



## Cherry Tree Care Home Limited



Cherry Tree Care Home, High Street, Coedpoeth, Wrexham, LL11 3UF



01978759925



[www.sferacare.co.uk](http://www.sferacare.co.uk)

The inspection visits for this service took place between 26/11/2025 and 05/12/2025

### Service Information:

Operated by:	Cherry Tree Care Home Limited
Care Type:	Care Home Service Adults Without Nursing
Provision for:	Care home for adults - with personal care, Provision for mental health
Registered places:	37
Main language(s):	English
Promotion of Welsh language and culture:	The provider makes an effort to promote the use of the Welsh language and culture or is working towards a bilingual service.

## Ratings:



Well-being

Requires Improvement



Care & Support

Requires Improvement



Environment

Requires Improvement



Leadership & Management

Requires Improvement

## Summary:

People experience inconsistent well-being because while some people report positive relationships with care staff, we saw many spend long periods with limited meaningful engagement. Care staff interactions with people are often task-focused, with missed opportunities to promote choice and inclusion.

The new manager is working to address inconsistencies and lack of personalised, risk-aware detail in people's care plans and is meeting with people and families to achieve this. Staffing shortages, high agency use, and gaps in mandatory staff training require improvement to ensure continuity and person-centred care.

People's outcomes are at risk because the environment requires improvement. Some areas need deep cleaning and systems for maintenance and repair in the home need strengthening.

Leadership in the home is in transition with some positive changes already seen, but essential governance activities, such as Responsible Individual (RI) visits and quality of care reviews, need strengthening. People's outcomes are at risk because staff vetting process are inconsistent.

## Findings:



### Well-being

### Requires Improvement

People living at Cherry Tree Care Home do not consistently experience good wellbeing, because they often lack a clear say in their care, support, and daily routines. Relatives reported difficulties in raising concerns with the provider. Both residents and their families told us they have positive relationships with care staff and expressed satisfaction with some aspects such as the food. A relative told us they feel improvements are happening, especially since a new manager took over shortly before our inspection. However, they also noted that they have difficulty with communication from the provider regarding complaints and concerns, and there remains a need for greater proactive engagement with families. People's preferences for how the service operates are not always clearly reflected in care plans. There has been limited involvement of people and their families in co-producing or regularly reviewing their care plans until very recently.

The service is working towards delivering the Welsh Language active offer, with some care staff able to communicate in both Welsh and English. Relatives told us their loved ones have made friends since moving to the service, and we saw this first hand when observing people interacting with each other in communal areas. People spend extended periods of time sitting passively in communal lounges, with limited meaningful activity, stimulation, or interaction from staff. We saw many people were quiet or asleep, and only interacted with others when care staff helped them with things like giving medicine or drinks. For example, one resident only joined in with breakfast when staff supported them; otherwise, they appeared withdrawn and did not engage with others in the room or watching the television. Care staff frequently engage with individuals only briefly, before promptly moving on to the next person or task. We observed that opportunities for friendly conversations, allowing people to make decisions, and making everyone feel acknowledged and included were often missed. We saw people were engaged when care staff offered choices, acknowledged people by name, and provided eye-level contact, but these practices are not consistent in the home.



## Care & Support

## Requires Improvement

People's outcomes are at risk due to lack of personalised care planning. Care plans do not fully consider risks and include contributions from families and health professionals. Some plans are not regularly updated and lack personal detail, leading to unclear or missing instructions for staff about essential needs and actions. For instance, one resident's plan did not specify how to encourage personal care if refused, while another described behaviour negatively, failing to highlight the person's strengths or provide constructive guidance for staff. The manager has begun inviting people and their families to discuss their individual plans; a positive move to help people achieve their desired outcomes. We saw care staff are kind, patient and friendly towards people, but they do not spend much time with them, instead focussed on completing required tasks. Care records confirm that staff escalate care appropriately and involve multidisciplinary teams when residents' needs change. Medication management has also improved after recent external healthcare audits, and during our inspection, we saw staff administering medication correctly.

