

South West Care Homes Limited

Ashfield

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This inspection took place on the 21, 26 and 29 November 2018. The first day of the inspection was unannounced, and started at 07:30am to allow us to meet with the night staff, be present at the staff handover and see how duties were allocated for the day.

Ashfield is a 'care home' without nursing, operated by South West Care Homes Limited. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

People living at Ashfield were older people, many living with long term health conditions or dementia. The service accommodated up to 25 people in one adapted building, with a chairlift to access the rooms on the first floor. 22 people were living at the service at the time of the inspection, with one other person in hospital.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection of the service on 5 and 10 January 2017 the service was rated as 'good' in all areas. On this inspection we found this had not been sustained and we have rated the service as requires improvement overall. The key questions for Safe and Well led have been rated as requires improvement. The service had identified many of the issues we had found, and taken or were planning to take some actions to address risks to people. However, we could not be assured the actions they planned to take would be effective in mitigating the risks as they were not all in place. These concerns did not yet give us confidence governance was reliable and effective, because many changes were still 'work in progress'.

We also asked the service to make a safeguarding referral as we were concerned medical advice had not been sought in a timely way for one person after an accident. This was being looked at by the safeguarding team from the local authority.

There were enough safely recruited staff on duty to meet people's needs. Staff had not all completed their training according to the service's training matrix. However, staff and people told us they felt they had the skills and knowledge to support people effectively and had access to senior staff for advice and support. Systems were in place to learn from accidents or incidents and for staff supervision.

People received their medicines as prescribed. We have made recommendations in relation to the management of medicines and competency assessments for staff. We have also recommended that the service ensures they contact people's GP and record this after any admission or re-admission to verify if any

prescribed medicines had changed since their last visit or the pre-assessment was completed.

People were protected from abuse. Staff understood what constituted abuse and were aware of how to report concerns about people's wellbeing. People told us they ate well and enjoyed their meals.

Care plans contained sufficient detail to enable staff to respond to people's needs in a person-centred way. We saw staff understood how to support people in ways that made use of known information about the person's history and choices. Risk assessments were in place to support people for example with pressure damage, choking risks, poor nutrition, falls and moving and positioning.

People's rights with regard to the Mental Capacity Act 2005 were well understood. Where Deprivation of liberty authorisations (DoLS) had been granted, conditions of the DoLS were well understood. This meant people's rights were being supported.

Ashfield is a long established care home, set in a converted period building in a residential area of Exmouth, close to the town centre, shops and facilities. Areas of the building were looking tired although a programme of updating and renovation was under way and significant improvements had already been made. The premises were not well adapted to meeting the needs of people living with dementia. The registered manager told us they had plans to do this. We have recommended the registered persons seek and follow best practice guidance on the adaptation of the premises to meet the needs of people living with dementia.

Activities were provided that people enjoyed, but some people told us there was not much for them to do. The registered manager told us they had plans to increase the number of activities for people in a more person-centred way, particularly for people living with dementia. We have made a recommendation about this.

Relatives and friends were able to visit the service at any time, and complaints procedure were well understood. The registered manager was not however recording all concerns as complaints, so it was not possible to see if issues were recurring. They have told us they will do so in future.

People told us the registered manager was approachable and responsive. People told us the staff worked well as a team, and we saw many friendly, positive episodes of engagement between people and staff. Management scrutiny and oversight had been strengthened since the last inspection which the registered manager told us they found supportive. Systems were in place and being further developed to ensure the quality and safety of the services provided.

We found a breach of regulation on this inspection and you can see what action we have asked the provider to take at the end of this report. We also identified a number of good practice recommendations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

People were not always being kept safe, because the service had not yet acted on or identified some concerns about risks to people's safety.

There were enough safely recruited staff on duty to meet people's needs.

People received their medicines as prescribed.

People were protected from abuse.

Is the service effective?

Good ●

The service remained effective.

Is the service caring?

Good ●

The service remained caring.

Is the service responsive?

Good ●

The service remained responsive.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Governance and associated action was not always reliable and effective, because required improvements or risks were not always identified or managed in a timely way.

We identified a number of concerns on this inspection where the service had also identified improvements were needed. These had not all taken place, but plans were in hand for many.

Systems were in place to support people to feed back their views of the service.

The registered manager was well liked and people told us they were approachable and supportive. They were receiving good

support from senior managers from within the provider organisation.

