North Yorkshire County Council

Ashfield (Skipton) (North Yorkshire County Council)

Inspection report

Inspection report
Carleton Road,
Skipton,
North Yorkshire,
BD23 2BG
Tel: 01756 792881
Website: www. northyorks.gov.uk

Date of inspection visit: 10 February 2015 and 16 February 2015
Date of publication: 01/05/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

We undertook this unannounced inspection on the 10 February 2015. We also returned on the 16 February 2015 to complete the inspection. We last inspected Ashfield (Skipton) on the 29 September 2013. At that inspection we found the home was meeting the regulations that were assessed.

Ashfield House is owned and managed by North Yorkshire County Council. The care home is registered to provide personal care for up to 30 people and is within a short drive of the centre of Skipton. It is a purpose built two-storey care home and is set in large grounds and has enclosed gardens. There is a small unit, which can accommodate five people living with dementia. There is also a day centre attached to the service.

Summary of findings

The home employs a registered manager who had worked at the home for over two years. 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.

The service was safe. People who used the service spoke positively about the care they received at Ashfield and they said they felt safe. We saw there were systems and processes in place to protect people from the risk of harm.

Medicines were administered, stored and disposed of safely and people using the service received their medicines as prescribed.

We found people were cared for, or supported by, sufficient numbers of suitably qualified, skilled and experienced staff. Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to show that staff employed were safe to work with vulnerable people.

Staff we spoke with understood how to make an alert if they suspected anyone at the home was at risk of abuse. Training had been given to staff about safeguarding procedures.

Safety checks were carried out within the environment and on equipment to ensure it was fit for purpose. We found that the main open plan lounge/dining area was sometimes cold and people told us that they were cold during one of our visits. We have asked the registered provider to make improvements.

Staff followed the principles of the Mental Capacity Act 2005 to ensure that people's rights were protected where they were unable to make decisions for themselves.

Staffing levels at the home were flexible to ensure people who used the service had the support they needed.

People were provided with nutritious food. Assistance and prompting was given by staff where necessary to assist people. Adapted cutlery and crockery were available to people for them to use to help maintain people's independence.

Staff were seen to be attentive and kind to people and they respected people's individuality, privacy and dignity.

Care plans were person centred and up to date. Risks to people's health and wellbeing had been identified. These risks were being monitored and reviewed which helped to protect people's wellbeing. However, we found that risk assessments we looked at needed some improvement as staff at the home were recording identified risks in different areas of people's care plans. This meant that records were not kept consistently, using the same template which would make any changes to people's care difficult to monitor.

Activities took place in the main part of the home but not always in the small dementia care unit.

The service was well led. The registered manager had an effective quality assurance system in place which ensured that the home remained a pleasant place for people to live.

We received information from Healthwatch. They are an independent body who hold key information about the local views and experiences of people receiving care. CQC has a statutory duty to work with Healthwatch to take account of their views and to consider any concerns that may have been raised with them about this service. We also consulted the Local Authority to see if they had any concerns about the service, and none were raised

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us that they felt safe living at the home. However, records such as risk assessments had not always been updated.

Staff had a clear understanding of their safeguarding responsibilities.

There were good systems in place to protect people from the risks associated with day to day activities, care tasks and the environment. However, the main lounge/dining area was not always warm. We have asked the provider to address this.

There were sufficient numbers of staff on duty to keep people safe. Staff had been recruited in line with safe recruitment practices.

Good

Is the service effective?
The service was effective.

Staff received the support they needed to carry out their roles effectively.

The staff team had a good understanding of the needs of each person at the service.

We found that risk assessments required some improvement as staff at the home were inconsistent when recording identified risks in people's care plans.

People were supported to consent to decisions about their care, in line with legislation and guidance.

People received the support they needed to stay healthy. People living at the home were supported to eat and drink and maintain a well-balanced diet.

Good

Is the service caring?
The service was caring.

People had good relationships with staff and were treated with kindness and respect.

People were encouraged to express their opinions and make their own decisions about care and support. People were encouraged and supported to be independent.

People were treated as individuals and their privacy and dignity was respected by staff.

Good

Is the service responsive?
The service was not always responsive.

Requires improvement

Summary of findings

We saw that limited meaningful activities were taking place with those people living with dementia. Activities in the dementia care unit needed to be improved to ensure people who lived with dementia had access to proper and appropriate activities.

