Bluecroft Estates Limited

Wrenbury Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 20 December 2017 and 04 January 2018 and was unannounced. Wrenbury Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. Wrenbury Nursing Home is registered to provide care and accommodation for up to 36 people. At the time of the inspection there were 28 people living at the home.

The home had a registered manager who was present throughout 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.

At the previous inspection on 01 and 04 March 2016, the overall rating for the service was Requires Improvement. We found some of areas of practice which needed to improve and two breaches of the regulations. This was because the provider had not ensured that people received person centred care and records were not always complete, accurate or contemporaneous. The provider sent us an action plan explaining how they would meet the requirements of the regulations. At this inspection we found that they had taken action to address the breaches of regulations and the quality of the service had improved.

People were positive about the care and support they received at Wrenbury Nursing Home. People felt safe and told us that they received the support that they needed, in a way that respected their wishes. We found that there were sufficient staff, who ensured that they supported people in an individualised and unrushed way. Improvements had been made to the way that staff were deployed.

Care files contained individual risk assessments which identified any risks to the person and gave instructions for staff to help manage the risks. However we found that on occasion staff had not followed guidance to mitigate risk. Some clinical records in relation to skin care needed to be more robust.

Staff had received training in safeguarding and understood their responsibilities to protect people from harm and abuse. Staff knew how to report concerns and told us that they felt able to raise concerns appropriately. The registered manager maintained a safeguarding file and where necessary, referrals had been made to the local authority to report safeguarding concerns. We found that the outcome of these had not always been recorded within the file, but the registered manager was able to provide this information verbally.

We found some minor shortfalls in the recording of medication administration, but overall medicines were administered safely. People were cared for in a clean and well maintained environment.

Staff had an understanding of The Mental Capacity Act (2005) and this was usually followed where necessary. However, we found there were occasional gaps in the staff's knowledge around MCA and the accurate completion of assessments had not always been carried out.

We saw that staff received an induction and regular training was provided. Staff told us that they received the training and support they needed to carry out their roles effectively. Staff were also supported through supervisions and staff meetings. We found that people's nutritional needs were being met. People's views on the quality of the food varied but were generally positive.

People and their relatives told us that staff were kind and caring in their approach. We observed that staff were very attentive and people were treated with dignity and respect. People looked well cared for and well presented. However, we found that nail care could be improved.

People received care that was personalised and responsive to their needs. Care plans contained sufficient information to enable staff to meet people's needs. However we noted that one care plan had not been fully written. The management team were in the process of undertaking reviews and had invited relatives to take part, where appropriate. People spoken with told us that they were given choices about the way their care was provided. We reviewed a number of daily charts and records and found overall that these had been consistently completed.

People told us that there were activities going on at the home and that they could choose whether they wanted to take part. The home had an activities coordinator who organised group activities and also supported people on a one to one basis.

We found that the home was well-led. People knew who the registered manager was and felt able to raise any concerns with her. Staff told us that they felt well supported. We saw that regular team meetings were held, as well as supervision meetings to support staff. There were comprehensive quality assurance processes in place and people's feedback was sought about the quality of the care.

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 consistently safe.

Improvements had been made to the way that staff were deployed and there were sufficient staff to meet people's needs.

Action to mitigate risk had not always been fully followed by staff and records needed to be more consistent.

There were some minor shortfalls in the recording of medicines administration but overall medicines were managed safely.

People were cared for in a clean and well-maintained environment.

Is the service effective?

Good

The service was effective.

There were some gaps in the staff's knowledge around MCA and the accurate completion of assessments.

Staff received an induction and training to ensure that they were appropriately skilled.

People's nutritional needs were met and people were generally positive about the food available.

People were supported to maintain good health and received health care support.

Is the service caring?

Good

The service was caring.

Positive caring relationships had developed between staff and people and we saw many examples of positive interactions.

We found that people's dignity and privacy was respected.

Where possible staff supported people to maintain their

independence and people were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

Care records reviewed were detailed and up to date. However we found one care plan which had not been fully written.