Ashfield

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 was 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. The inspection was brought forward in response to concerns that had been identified at another service operated by the same provider. We inspected this service to make sure the same issues were not being repeated at Ashfield.

This inspection took place on 21, 26 and 29 November 2018 and the first visit was unannounced. The inspection started at 7.30 am to allow us to meet with the night staff team, be present at the staff handover and see how duties were allocated for the day. On the first day the inspection team consisted of one adult social care inspector and an 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. On the second day the adult social care inspector visited on their own. The third visit was carried out by a specialist pharmacist inspector, who looked at how the service managed people's medicines.

Prior to the inspection we reviewed the information we held about the service and the notifications we had received. A notification is information about important events, which the service is required by law to send us. The registered manager had previously completed a PIR or provider information return which had informed the last inspection in 2017. This form asked the registered manager to give us some key information about the service, what the service did well and improvements they planned to make. We looked at this information while taking into consideration that some of this information would be out of date.

During the inspection we spoke with or spent time with nine people who lived at the service. We met with the registered manager, the area manager, and deputy area manager from the provider organisation. We also spoke with three visiting relatives, five care and support staff, a cook, and two visiting healthcare professionals. We also spoke with the local authority Quality Improvement Team who had previously supported the service and received information from the local safeguarding authority.

Most people living at the service were living with dementia or mental health needs but were largely able to

share their experiences of the service with us. We also spent several periods of time carrying out a short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

We looked at the care records for five people with a range of needs and sampled other records. These records included care and support plans, risk assessments, health records, medicine profiles and daily notes. We looked at records relating to the service and the running of the service. These records included policies and procedures as well as records relating to the management of medicines, accidents, staff training, moving and positioning, nutrition and fluid support, food, complaints and health and safety checks on the building. We looked at two staff files, which included information about their recruitment and training records. We viewed a number of audits and documents the organisation's quality assurance and senior management were implementing, but which had not been used prior to the inspection.

Is the service safe?

Our findings

On our last inspection in January 2017, we rated this key question as good. On this inspection we have rated this key area as requires improvement. This was because although the service had identified many of the issues we found, we could not be assured actions they told us they were planning to take would be effective at resolving the issues, as they were not yet in place.

People told us they felt safe at Ashfield. They told us "Yes, I do. I can't be happier here. It's a happy place, we have a lot of freedom." A relative told us "We know them [staff]. We have no concerns."

During the inspection we asked the registered manager to make a safeguarding referral as it appeared medical advice had not been sought for a period of three days by the service for a person who had fallen. This fall had occurred between the first and second inspection days. The person had subsequently been found to have a significant injury, and the safeguarding concern was awaiting investigation by the local authority at the time of the report. On the second day of the inspection the area manager implemented a new falls assessment tool, which replaced the pre-existing protocol on falls management.

The person's risk assessment had been updated but contained information that was no longer accurate. This had not led to the person being at additional risk but did not give us confidence all the risk assessments contained accurate information. A member of staff had already been identified and was working through the care and support plans to ensure that old information on people's needs and any conflicts were removed.

Not all risks to people from the environment had been identified, or actions taken to address them consistently. Where we identified new concerns, action was promptly taken. For example, we found a small electric oil filled heater in use in the lounge area. This was plugged in and had trailing electric leads across the floor. A person with significant dementia was resting their arm on this hot unguarded surface and moving the device about whilst it was plugged in. This could have caused significant injury to the person. We pointed this out to staff in the area and it was immediately removed.

One fire exit had a sign saying this door was not to be blocked by frames or walking aids. A walking aid was propped against the door, which along with the positioning of chairs would have made exiting the building from this area difficult. The registered manager confirmed this was discussed with the person who owned the frame several times a day and they would again re-enforce the need to keep this area clear. However, we were concerned this action taken previously had not been effective in ensuring the area was kept clear.

The laundry area had been re-sited since the last inspection, where concerns had been identified. On this inspection we saw this new area was cluttered and new flooring was needed to ensure this laundry could be kept clean in order to limit the risk of possible infection. The registered manager could show us evidence this flooring was on order. We discussed how the service separated clean and dirty linens to reduce the risk of cross contamination from dirty or soiled linen, as this was not clear because the room was so untidy. The registered manager told us this had already been identified as an issue and they would be providing a

system of individual laundry bins and washing days so any potential risks of cross infection could be mitigated, but this had not yet happened. Soiled linens were taken to the laundry in sealed dispersible bags, which helped reduce the risks of cross contamination.