Staff were knowledgeable about people's changing health care needs. They worked closely with health care professionals to maintain people's wellbeing.

There were good opportunities for people to talk about any concerns or complaints that they had. People told us that they felt listened to and that any issues were acted on.

People were supported to maintain contact with their relatives if they wished and visitors were welcomed into the service to visit people.

Is the service well-led?

Good

The service was well-led.

There was effective management of the service and a clear culture which promoted independence, involvement and community participation.

The registered manager had good oversight of the service. Staff told us that the manager was available if needed and acted promptly.

There were effective systems in place to make sure that the service continued to deliver good quality care.

Ashfield (Skipton) (North Yorkshire County Council)

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 registered 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 10 February 2015 and was unannounced. We also returned on the 16 February 2015 to complete the inspection.

The inspection team consisted of two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. This document should be returned to the Commission by the provider with information about the performance of the service. We were unable to review a Provider Information Record (PIR) as one had not been requested for this service.

During our visit we spoke with the registered manager, the deputy manager, four members of care staff, the cook and a domestic. We spoke with seven people who used the service and one relative. We also spoke with one community nurse and a health care support worker who visited the home regularly. We looked at all areas of the home including several people's bedrooms, the kitchen, laundry, bathrooms and communal areas. People who lived at the home could not always tell us their experiences of living at the home. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed records relating to the management of the home including the statement of purpose, surveys, the complaints procedure, audit files and maintenance checks. We looked at four care plans and observed how medication was being given to people. We checked the medication administration records (MAR) for four people including a random check of controlled drugs stock against the register for one person and we observed a medicines round.

We also reviewed the information we held about the service, such as notifications we had received from the registered provider. We planned the inspection using this information.

We contacted the local authority commissioners and Healthwatch to ask for their views and to ask if they had any concerns about the home. From the feedback we received no one had any concerns.

Good

Is the service safe?

Our findings

We found this service to be safe. People we spoke with told us they felt safe. One person said, "They can't do enough for you". This person was relatively new to the home and stated, "They've made my room lovely and helped me make it mine." Another person commented "It's lovely here, I'm very settled, and I've been here for 10 years on and off."

Staffing levels and the deployment of staff meant that each member of staff knew where people were whether that be in the 'dementia area', the main lounge, in reception or the 'quiet' lounge. Staff also called in to the rehabilitation lounge to ensure those residents progressing through back to independent living were also safe.

We spoke with people about whether they felt that there always were enough staff to provide good care. Everyone we spoke with felt there were sufficient staff. Our observations throughout the day were that staff did not appear to be rushed or constantly busy and that staff had time to chat with people. We saw call bells were being answered and responded to in good time by the care staff.

We spoke with members of care staff about their understanding of protecting vulnerable adults. They had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. All the staff we spoke with confirmed that they had received safeguarding training. Staff said the training had provided them with enough information to understand the safeguarding procedures and they knew what to expect if they reported an incident. The staff training records we saw confirmed staff had received safeguarding training. One member of staff when asked about reporting any concerns said, "I'd have no qualms at all, at the end of the day these people are my main concern." Staff were aware of the Whistleblowing policy and said that they had never had the need to whistle blow but would have no hesitation in reporting anything if they had concerns.

The atmosphere throughout the home was welcoming and people who lived at Ashfield appeared relaxed and very much 'at home'. The unit which supported people living with dementia was homely and relaxed. We saw that names were on bedroom doors with pictures that people were able to relate to such as donkeys or dogs which were their particular interest or favourite animal. The date and day was written up on a chalk board in the communal area. This helped to prompt people who live with dementia. We saw people who lived at the home and staff interacting well throughout the day. Everyone we spoke with told us there were sufficient staff on duty at all times.

The larger open plan lounge/dining room felt cold and people had fleeces on and blankets around their legs. When we asked the deputy manager about the heating, the explanation given was that the temperature was controlled centrally by the council in Northallerton. The space was large and there were several opening doors on to the seating area. Some people chose to sit in the hallway area which was pleasant, well decorated with comfortable chairs but we noticed that when people came in and out of the building, the front door was occasionally left open which made the area cold. Several people told us they were cold when asked. On one occasion the lead inspector closed the inner front door which was fastened back by staff when they had gone out to assist a person arriving by mini bus into the home. Staff and visitors seemed to be unaware of the impact of people being cold when sitting in this area. Although this area did not feel cold during our second visit we discussed this with the registered manager. The registered manager agreed to raise this at the next staff meeting to make sure staff become more diligent about the front doors being left open. The registered manager also said that they would discuss how they could make improvements to ensure people were not cold.