Daily charts and records had been consistently completed.

The home had an activities coordinator who organised group activities and also supported people on a one to one basis.

There was a complaints procedure in place. Some people said they did not know how to make a complaint but felt able to raise any concerns with staff.

Is the service well-led?

Good

The service was well-led.

Suitable management systems were in place.

Staff were positive about the management team and said that they felt supported.

The registered manager used a variety of methods in order to assess the quality of the service they were providing to people.

People's views on the quality of the service were sought.

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 20 December 2017 and 4 January 2018 and was unannounced. The inspection was carried out by one adult social care inspector and an expert by experience on the first day and one adult social care inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was aware of our visit to conclude the inspection on the second day.

We received a Provider Information Return (PIR) from the registered manager, 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. 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 but we read the latest report available.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with12 people who lived at the home and six relatives/visitors, to seek their views. We spoke with 11 members of staff including the clinical lead, one nurse, two care staff, two senior care staff, the registered manager, the head of housekeeping, one domestic, the activities coordinator and the maintenance person. We also spoke with a visiting health professional.

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 and observed the lunch-time meal.

Requires Improvement

Is the service safe?

Our findings

People spoken with told us that they felt safe living at Wrenbury Nursing Home. One comment included, "I would say that it is safer for me to be here because staff are available." People's relatives told us, "I definitely feel that (name) is much safer here. It is the right place for them" and "(Name) has settled in well, I feel she is safe here, it's a weight off the mind to know that she is being looked after here."

At our last inspection in March 2016 we raised concerns that people's needs were not always being met appropriately. We had found that people were occasionally left waiting for care and support. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the registered provider was no longer in breach of this regulation.

Staffing levels had been increased since the last inspection and two nurses were deployed during the day. The staff rotas, our observations and what people and staff told us confirmed that there were sufficient suitably qualified members of staff on duty at all times. People told us that there seemed to be enough staff to provide care and support. One person said, "I came here from hospital and stayed. Staff are very good. I feel there is plenty of staff. I'm well cared for and they're not short of staff any time as far as I know." A relative commented "I visit twice a week, at different times. Staff seem OK, they are not short," and "I'm quite impressed with the staffing levels. (Name) said today that if you want anything, they'll get it for you. Staff give excellent care." Responses from people were generally positive about how quickly call bells were answered and we were advised that they did not usually have a to wait long for support.

Previously we were concerned that people were left waiting in the dining room until everyone had received support with personal care and eaten their breakfasts We spent time in the dining room during the first morning of the inspection and observed the support provided. We saw that improvements had been made and care was given in a more personalised way. The activities coordinator also supported people in the dining room during breakfast time. We saw that staff frequently asked people whether they would like more breakfast/drinks and checked whether people were ready to move into the lounge. Staff told us that the organisation of the shift had improved.

The registered manager advised that home had been through a period whereby it had been necessary to use agency staff to cover some of the shifts. These are staff who are employed by a separate organisation which provides staff to any service which requires them. However recruitment was in progress and a new nurse and care staff were due to start at the home in the near future, which meant that the use of agency staff would be reduced.

Staff had completed a thorough recruitment process to ensure they had the appropriate skills and knowledge required to provide care to meet people's needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

Care files contained individual risk assessments which identified any risks to the person and gave instructions for staff to help manage the risks. These risk assessments covered areas such as nutrition, pressure ulcers, falls and choking. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care and the Malnutrition Universal Screening Tool (MUST). In most cases where risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk. We saw that pressure relieving mattresses and cushions were in use where identified. We saw that it had been identified that a person was at risk of sliding from their wheelchair and action had been taken to provide equipment to help to mitigate this risk. Suitable seating had been provided for people who required specific support which enabled them to spend time in the communal areas if they wished.

However, we noted in one case that a person had a soft diet and thickened fluids but it was unclear why these measures were in place and a risk assessment had not been undertaken around the risk of choking. The nurse advised that the person had returned from hospital with these measures in place and there was information in the person's care plan about their requirements but a risk assessment had not been undertaken. The nurse arranged for a referral to be made to a speech and language therapist to undertake a further assessment and a risk assessment was completed.