The failure to ensure the premises were properly maintained, standards of hygiene were maintained and services met people's needs was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified some bathrooms had loose bottles of antibacterial hand wash. Good practice in services for people living with dementia would be to have wall mounted dispensers to reduce risks of people misusing them or ingesting the contents. The day after the inspection the registered manager contacted us to confirm an order had been placed for wall mounted hand wash dispensers.

A recent audit of the water temperature regulators had identified they were not all working effectively and arrangements had been made to have these repaired shortly after the inspection. This was in line with the organisations policy on water temperature regulation.

A new stairgate had been fitted to the top of a short staircase, as it had been identified people may be at risk from falling downstairs. We discussed this with the registered manager who as a result ensured this was discussed with the fire authority, who said they had no concerns.

People were being safeguarded from abuse. The service had policies and procedures available to identify what constituted abuse and how to raise concerns about people's welfare. Staff told us they were clear about the need to raise concerns about any potential abuse, and told us how they would escalate these through the organisation or outside if no action was taken. Staff had received safeguarding training and one staff member told us how they had raised concerns in the past when they had been concerned for a person's wellbeing. Information about whistleblowing was on display. The registered manager had a clear system in place for reporting, auditing and analysing incidents or accidents. This meant the service could learn from them and take actions to prevent repeated incidents of harm. The registered manager told us about how they had used a recent safeguarding alert made about unexplained bruising as a learning experience to help staff embed what they were learning on the safeguarding course.

Food and fluid records were completed where risks of poor nutrition or hydration had been identified, and there was regular management oversight to ensure people received sufficient food and fluids each day. Risk assessments and support plans were in place, such as for pressure damage to skin, falls, choking, moving and positioning and poor nutrition. One person had been assessed as being at high risk of pressure damage to their skin. Their plan contained clear information for staff on how this risk was being reduced using equipment and an overall plan for good skin health. People and their relatives told us they were supported in line with their plans. One said "I have no concerns. Always two to hoist."

Where there had been concerns over people's skin condition we saw advice had been sought from the community nursing team, who kept some people who were vulnerable under review. Regular checks were made to ensure the person's pressure relieving equipment was working effectively and was appropriately adjusted to ensure it was effective. Plans also covered guidance for staff on how to support each person with risks associated with long term health conditions or distressed and anxious behaviours.

People were given their medicines in a safe and caring way. Staff recorded when medicines were administered to people on Medicines Administration Records (MARs). A sample of 15 people's MARs showed that they were given their medicines correctly in the way prescribed for them. Staff recorded the

administration of non-medicated creams or external preparations on separate care records. If people were prescribed medicines to be given 'when required' there were protocols to guide staff as to when doses may need to be given. For example, we saw a protocol for someone prescribed a sedative medicine if needed for anxiety. There were clear guidelines for staff to make sure doses were only given appropriately.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective.

There was a policy and system in place so that some non-prescription medicines were available to treat people's minor symptoms in a timely way if needed. The updated policy from the clinical commissioning group (CCG) had been implemented, although the completed forms had not been signed off by the GP surgeries, as recommended.

There were systems for checking and auditing medicines. Staff completed weekly and monthly audits and we saw that any actions needed were identified and completed. The supplying pharmacy also carried out advisory visits and we saw that their recommendations had been put into place to help improve medicines management. Staff received updated medicines training and had been checked to make sure they were competent to give medicines safely. However not all staff had been rechecked in the last year, in line with national guidance or the homes policy. The manager told us this would be completed as soon as possible. There were detailed policies and procedures, and information to guide staff on looking after medicines.

We recommend that staff competencies are reviewed annually, and that the non-prescription medicines policy be reviewed in line with current guidance. We also recommend the service ensures up to date information is gathered on people's medicines when they return from another care setting or on a re-admission for respite care. This could not always be evidenced in people's plans.

People and relatives told us there were sufficient staff on duty to meet people's needs. One said, "There's usually some here [in the sitting room]" and another said "The ones that are here work very hard. I think the numbers are adequate." One person told us about the impact of staff having time to spend with them and how it cheered them up. They said "When they come in the mornings they cook my breakfast, make coffee and sit down and natter. I have my breakfast in here [sitting room] watching TV." There was a tool in place to assess the level of staffing needed, based on the needs of the people living at Ashfield. People were being kept safe, because robust systems for staff recruitment were in place. The files we saw evidenced a full recruitment process had taken place.