We recommend that the registered provider looks at how the main open plan lounge/dining area could be improved to ensure people are not put at risk from being cold.

We saw that there were sufficient staff on duty during our visit. The deputy manager told us that most days were staffed consistently with five care assistants on duty each morning and a senior manager. The home had on call arrangements in place during the hours the manager was not on duty at the home. Staff confirmed when we spoke with them that they knew who they had to contact when an emergency arose when the registered manager was not available. The home was also supported by a number of ancillary staff which included a cook, a kitchen assistant, domestic staff, one maintenance staff, and one laundry staff. We were told that on some days there could be up to three domestic staff on duty. Currently the home has vacancies for a laundry assistant and two domestic staff one, of which was for the kitchen. The home also employed

Good

Is the service safe?

an independent living facilitator who organised activities and fund raising. We were given copies of rotas for the month of February 2015 which reflected what we had been told. This meant that staffing levels were maintained consistently to support the needs of people who used the service.

Before our visit the local authority contracts and compliance team confirmed there were no safeguarding or other concerns that they were aware of. The Care Quality Commission (CQC) had not received any notifications in relation to serious incidents, whistle blowing or safeguarding alerts in the past year.

Records showed that staff recorded all accidents and incidents that happened at the home. The registered manager told us that accidents and incidents were all investigated and reported upon. A risk assessment was devised where necessary and used to reduce the risk of a reoccurrence. We observed throughout our visit that call bells were being answered and responded to in good time by the care staff. We saw that there was a personal emergency evacuation plan (PEEP) in each person's care plan we looked at.

Safe recruitment practices were followed. We examined three staff recruitment files and saw that appropriate checks had been made to determine whether or not people were suitable to work at this service. People had been checked through the Disclosure and Barring service to check if they had a criminal record and had two references to check their suitability to work in a care setting and with vulnerable people.

We looked at the arrangements in place for the administration, storage, ordering and disposal of medicines and found these to be safe. Medicines were stored securely in locked cabinets, which were kept in locked medication rooms. We observed medication being given to people. We saw that people had a photograph attached to their medicine record. We looked at the medicines for four people, including someone who was receiving a controlled drug. We completed a random check of controlled drugs stock against the register for one person and found the record to be accurate. A register was kept, as required, and this was signed and checked by two members of staff at the time controlled drugs were given. We also randomly checked four people's medicines from the monitored dosage system (MDS). These were found to be accurately maintained as prescribed by the person's doctor. The medicines needing to be kept in a refrigerator were being stored in a designated fridge and staff were recording the temperature of this daily. We saw, from the training records, all staff had received up to date medicines training. This meant that people could be confident that medicines were administered by staff who were properly trained. We saw from records we looked at medicines were audited weekly. This helped ensure there was accountability for any errors. We saw that medicines were stored securely and appropriately and staff had recorded correctly leaving a clear audit trail.

People living at the home and visitors we spoke with did not have any concerns with the standard of cleanliness of the home.

We spoke with one visiting community nurse and a health care support worker during our visit. The nurse said, "The home is always clean." The health care support worker told us, "The home is always clean, as there are never any smells and it is maintained to a good standard."

The rotas we looked at showed that there were dedicated cleaning and laundry staff at the home, although currently the laundry was being completed by care staff due to the post being vacant. We saw cleaning schedules were in place which identified specific areas to be cleaned. We saw these records were audited by the registered manager. We looked at and saw that the home had infection control policies and procedures in place.

We spoke with one domestic staff who confirmed that the home was short staffed because of the vacancies. We discussed the process used for deep cleaning the home as there had been a recent outbreak of diarrhoea and vomiting and the member of staff explained the process used to minimise the spread of infection. They told us that they had undertaken infection control training which was via e-learning. They were able to describe what a 'deep clean' involved. They told us, "We clean all walls, skirting boards, we use one cloth wear a mask, aprons, gloves, we use diluted Milton and then throw everything away." They explained that there was a rota for the areas/ rooms to be cleaned. They also went on to explain that they worked hard to ensure that the home was clean and said, "People and relatives don't want to be coming into a mucky home. We need more people because it's a big home, we never seem to be fully staffed people are off sick or on holiday all the time."