We also found in one case that action identified to mitigate risk was not always followed by staff. There was a risk assessment in place around the need to thicken a person's drinks to reduce the risk of choking. We observed that a drink which was given to the person was thickened, however it was not thickened to the correct consistency. When we checked the records and spoke with staff, the correct information was recorded and staff were aware of the person's needs. However one staff member told us that they realised that they had not put enough thickener into the drink on this occasion. We raised this issue with the registered manager who advised us that she would remind all staff about the requirements of each person.

Other risks associated with people's skin conditions were managed by nursing staff and a "wound file" was in place. The nurses kept wound assessments along with care plans and progress information within this file. We found that some of the information in the file was not up to date and some information needed to be archived when wounds and ulcers had healed. We also noted that the system was unclear and was not sufficiently robust to ensure that staff knew when a wound was due to be reviewed or re-dressed; this was particularly relevant if agency staff were on shift. We discussed this with the registered manager and when we returned for the second day of the inspection, they had purchased a white board for the treatment room so that nurses could easily record, identify and update when any clinical interventions were due. The registered manager had also introduced a system to audit the wound file on a monthly basis to ensure that all information was current and accurate. Information about people clinical needs was also recorded within people's care plans.

Accidents and incidents were being monitored and appropriate steps had been taken to protect people from the risk of harm. For example, some people had pressure mats next to their beds which would alert staff if they tried to get out of bed without assistance. We saw that staff completed accident and incident forms when any incidents occurred. The registered manager also completed a monthly report which reviewed any accidents and incidents as well as other risks to ensure that appropriate action had been taken.

The provider had policies in place for safeguarding vulnerable adults and whistleblowing. These contained guidance on the action that would be taken in response to any concerns. Staff we spoke with had an understanding of the signs of abuse and told us that they knew how to report any safeguarding concerns. We saw from the training records that staff had received training on the subject. Staff were aware of their

responsibility to report any concerns. They told us they would be confident to report any worries to the registered manager and believed they would be dealt with appropriately. They told us that information and contact numbers were available in the staff room if they needed to report any concerns outside of the organisation.

We saw that the registered manager maintained a safeguarding file and where necessary, referrals had been made to the local authority to report safeguarding concerns. We found that the outcome of these had not always been recorded within the file, but the registered manager was able to provide this information verbally. For example we saw an accident form which suggested that a person had an injury to their leg which was unexplained. The registered manager has taken steps to investigate this further and made a decision that a safeguarding referral was not required however the action taken had not been clearly recorded. Following the inspection the registered manager told us that she had implemented a log to record the outcomes of safeguarding referrals and any informal guidance or advice sought from the local authority would also be recorded in this file in future.

We looked at the administration and recording of medicines. Medicines were stored securely and temperatures were monitored to ensure that storage facilities remained within the required temperature range. We observed medicines being administered safely by staff who were trained. We saw that competency assessments had been undertaken for all of the nurses apart from the clinical lead. The registered manager told us that she planned to ask for support from the local surgery to undertake this assessment. The provider worked with a local pharmacy who had recently undertaken a medication audit. The clinical lead told us that she was currently implementing medication care plans for all people living at the home as these were inconsistent at present. Some people were receiving PRN (as required) medicines. However there was no clear guidance for staff about when and how such medicines should be administered. Following the inspection the registered manager informed us that protocols had been introduced for all PRN medicines to provide staff with the appropriate guidance.

We reviewed the medication administration records (MARs) and found some minor short falls in the recording of medicines administration. For example 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. However MARs confirmed people received their medicines as prescribed. Creams and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. We saw that there were charts in place for staff to sign when they had applied any creams, however there were some gaps in these and information was not clearly recorded on the charts about when or where these creams should be applied. This could lead to potential confusion and treatment not being administered as prescribed. We discussed this with the registered manager who told us that action would be taken to address this straight away.