People's well-being outcomes are at risk due to low staffing levels in the home, especially at night. There has been a high turnover of staff in the home following recent management changes. This has resulted in high agency staff use, new care staff, and increased risk of inconsistent care for people and the potential for errors. New staff being inducted and shadowing experienced staff, and getting to know the people they support. This is placing additional pressures on longstanding staff who are mentoring them and supporting their induction. Care staff were task focussed throughout our inspection visits and did not spend time with people or engage with them in a way that enhances their daily lives. The new manager has made some progress recruiting to permanent roles to reduce agency use and increasing numbers of staff in the home at night. However, the staffing levels, lack of permanent, experienced care staff, and reliance on agency staff to back fill gaps in rotas, all impact on continuity of care and the delivery of person-centred care. This places people at increased risk of harm and of not achieving their desired outcomes. This is an area for improvement until the provider can demonstrate ongoing improvements have reduced risks to people and are sustainable. We expect the provider to take action to address this issue.

People's outcomes are at risk of not being met because staff have not received adequate training. We found gaps in mandatory training for care workers in areas like fire safety, moving and handling, and safeguarding. As a result, people face greater risks and may not achieve their goals, because staff might lack the necessary skills and confidence to support them effectively. During our inspection, the new manager began addressing these issues by ensuring care staff complete all required training to maintain people's safety. Although this has helped lower risks, care staff maintaining mandatory training skills is still a concern given the large numbers of new starters in the home. This is an area for improvement and we expect the provider to take action and demonstrate consistent and sustained progress.



## Environment

**Requires Improvement**

We visited just before Christmas and saw communal areas were pleasantly decorated for the season. There was evidence of recent servicing checks of key equipment such as air mattresses and profiling beds. There are large communal lounges and dining areas offering space for people to socialise and eat together as they wish. These spaces have ample comfortable seating for everyone and are decorated in a homely style. There is a space on the first floor linking the two separate buildings that comprise the home. This contains dining furniture and a bar area, although this is not used currently. We saw the space being used by the hairdresser who visits regularly. People can decorate their bedrooms with photos, ornaments, and other meaningful belongings to create a personal space. Bedrooms contain the equipment and furniture people need, which is maintained and securely fixed to the walls for safety. There are small, enclosed garden areas to each side of the home that are accessible from the main lounges for people to enjoy time outside in warmer weather. We saw ample specialist equipment to meet people's needs in the home. Although some equipment is stored in people's rooms while not in use due to a lack of dedicated storage space, we noted the corridors remain clear of clutter that might make it difficult for people to move about safely.

The environment of the home requires improvement to ensure people achieve consistently good outcomes. Multiple areas require deep cleaning, including lounges, kitchenettes, and bathrooms. We saw furniture in dining areas needed a deep clean to remove debris from the legs and feet. Broken fixtures such as dado rails and wall fixtures in bedrooms require addressing and rooms require redecorating and refurbishment. During our first inspection visit we noted a broken bedroom window handle and a broken bathroom door; despite raising these with staff they remained broken at our next visit a week later. There is a small team of maintenance staff who work in the home. They are currently undergoing training to ensure all routine health and safety checks are completed and recorded as required by legislation. The provider has commissioned an external company to audit all aspects of the environment and health and safety of the home. The provider told us they will use the audit findings to prioritise improvements in the environment, and they are planning refurbishments of the home. During our second visit ancillary staff told us they have begun deep cleaning of the service following the purchase of new cleaning equipment and are working extra shifts to get the work done at night without disturbing residents.

Despite some work that began to be implemented during our inspection, the provider has not demonstrated sufficiently robust maintenance and audit systems were in place prior to our inspection. This places people well-being and dignity at risk of harm through poorly maintained environment. It is an area for improvement and we expect the provider to continue to drive and sustain improvements to ensure good outcome for people.



