which checked that people's records were up to date, reflected people's care level of need and were signed by people or their relatives. Environmental risk assessments were also carried out and there were personal evacuation plans for each person so staff knew how to support people should the building need to be evacuated. We noted however that the systems had not identified that some people's care records such as when they had been assisted to move position, had not been completed at the time that the care had been provided and there were sometimes gaps in these records.

We saw that the provider carried out monthly audits and a monthly manager report was produced to evidence that all quality assurance audits had been carried out, along with other checks including staff meetings and service user/relative meetings.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. This is called a notification. We checked our records and found that the registered managers had made the appropriate notifications to CQC as required.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 did not always meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An accurate, complete and contemporaneous record was not kept in respect of each service user.