We carried out a tour of the premises and we saw that people were cared for in a clean environment. We spoke with the head housekeeper who demonstrated that systems were in place to ensure that effective cleaning was undertaken. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. We saw that the home and it's equipment were clean and well maintained. There was an infection control policy and other related policies in place. Protective Personal Equipment (PPE) such as aprons and gloves were available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the home. The laundry was organised and had appropriate systems and equipment in place.

The registered manager told us that some areas were due to be decorated in the near future. Risks associated with the safety of the environment and equipment were identified and managed appropriately. A

fire risk assessment had been completed and regular fire alarm checks had been recorded. Staff received training and knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP). Equipment was also available around the home to aid evacuation if required. Health and safety checks had been undertaken to ensure safe management of utilities, these included amongst others water and legionella checks, electrical appliance testing, regular checks and maintenance of moving and handling equipment, and the lift. We noted that bed rail safety checks were not formally recorded and the registered manager immediately put a system in place to record these in future. There was an emergency plan which informed staff what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the home.

Good

Is the service effective?

Our findings

We asked people living at Wrenbury Nursing Home whether they found the care and support to be effective. People told us, "I am impressed. It is clean and staff are helpful" and "I'm looked after here, fed and watered. Staff are all very nice. I don't have any problems with them."

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had identified cases where people may be being deprived of their liberty to ensure their safety and wellbeing. They had appropriately applied for authorisation from the local authority (supervisory body).

We saw that some staff had an understanding of the principles of the MCA. They told us that people needed to be supported to make decisions about their care and consent was needed. They also told us that there were times when they needed to make decisions for people in their best interests. For example a staff member said, "People are given as much choice as possible and have their own routines. But we also have to take into account best interests."

We saw that mental capacity assessments had been completed. In some cases where necessary, decisions had been made in people's best interests, for example for the use of bed rails. Where a person received their medication on a covert basis (medicines which are hidden in people's food or drink), we saw that this decision had appropriately been made following the MCA. However, we found there were some gaps in the staff's knowledge around MCA and the accurate completion of assessments. In one care plan we found that information was contradictory because the registered manager told us that the person had capacity to make decisions about their care needs. Another member of staff had completed a best interest decision about the use of bed rails for the same person without first undertaking a mental capacity assessment to ascertain whether the person was able to make the decision themselves, this did not follow the MCA correctly. We also noted that the form used to undertake mental capacity assessments and best interest decision could be improved. We discussed this with the registered manager who agreed to review this with staff.

People's need and choices were assessed prior to moving into the service. This helped ensure people's care needs could be met by the home. Staff were knowledgeable about the people living at the service and had the skills to meet their needs. Staff spoken with clearly knew people well including their likes and preferences.

We found that people's nutritional needs were being met. People's views on the quality of the food varied but were generally positive. People told us that there was sufficient food available and they were able to choose from a menu. We saw that people were supported with drinks but noted from the records that there was little evidence of drinks being offered during the evening or at night. The registered manager told us that drinks were available during these times and would remind staff of the importance of recording when drinks were offered and provided. Comments included, "I like the food here, yes, and it is just enough for me"; "Food is OK. I get to eat some chips every day, which I like. I enjoy my cup of tea. I like it hot, not cold, it's usually hot when I get it, and "Food is average."

We observed breakfast and lunchtime and people told us that they were enjoying the food. People were provided with several choices at breakfast time, including porridge, cereal and toast. There were two choices of main meal available at lunch time; alternatives were available if people did not like the choices. Most people ate in the dining rooms but we saw that some people ate in the lounges or in their bedrooms as was their choice.

The cook and other staff were knowledgeable about people's nutritional needs. For example the cook was aware that one person currently had a reduced appetite. Another staff member was able to tell us which people had specific dietary requirements, such as those with diabetes, at risk of weight loss or who required a pureed diet. We observed that staff supported people at meal times in an unhurried and sensitive manner. Some people needed encouragement and/or support to eat their meals, which staff provided. We observed that in some instances meals were served before a staff member was available to provide support, which meant that the meal was left to go cold. We pointed this out to the registered manager who told us that she would discuss this with the staff and ensure that meals were kept hot until the staff were available in future.