## Leadership & Management

## Requires Improvement

The leadership and management of the home are in transition with some positive changes noted. Our inspection fell during the manager's first week, following a three-month period where the home was without a registered manager. During this time various managers from other homes with the same provider supported the management of the service. Over the course of the inspection, we saw an increase in the managers day to day oversight and engagement with people, staff and families due to their consistent and thorough approach. Care staff told us they feel well supported by the new manager, who is visible and approachable. New staff told us they are well supported by colleagues during their induction and enjoy working in the home. Structures are being put in place to support further improvements, including more robust audit systems and support from other managers in the service provider's group of homes whilst care plans are improved. There continues to be areas that require improvement to ensure the service is consistently meeting people's needs.

We found inconsistent oversight by the RI has put people's well-being at risk, with insufficient progress in improving service quality. Since the provider acquired the home in December 2024, the RI's visits have not occurred as frequently as required. Quality monitoring reports from both the RI and other senior management show issues they previously identified were not addressed prior to this inspection. We requested copies of the RI's biannual quality of care review report to the provider, but this was not provided, and records in the home lack of evidence of adequate analysis of complaints, events, or feedback from people. Some policies we saw needed reviewing, including the safeguarding policy which referenced incorrect legislation. Despite staff turnover and the absence of a registered manager, the RI has not taken adequate action to resolve these quality concerns. This is an area for improvement and we expect the provider to take action.

We found people's outcomes are being placed at risk of harm because the provider has not ensured robust recruitment processes for new staff. Recruitment and vetting processes are incomplete for some new staff, with unclear vetting and professional registration status recorded for them. The provider has identified these issues prior to our inspection and told us they are working to address them, but insufficient action has been taken to ensure improvements to processes happen in a timely manner. This is an area for improvement and we expect the provider to take action.

We found gaps in training for new and existing care staff, particularly those who work nights. The gaps in training included mandatory areas such as fire safety, safeguarding of vulnerable people, and infection prevention and control. This is placing people at risk because care staff do not always receive the training required to carry out their roles safely and effectively, and to meet people's needs. The new manager has begun to take steps to address this, however this remains an area for improvement and we expect the provider to take action.

## Areas identified for improvement

Where we identify **Areas for Improvement** but we have not found outcomes for people to be at immediate or significant risk, we discuss these with the provider. We expect the provider to take action and we will follow this up at the next inspection.

Where we find outcomes for people **require significant improvement** and/or there is risk to people's well-being we identify areas for **Priority Action**. In these circumstances we issue a Priority Action Notice(s) to the Provider, and they must take immediate steps to make improvements. We will inspect again within six months to check improvements have been made and outcomes for people have improved.

The table(s) below show the area(s) for priority action and/or those for improvement we have identified.

Summary of Areas for Improvement	Date identified
People may not receive safe or consistent care because there are not always enough suitably qualified and competent staff deployed to meet their needs.	26/11/25
People may be at risk of harm or inconsistent care because care staff do not always receive the training required to carry out their roles safely and effectively, and to meet people's needs.	26/11/25
People's outcomes may be placed at risk the service provider cannot fully demonstrate that all staff are appropriately checked and registered before commencing work due to because gaps and inconsistencies in recruitment and vetting records.	26/11/25
People are at risk of harm because the Responsible Individual has not ensured regular and effective oversight of the service. Issues identified by the provider, such as environmental hazards, staff training gaps, and care planning deficiencies, have not been addressed in a timely manner, placing residents' well-being at risk.	26/11/25
People are at risk of harm because the provider has not ensured a robust system for reviewing and improving the quality of care and support. The absence of a formal quality of care review and inadequate analysis of trends and outcomes have resulted in persistent risks to residents' well-being not being address effectively or in a timely manner.	26/11/25
People may not achieve positive outcomes because the building and environment are not well maintained, and the environment is not consistently clean or safe. Improvements are required to ensure the premises support residents' well-being and dignity.	26/11/25

**CIW has not issued any Priority action notices following this inspection.**

**Welsh Government © Crown copyright 2026.**

*You may use and re-use the information featured in this publication (not including logos) free of charge in any format or medium, under the terms of the Open Government License. You can view the Open Government License, on the National Archives website or you can write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gov.uk](mailto:psi@nationalarchives.gov.uk)  
You must reproduce our material accurately and not use it in a misleading context.*