Good

Is the service safe?

During our visit we saw all areas of the home were clean and well-maintained. We saw that the home had invested in new furniture to make it look homely and comfortable. Overall the home was in good decorative order. Some rooms had been redecorated and wardrobe and vanity units had been painted white, whilst others remained in the original brown varnished wood which looked dated. We saw that people had personalised their rooms.

Records showed that the registered manager completed a range of safety related checks such as first aid, infection control and medication and these were audited. We looked at a range of maintenance certificates relating to the safety of the home including gas safety checks, fire alarm system checks and electric safety and these were all up to date.

Good

Is the service effective?

Our findings

This service was effective. People told us that they felt well supported with their care. One person said, “Staff are always there for us. They help you with whatever you need.” People also told us that staff responded to call bells quickly. Another person said, “You just have to ring for them and they are there.” We observed call bells being answered quickly during our visit.

Staff we spoke with were well informed about the people they supported and had a clear understanding of each person’s needs. When we spoke with staff we found that they had a detailed knowledge of the people that they supported. One member of staff explained that they had gradually got to know the person and what their preferences were. We saw from the care plans we looked at that people were involved in discussions about their care, their preferences and this was recorded and signed by the staff member and the person themselves.

We found that people were supported by staff who were trained to deliver care safely and to an appropriate standard. Staff had a programme of training, supervision and appraisal. The registered manager told us a programme of training was in place for all staff. We saw that staff had received training in areas which the registered provider had deemed mandatory such as health and safety, medication, fire safety, first aid, food safety and safeguarding adults.

We saw from records that staff received regular supervision from the registered manager or a senior member of staff. This gave them the opportunity to discuss work related matters and share information in a one to one meeting. Staff we spoke with confirmed that they received regular supervision and all the necessary training. Staff described the programme of training available for induction, ongoing mandatory training, updating training, qualifying training and any additional training that staff might discuss during supervision.

We observed a handover between morning staff and afternoon staff. We saw that the handover was very detailed. Staff discussed their concerns about people and highlighted what staff needed to do during their shift.

The service had policies and procedures in place in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). We spoke with the registered manager about how consent was obtained from people especially those who were unable to give their consent to care and where they maybe at potential risk. The registered manager explained that in those instances where people were unable to give consent to their care, a mental capacity assessment was undertaken. Where appropriate a Deprivation of Liberty Safeguards (DoLS) authorisation was applied for or a best interest decision was made. Best interest decisions are a collective decision about a specific aspect of a person's care and support made on behalf of the person who did not have capacity following consultation with professionals, relatives and if appropriate independent advocates.

We saw appropriate policies and procedures were in place for staff to refer to. Staff received training to understand when a DoLS application should be made, and how to submit one. The registered manager was clear about what action they must take to ensure safeguards would be put in place to help to protect people, and that the home was implementing the least restrictive practice. The registered manager informed us that applications for assessment were being submitted for five people living at the home.

We observed both breakfast and lunch during our visit. When we spoke with the cook she explained how individual needs were supported. She explained that she preferred to talk with people individually about what they liked and what they wanted. In discussion we saw evidence that she knew each person’s preferences and requirements. She said, “We’ll go and talk to them to know why they’re not eating and what they like” We ask what cakes would you like.” The cook described the way in which she tried to encourage one person who had a small appetite to eat. “We’re struggling to get (name) to eat. I said to them will you eat a baked potato with butter, will you have a bit of chicken pie tomorrow?” The cook was aware of people’s dietary needs, and was able to discuss ways in which they fortified food with cream and butter and was aware of the new legislation about allergies.

We also observed lunchtime and sat in two dining rooms. We sat in the large dining room in the main part of the home and we also sat in the small dementia care unit. The food appeared to be good with everyone stating they knew what was on the menu and one person commented, “It’s meatloaf today which I’m not bothered about so they are making me soup.” We were informed by staff that people had made their choice the previous day.On the dementia

Good

Is the service effective?

care unit we observed people were provided with serving dishes and people were supported to help themselves. Milk was provided in a milk jug and we saw people being encouraged to pour their own drinks. People also had a tea pot per table to serve their own tea, most people told us they liked this idea too. We observed a member of staff engage with the three people sitting at the dining table. We saw the member of staff was patient, talked with people throughout the meal and involved them in decisions about what they wanted to eat and drink.