We saw from the records that people's nutritional and hydration needs were recorded. There was evidence that staff monitored those people who were at risk of losing weight and action taken where concerns had been noted. For example we saw that where it was noted that a person had lost weight staff contacted the GP and a referral was made to a dietician. We spoke with staff who knew this person was a risk of weight loss and the plans in place to support them. We saw that the dietician had offered guidance about a person's diet which was being followed and the person had gained weight. The registered manager had oversight of people's weight and monitored these to ensure that appropriate action had been taken where necessary.

Staff had received the training they needed to carry out their roles effectively. New staff had completed an induction and this had included working alongside more experienced staff, until they were confident and competent to work unsupervised. Staff had completed training and refresher training in areas such as moving and handling, basic life support, safeguarding, privacy and dignity the Mental Capacity Act 2005. Staff competencies were also monitored following the completion of training to ensure they had acquired the skills needed to support people safely.

Staff supervision was carried out with staff on a routine basis. This gave staff the opportunity to discuss any training or development needs they may have. It also enabled management to raise any performance related issues with staff and set objectives for improvement. We saw that the registered manager maintained an electronic record to monitor and ensure that supervision sessions were undertaken as per the organisation's policy. However we noted that there was no opportunity for the nursing clinical lead to receive clinical supervision as the registered manager was not a qualified nurse. We raised this with the registered manager and following the inspection the registered provider told us that they had made arrangements for this to take place in future.

People were supported to maintain good health and receive health care support. We saw records to confirm

that people had received care from chiropodists, dieticians and their doctor when required. The home had links with a local GP surgery and a GP carried out a weekly visit to the home. A relative commented "My (name) got good medical care. He was seen by a doctor and referred to hospital." We spoke with a visiting health professional, who told us that they had noticed improvements in the service. They told us that they received good information, as staff knew the people living at the home well and that any advice given was actioned by the staff.

Good

Is the service caring?

Our findings

People and relatives spoken with told us that staff were caring. People commented, "They are marvellous here. They can't do enough for you. Whatever you ask for they will do it if possible"; "Staff are very helpful. I like the idea that my friend (resident) is always up and dressed in lounge whenever I come. It is lovely. She is clean and washed." A relative said "I am impressed with staff's care and helpfulness."

During the inspection we observed how well staff interacted with people who used the service. It was evident that positive caring relationships had developed between staff and people and we saw many examples of positive interactions. The atmosphere was relaxed and sociable. We saw that staff were laughing and joking with the people and one person was enjoying a sing song with a member of staff. We observed that when someone felt unwell, a staff member showed concern and took time to comfort the person. In another example staff were supporting a person, using a hoist. They spoke to the person, telling them what they were doing and making sure they were comfortable. This prevented the person from becoming distressed and showed that staff were acting in a person-centred way.

There were a number of thank you cards about the service available to read. One comment included, "We would like to congratulate you on the first class care and understanding that was shown to him during this period."

We found that 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. Staff spoken with understood the importance of providing support in a dignified manner. One staff member said, "People are definitely treated with dignity." Records were written in a manner which respected people's privacy and we saw references within care plans to staff ensuring that people were treated with a dignified approach.

Where possible people were involved in decisions about their care. We spoke with staff who were aware of the importance of offering people choices about their care and support. We heard for example, a carer asking a person what they would like to wear. Furthermore, we were advised that one person preferred to stay in bed as they were more comfortable and staff respected this choice. Where possible staff supported people to maintain their independence. We saw guidance for staff in one person's care plan to ensure that they could remain as independent as possible with aspects of their personal care.

