Review of compliance

Wren Hall Nursing Home Limited Wren Hall Nursing Home	
Region:	East Midlands
Location address:	234 Nottingham Road Selston Nottingham Nottinghamshire NG16 6AB
Type of service:	Care home service with nursing
Date of Publication:	January 2012
Overview of the service:	Wren Hall Nursing Home is located in Selston, a village in the district of Ashfield 14 miles north of Nottingham. It offers accommodation for up to 53 older men or women. It is registered to care for people who need nursing or personal care and it provides nursing care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Wren Hall Nursing Home was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 24 November 2011 and talked to people who use services.

What people told us

Residents told us that that staff showed them respect and ensured that their right to privacy and dignity was maintained. One relative said that staff were, "absolutely wonderful." The people we spoke with felt that all their needs were met at Wren Hall and the quality of care they received was of a good standard. They were asked by staff about all their personal preferences they were offered a range of stimulating activities. They felt safe living at Wren Hall and considered that staff were very competent at their job.

The people we spoke with were generally very positive about the quality of the service they received. One relative told us, "It's a nice, happy, friendly, family place." People told us they could have their say about the service and one relative said they felt they were listened to, "about anything, little or big."

What we found about the standards we reviewed and how well Wren Hall Nursing Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Residents were protected from the risks of inappropriate or unsafe care through individually focussed support, sensitively delivered by competent staff.

Outcome 16: The service should have quality checking systems to manage risks

and assure the health, welfare and safety of people who receive care

The registered person was protecting the people who use the service, against the risks of inappropriate or unsafe care, by means of robust and pro-active quality monitoring systems.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with four residents and two relatives at this inspection. They were most positive about how residents were treated by staff. They told us that staff showed people respect and ensured that their right to privacy and dignity was maintained. One relative said that staff, "are absolutely wonderful…I can't fault them …I'm here every day, so I see it all."

Only some residents recalled seeing their their written plan of care but all the people we spoke with felt that the quality of care they received was of a good standard. Residents said they were asked by staff about their personal preferences: they told us they can rise from their beds, and have breakfast, at any time, for example. All the people we spoke with felt that all their needs were met and that a range of stimulating activities were offered. They spoke about having trips out, planned entertainment and visits by a local vicar. One relative particularly pointed out that the food was, "very good."

All the people we spoke with said they felt safe living at Wren Hall and one person spoke positively about the external doors having alarms fitted. We heard mixed opinions from people as to whether there were sufficient staff available at all times. Some said there were and that staff were available to come into bedrooms and talk to residents. However, one resident felt the care home was, "too short of staff…they work too hard." Everyone we spoke with was clear that staff were very competent at their job.

Other evidence

We read three residents' personal records and saw that they included a full assessment of people's needs at the time of their admission. Individual life histories were recorded in a very person centred way. Care plans addressed a wide range of residents' needs and included personal preferences regarding diet and daily routines. We discussed with the person in charge how care plans could be further improved through more explicit reference to people's social, emotional and recreational needs.

Records included a good range of guidance notes for staff so they were clear as to how to fully meet residents' needs. Recorded risk assessments were clearly worded and were being reviewed each month. There was recorded evidence that residents' mental capacity was being considered in relation to their decision making.

We spoke with several nursing staff and, in more detail, with one member of care staff at this inspection. The member of care staff felt they were given enough information about residents' needs as soon as they were admitted to Wren Hall. They confirmed to us that staff were expected to read residents' written plans of care and risk assessments, which laid out people's needs and the risks to which they were potentially exposed. However, this member of staff was uncertain about some of the areas of risk to which residents in a care home may be exposed. They told us that residents and their families were involved in discussions about individuals' needs on a regular basis.

The care staff member described to us the ways they find out the views of people with dementia, who find it difficult to communicate verbally. They said they had had training in managing dementia. They had also had training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) code of practice from the MCA. These safeguards aim to protect people in care homes and hospitals from being inappropriately deprived of their liberty when they do not have the mental capacity to make an informed choice. This staff member showed understanding of these areas. Records showed that all, or the large majority, of staff had completed mandatory training including safeguarding vulnerable adults, the MCA and DoLS, managing dementia and equality and diversity.

The member of care staff gave a positive account of person centred activities organised for residents. They told us that care staff spent time with residents in activities every day in every lounge. These activities were in addition to those organised by the care home's full time activities coordinator.

We read staff rotas and observed positive and sensitive interactions between staff and residents. We concluded that there were sufficient staff on duty. The 2011 residents' survey results showed 87.5% of people felt there was an adequate number of staff on duty.

The cleanliness, hygiene and homeliness of the environment was of a high standard. We were impressed with the way that residents' dementia was being managed through auditory and visual stimulation throughout the premises as well as sensory planting in the garden. Staff were wearing informal, and often 'fun', clothing and there was clear evidence of a significant person centred approach that reflected current thinking on how to meet the individual needs of people with dementia.

Our judgement
Residents were protected from the risks of inappropriate or unsafe care through

individually focussed support, sensitively delivered by competent staff.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The people we spoke with were generally very positive about the quality of the service they received. One relative told us, "We're delighted. It's a nice, happy, friendly, family place."

People told us there were monthly residents' meetings at which they could have their say about the service and there was a monthly magazine too, to give them ongoing information about Wren Hall. One relative said they felt they were listened to, "about anything, little or big…staff will respond very quickly to any problems."

Other evidence
Staff told us that the care home's computerised management system prompts reviews of staffing levels in order to ensure adequate cover of people's needs. For instance, there had been a recent increase of care staff, from two to three, in one area of Wren Hall. We were told that bank staff were occasionally used to cover night nurse duties; otherwise the existing staff group covered emergencies and other unexpected circumstances. We read a comprehensive business contingency plan.

A wide ranging set of quality monitoring tools were in place. These included a review of the statement of purpose, business plan for 2011/12, monthly residents meetings and periodic meetings for relatives and friends, regular staff meetings, recorded analysis of accidents and incidents, and collated residents' satisfaction questionnaires. All these monitoring tools were supported by full records. Residents' completed surveys indicated a generally positive view of the service.

The care staff member we spoke with felt they had an opportunity to have a say in how the service was run. For example, this would be through staff meetings and, daily, through the care coordinator. They felt the manager and senior staff were approachable and confirmed there was an open culture that allowed staff to feel supported to raise concerns without fear of recrimination.

Overall, we saw evidence that Wren Hall was meeting the needs of people living there, most of whom had varying degrees of dementia, in a particularly caring, person centred way and non-institutional way.

Our judgement
The registered person was protecting the people who use the service, against the risks of inappropriate or unsafe care, by means of robust and pro-active quality monitoring systems.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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