During lunch in the main dining room we observed a doctor had arrived to see people. We saw members of staff taking two people away from their lunch. We discussed our observations and fed this back to both the manager and deputy. We asked if the home had considered having protected mealtimes, for routine visits, otherwise people having their meals disturbed could have a detrimental effect, especially to those people who did not eat well. The registered manager of the home informed us that following our visit they had contacted both doctors surgeries to discuss doctors visits to the home at mealtimes. The registered manager also informed us that they would ensure that all health care professionals were made aware of avoiding visiting over mealtimes whenever possible.

We contacted the practice manager from the surgery that was involved with the visit and spoke with the practice manager who confirmed that they would look at the issue of visits from doctors during mealtimes. The registered manager of the home informed us that they would ensure that all health care professionals were made aware of avoiding visiting over mealtimes whenever possible.

We spoke with one visiting community nurse and a health care support worker during the morning of our visit. The nurse told us they visited the home two weekly or as necessary and went on to say, “We (nurses) love the home. We are happy with the care here. All the care staff knows each of the patients well.” The health care support worker told us that they visited the home two or three times weekly. They went on to say, “I like Ashfield, staff here are always helpful. The residents are well care for. They (staff) try and maintain people’s independence. Staff are lovely they are knowledgeable, work efficiently there is good communication between all of the staff.”

We looked at four people care plans. People’s care plans contained several sections which covered for example, an initial assessment, life history, medical history, including body maps, risk of pressure sores, mobility and dexterity and diet and weight. There was an overall assessment which described people’s needs and how these were to be met. Care plans seen incorporated people’s choices and preferences as well as their identified needs. We found that people had details in their care plans of specific dietary requirements. We saw where there were concerns about either people’s weight or diets they had been referred to their doctor and/or a dietician. In each care plan there were details of visits to or visits by other health professionals which demonstrated that people had regular check- ups for vision, hearing and chiropody. This meant that co-ordinated assessments and care planning was in place to ensure effective, safe, appropriate and personalised care.

Risk assessments were in place for each individual plan of care. Although some dates were missing on some specific risk assessments. For example, one person’s pressure ulcer risk assessment had not been signed or dated. In two people’s care plans weight had been recorded in two different areas making this difficult to follow. In one person’s care plan their weight was recorded on the malnutrition universal screening tool (MUST) sheet whilst another person’s weight was recorded on a summary sheet. This meant that records were not kept consistently using the same template which would make any changes difficult to monitor. Although we saw no evidence that people’s health was at risk. One relative told us of their concerns they had about their relative’s weight loss. They told us, “I am concerned about mum’s weight but the home does have this in hand.” We were able to confirm from the person’s care plan we looked at their weight was being monitored and action had been taken by the home to involve other health care professionals including the doctor to ensure that the person’s health was not put at risk.

We recommend that the registered provider looks at how improvements can be made to people’s risk assessments, to ensure the home is effective and consistent when recording any identified risks to people’s health.

Good

Is the service caring?

Our findings

The service was caring. People told us that staff at the home were caring and that they were well looked after. One person told us "They can't do enough for you and it's lovely and clean here". A relative we spoke with told us, "Everyone (staff) is lovely. I think mum gets good care here."

We observed breakfast and the lunchtime meals during our visit. When we arrived breakfast was being served in the main dining room. We sat and observed and saw that there were twelve people sat having their breakfast. We saw people were being asked by staff what they would like for their breakfast. We saw that people were given plenty of choices of food and drink. There were two members of care staff helping to assist people where necessary. We saw that the cook and kitchen assistant were both available and helped people in the dining room. Later in the morning we observed the cook speaking with people in caring and supportive manner whilst trying to encourage people with a variety of meal options for their lunch.

We saw one example where someone was not feeling particular well and did not want to go to the dining room for their lunch. We saw staff could not do enough offering the person support in a warm and sensitive way.