We observed in the majority of cases that people were well presented and smartly dressed. Relatives commented that people's personal care and appearance was always attended to. They said, "(Name) needs quite a bit of care. She is kept very clean. They change her clothes every day. You definitely cannot smell anything here." However we did note that one person's nails were in need of cleaning and despite having received personal care that morning, they still remained in need of cleaning. We pointed this out to the registered manager who told us that they would address this. They had been working with staff to ensure that people's personal care needs such as oral care and nail care were attended to as part of their daily personal care. Staff told us that the registered manager had discussed this with them.

Relatives and visitors spoken with told us that they were able to visit at any time and were made to feel welcome.

Good

Is the service responsive?

Our findings

We asked people whether the service provided at Wrenbury Nursing Home was responsive to their needs. People told us, "(Name) is my care assistant, she helps me to get dressed and washed. I am happy with her. I feel I can more or less do what I like"; "What I like best here is that I am helped to get up and out of bed"; "I feel happy generally about how I am cared for. I don't know what a care plan is, but feel able to say what I prefer if necessary," and "I can do pretty what I like for getting up and going to bed. Staff more or less know what I like and dislike."

At our last inspection In March 2016 we raised concerns that records were not complete, accurate and contemporaneous, especially in relation to the daily charts used to record care provided in specific areas. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the registered provider was no longer in breach of this regulation.

During this inspection we reviewed a number of daily charts and records and found overall that these had been consistently completed. For example, some people were at risk of losing weight or becoming dehydrated. Food and fluid charts were in place and completed so staff were aware if people were not eating or drinking enough to maintain their well-being. This information was reviewed on a daily basis by a member of the nursing team and meant that any areas of concern would be quickly identified. For example, the charts highlighted that a person had not had a bowel movement for a number days, when we checked this information we was saw that this had been identified and discussed by staff in the daily handover meeting and appropriate action had been taken.

However we noted that the chart templates had pre-typed times in place, which meant that staff signed to the nearest hour rather than recording the specific time the support was provided. The registered manager told us that she had already identified this and the forms were amended during the inspection to enable staff to record the times more accurately.

During the inspection, we spoke with staff to see how well they knew the people living in the home and they demonstrated that they had a lot of knowledge about the people and their likes and dislikes. They were able to tell us about people's individual care needs. For example a member of staff was able to tell us about a people's specific preferences, such as those who liked to get up very early and who generally preferred a lie in. Another staff member told us that they were aware that a person's mood may fluctuate and that it was important to give this person extra support and time during these periods.

A system of daily handovers and meetings provided staff with information about people's needs and kept staff informed as people's needs changed. 'Flash' meetings were held each day with the registered manager and various staff to get an overview of what was planned for the day and any specific issues or concerns.

The care records reviewed included care needs assessments, risk assessments and care plans. We found overall that these reflected how people would like to receive their care, including their individual

preferences. The activities coordinator had spent time with people on a one to one basis to discuss people's life histories including their likes and dislikes. The care plans included information covering personal care, mobility, continence, communication, social activities and sleeping and had been evaluated on a regular basis. However we found that one person's care plans had not been fully written. We were informed that the person had originally moved to the home for respite but now planned to remain at the home. The registered manager told us that the nurse had just completed an audit and had highlighted the need to complete this care plan. The registered manager subsequently demonstrated that the person did have a shorter "respite" care plan in place which provided guidance to staff about the person's care needs. She acknowledged that the full care plan however should have been in place and actioned this straight away.

We saw that care plan audits had identified that reviews of people's care plans needed to be undertaken in some cases and where appropriate people's families and representatives would be invited to take part in the review. The registered manager told us that they were in the process of arranging these and that a number of letters had gone out to families to invite them to take part.

People's care records showed that people had been offered the opportunity to discuss their end of life wishes. Where people did not want to be resuscitated in the event of a decline in their health, a signed form completed by a health professional was displayed at the front of their care record. This helped ensure staff had access to important information. The GP also supported the home to develop care plans which considered priorities for end of life care.

We saw that the registered provider had a policy in place to help support staff achieve the accessible information standard. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. We saw that as part of their assessments people were asked whether they had any specific communication needs , which was recorded. Any support people needed with communication was included within their care plans, such as when people might need additional support and what form that support might take. For example, some people had hearing loss or had restricted vision. Care plans stated if they required hearing aids or glasses.

People told us that there were activities going on at the home and that they could choose whether they wanted to take part. The home had an activities coordinator who organised group activities and also supported people on a one to one basis. We found her to be very enthusiastic about her role. There was a notice board in the reception area which advertised the activities on offer, including arts and crafts, film afternoons, and a choir amongst other activities. We saw that people's spiritual needs were supported within the home. The activities coordinator was also encouraging more involvement with the local community and for example had arranged for a local school choir to visit the home.

There was a complaints procedure in place and information about how to make complaint was displayed on a notice board within the home. Some people commented that they did not know how to make a complaint, but did not feel that they had had cause to do so. However people told us that they would be able to raise any concerns with the management and other staff members. One person commented, "I don't know if there is a complaints procedure but I am not afraid to make a complaint if necessary." We reviewed the complaints file which the registered manager maintained. This demonstrated that the registered manager dealt with the complaints following the organisation's procedures and had taken appropriate action in response.

Good

Is the service well-led?

Our findings

We found that the service was well-led. People told us that they knew who the registered manager was and found she was responsive. One person said, "(Name) is the manager here. I feel we could talk to staff." We saw that the registered manager was visible and accessible to people and visitors to the home.

We saw that suitable management systems were in place. The registered manager was registered with The Care Quality Commission (CQC). The registered manager was available throughout the inspection and engaged positively with the inspection process. She demonstrated good knowledge of all aspects of the home including the needs of people living there, the staff team and her responsibilities as registered manager. Documentation was organised and available on request throughout the inspection. The registered manager was proactive and took immediate action with regards to any issues highlighted during the inspection. She provided CQC with an initial action plan for any on-going improvement the day following the inspection.

We saw that the registered provider had appropriate policies and procedures in place. These included adult safeguarding, complaints, medication, consent, duty of candour and were available to staff.

Many of the staff told us that they enjoyed working at Wrenbury Nursing Home and felt well supported by the registered manager. Staff told us that they worked as a team and that they felt able to raise any concerns with the management. Comments indicated that staff found the registered manager to be approachable and supportive. They included "I feel supported, I'm 100% able to raise and concerns" and "I really enjoy it." We observed that staff communicated well and the approach was one of team work. Observations made during the inspection demonstrated that staff were generally organised and direction was provided by the senior and nursing staff. We saw records which evidenced that staff meetings were held and covered topics, including any improvements that could be made to the quality of the care.

We found that the registered manager used a variety of methods in order to assess the quality of the service they were providing to people. A monthly monitoring report was completed which meant that numerous areas were reviewed on a regular basis, including safeguarding, weight loss and pressure ulcers amongst others. These were reviewed by the registered provider to ensure that appropriate action had been taken where necessary. There were a number of audits also undertaken by the management team to monitor the quality of the service. We reviewed these and saw that they had been undertaken in a number of areas including, care plans, infection control, medication and health and safety. Generally any actions identified were followed up within the subsequent audit. However, we noted that where actions had been identified within the care plan audits, systems had not been implemented to ensure that these actions were always completed. Following the inspection the registered manager advised us that measures had been taken to ensure that any outstanding actions were followed up in future.

People's views on the quality of the service were sought. A satisfaction survey had been carried out in October 2017 and we saw that all of the responses were favourable. We saw that the registered manager involved people and their relatives in discussions about the running of the home and regular residents and

relatives meetings were held. Some people told us that they had attended these meetings. We saw that people had been asked for their views in aspects such as what the home could do better, the food and generally safety issues.

The registered provider is required by law to notify the CQC of specific events that occur within the service. Prior to the inspection taking place we reviewed the notifications that we had received from the registered provider and found that this was being done as required. The registered provider is required by law to display the most recent rating awarded by the CQC. During the inspection we observed that this was on display as required.