We observed that the staff spoke quietly and kindly at all times and knew and understood people well. We saw throughout the day that the staff treated people with respect and dignity. The deputy manager knocked on bedroom doors before going in. We asked staff how people were treated with respect. Staff were able to provide clear examples and spoke with confidence about the different needs of people they cared for. One member of staff provided a detailed explanation of one person that lived in the home, saying "(Name) is an independent person who I think feels a bit abandoned. For a while they were unsteady and needed two care assistants. They are a lovely person, we're being as supportive as we can with lots of reassurance and making them feel wanted. Now they are managing to walk about and are rallying a bit." During the time we spent in the home we saw staff encouraging people to be as independent and make choices where possible.

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found people responded in a positive way to staff in their gestures and facial expressions. We saw staff approached people with respect and support was offered in a sensitive way.

We saw members of staff supporting people during lunch and found that they created a relaxed atmosphere. For example, one person appeared tired and the member of staff explained that they had not slept well and had been awake early. The person appeared confused but the member of staff tried to encourage the person to eat some lunch and put it in front of them in the lounge. They sat down with the person and we saw them explaining gently what the food was and then left the person to see if they would eat it. We saw the member of staff later trying to encourage the person to eat a desert.

We spoke with staff during our visit and found that they had a detailed knowledge of the people that they supported. When we spoke with one member of staff they described how they had gradually got to know the person and what their preferences were. We saw from the care plans that people were involved in discussions about their care, their preferences and this was recorded and signed by the staff member and the person themselves.

We observed that people were relaxed with staff and confident to approach them throughout our visit. We saw staff interacted positively and warmly with people, showing them kindness, patience and respect. There was a relaxed atmosphere in the home and staff we spoke with told us they enjoyed supporting people.

We saw reference to 'What is important to me' in all of the care plans we looked at and records were clear as to the discussions that had taken place and what was important to that person. We also saw that people's wishes regarding end of life care was discussed and recorded in their care plan.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive. People's needs were assessed and care and support was planned and delivered in line with their individual care plan. People had their own detailed and descriptive plan of care. The care plans were written in an individual way and had the person at the centre, which included family information, how people liked to communicate, nutritional needs, likes, dislikes and what was important to them. We saw reference to 'Life journey' and 'what is important to me' in all of the care plans we looked at and where discussions that had taken place about people's life histories and what was important to that person. However, we saw that limited meaningful activities were taking place with those people living with dementia.

We spoke with people about how they passed the day and whether there was enough to do. People told us they were satisfied with the level of activity and that they could choose whether to get involved or not.

We observed that activities were available to people who sat in the main lounge area. Other people in the hall /reception area were reading and talking with each other. We saw that in the main lounge the television was on throughout the inspection and the arrangement of seating and the design of the lounge area meant that only people who sat at the one end of the room were able to fully see the television. However, people we spoke with did not raise this as an issue. Activities provided by the co-ordinator included manicures and gentle activities and exercises.

On the dementia care unit we saw there were no planned activities during the inspection and the member of staff who was on the unit said that they did not have time for specific activities. During the morning we saw that people in this unit were sitting in chairs and watching television. We observed that the member of staff engaged with the four people during lunch but she explained that there was little time for activities as she had to also undertake some cleaning on the unit including mopping floors of the toilet and bathroom. We asked what activities people were involved with when there were enough staff and she explained that there were simple quizzes and reminiscence. During lunch we observed that the carer knew people well, where they had originally lived and what work they did.

We recommend that the registered provider looks at how improvements can be made for people to have access to proper and appropriate activities.

We saw the complaints policy was displayed in the entrance to the home. The registered manager told us people were given support to make a comment or complaint where they needed assistance. They said people's complaints were fully investigated and resolved where possible to their satisfaction. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints records and saw there was a clear procedure for staff to follow should a concern be raised.

People we spoke with told us they did not have any worries about their care. People told us that if they did have any concerns they would speak with staff or senior staff at the home.

Each care plan we saw was reviewed on a regular basis and where any changes had been made these were recorded in the review with the date of changes documented. The care plans we looked at had been signed by the person where possible or by their representative. There were details of people's personal history which described their family background, work life and the interests that they enjoyed. In the front of each plan was a blank audit form which had not yet been completed. When we discussed this with the deputy manager they explained that these forms were new and had only recently been introduced. The audit form was to be completed by the manager or senior staff to monitor the care plans and ensure that they were dated, signed and reviewed appropriately. The care plans demonstrated that care staff had time to assess people's needs, regularly review those needs and spend time with people discussing their plan of care.

People living at the home were encouraged and supported to make their views known about the care provided by the service. People told us that there were regular residents meetings held. We saw the minutes from the last meeting which had been held on the 15 January 2015. We saw that the registered manager at the home listened to people's views and their suggestions and took action. For example, mealtimes had recently changed following a residents meeting where people had made requests about how they would like their food to be served. Vegetables were now being served in terrines, and tea pots were provided per

Requires improvement

Is the service responsive?

table for people to serve themselves and maintain some independence which they liked. People we spoke with also told us that there were no restrictions as to when their relatives or friends visited them.

People living at the home relatives/friends and other professionals were also asked about their views via surveys which were sent annually. The last survey was sent in August 2014. We saw positive feedback from these questionnaires. This made sure that people had the opportunities to express their views about the running of the home.

Good

Is the service well-led?

Our findings

This service was well led. Throughout our inspection we observed an open, relaxed atmosphere in the home. The home employs a registered manager who had worked at the home for over two years. During the visit we saw the registered manager was regularly in the communal areas of the home. They engaged with people living in the home and were clearly known to them.

One relative told us "I think it is a lovely home. I certainly think it is the best one in the area. Overall I am quite happy with everything here."

People were encouraged to decide for themselves how they wanted to receive care and support. Care plans showed clear evidence of people being involved throughout.

Care staff told us that they thought the service was well led. Staff we spoke with told us that they would feel confident in reporting any issues to the registered manager or senior member of staff on duty. They told us that the registered manager was approachable and staff described the manager as being on the ball. One member of staff said, "The manager is good and she is fair. She does her best, she's a good manager. She is straight and on the ball, she discusses everything with us." A senior care staff told us, "I have support from (name of manager) and all the other team managers. They're always at the end of the phone, I feel really supported." Another member of staff told us they were happy in their work and felt they were treated well by their employer. In our discussions with members of staff working at the home, it was clear that they were well supported by the management team who provided support for all members of staff through regular supervision and appraisals.

Staff meetings took place every other month and the minutes of recent meetings showed that discussions took place about all aspects of the service. Areas covered included safeguarding, complaints, training and any audits that had been undertaken. Staff we spoke with told us that staff meetings were held regular. One member of staff said, "They are for everybody, and are helpful but everyone has their own opinions." Another senior member of staff told us that staff did not always speak up at these meetings, however they were going to suggest that a spokesperson for staff was appointed who staff could approach in advance of meetings to raise any issues they would like discussed at the meeting. This member of staff was relative new in post but in our discussions was able to demonstrate that senior staff had the time to provide support to care staff through supervision, appraisals and training.

We saw there was a culture of openness in the home, to enable staff to question practice and suggest new ideas as we saw this in minutes from staff meetings that had been held.

The registered manager had sent out questionnaires in August 2014 to people who lived at the home their relatives/friends and to health and social care professionals. We saw positive feedback from these questionnaires. One relative wrote 'Ashfield is a very welcoming and caring establishment. The staff do a brilliant job. My mum is very independent in her activities as she likes to read, knit, and watch her T.V. so she does not join in as much as she might – but that is her choice. All in all we are more than happy with her care and welfare. Thank you' Another questionnaire from the district nursing team said, 'Visits from the district nursing team always met by member of staff and taken to patient/resident. Staff always attentive and approachable.'

The registered manager and senior managers carried out regular checks on different aspects of the service to make sure that quality and effectiveness was maintained. We saw that audits had been completed monthly in areas such as medication, health and safety and infection control. Where any failings were identified, action plans were put in place to ensure any issues were addressed. We saw evidence that any issues raised were dealt with in a timely manner. We saw that these were checked by the service manager.

The registered manager informed us that they kept up to date with learning and good practice through training made available by the organisation and attended regular managers meetings.

Records showed that staff recorded accidents and incidents that happened at the home. The registered manager told us that accidents and incidents were all investigated and reported upon. A risk assessment was devised where necessary and used to reduce the risk of a reoccurrence. This meant that people received safe care and accidents were minimised wherever possible.

We saw that notifications had been reported to the Care Quality Commission as required.