Records were maintained securely on the computer tablet system. Tablets were password protected, and could identify a full audit trail of staff members who had accessed records and who had made changes to them at any given time.

Information on how to reach senior staff or emergency contractors was on display in the office. People had individual personal evacuation plans available to support staff in an emergency.

Is the service effective?

Our findings

At the last inspection in 2017 we had rated this key question as good. On this inspection we found this had been sustained, however we have made a good practice recommendation.

Most of the people living at Ashfield were living with a dementia. There had been limited environmental adaptation of the premises to support people living with dementia to orientate themselves or make sense of their environment in line with best practice. For example, through the use of colours, décor and signage to help people distinguish different areas. The overall environment was looking tired and in need of renovation, including carpets and furnishings.

The registered manager told us they had already identified the environment had not been well adapted to meet people's needs, and would be acting to address this. Corridors were narrow and roof lights were discoloured which meant they were not always brightly lit. We were told these were to be replaced. Communal areas were small and we found televisions on loudly in two out of the three lounges. The third quiet lounge was also where staff had handovers, ate their lunch and was next to the medicines room. One person told us they preferred to be in the quiet lounge as the two sitting rooms were very noisy and busy.

We recommend the provider seeks and follows best practice guidance on the adaptation of the premises to meet the needs of people living with dementia.

The registered manager told us "In the last 3 months, we have redecorated (six numbered rooms) as well as ground floor communal toilets. We are currently decorating the right wing corridor and then planned to redecorate the first floor. We have a redecoration programme in place and have been working through the home on the basis of that plan." The exterior of the building had been renovated in the last year to include an attractive garden space, and the registered manager had ideas for the renovation of the rear garden. This included people having access to outside space and being involved with gardening. We also heard about plans to renovate some communal areas including new carpets and furnishings. Two people's bedrooms were malodorous and some occupied areas of the service were awaiting redecoration due to water intrusion. Roof lights in the corridors were discoloured and did not allow much light to enter. We discussed with the registered manager the concerns over another person's room. We were told the service had been working with multiple agencies to improve the environment at a pace and time acceptable to the person, which was good practice.

Prior to admission to the service people received a pre-admission assessment. One person told us "I had had a short visit here before, so they knew me already." Other people had come straight to the service, with relations having chosen the service for them. We heard from the registered manager of how they had worked with the local authority to support one new person's pre-admission period over several weeks to reduce distress and disruption to them. The person had now settled and was being supported gradually to accept care and support at their own pace. A relative told us about the admission process that had been followed with their relation. They told us "In the hospital we were given addresses of homes. We just loved the staff we met [at Ashfield], the atmosphere was nicer than anywhere else. She has settled better than I thought."

People told us staff had the skills and experience they needed to support people, and we saw staff supporting people well. People told us "Absolutely" and "I think they have." The service had a system for identifying where staff needed additional skills and the overall training needs for the service, including core skills and mandatory training. The training matrix we saw showed staff had not all yet received or were up to date with training, but the registered manager told us this was because they were new staff working through the training programmes. They also told us informal learning was delivered to staff in daily handovers, meetings and discussions over people's care. We saw evidence additional training had been scheduled and booked. Rotas were constructed to show a mix of experienced and more junior staff. Staff told us they felt they had received sufficient training to do their job and could ask for support and guidance at any time. New staff were given a 'buddy' to work alongside to support them in developing new skills and give feedback on any areas needing additional support.

The registered manager had completed courses in supporting people living with dementia with a recognised dementia expert. Staff worked through dementia training modules to ensure this training was followed through the whole staff team. New staff completed the care certificate, which is a series of standards for staff working in care. Staff received individual supervision and there were regular staff meetings and updates on changes.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 told us "Yes, they always ask. They never take anything for granted." Staff often referred to people being able to make choices and respected their wishes. One person was looking dishevelled and untidy. We discussed this person with staff who could tell us about the strategies they used to support this person. Staff could explain why the person was resistive to being supported, which was based on a good understanding of the person's life history, personality and events. If the person did not wish to receive support staff would later return and see if they could persuade and engage them differently. These approaches were being assessed by the person's community psychiatric nurse.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Applications had been made to appropriately deprive people of their liberty where necessary. Staff could tell us who had a DoLS authorisation in place, and what this meant for people. Although the front door was locked, some people living at the service had keys and could go out without staff support. Some people also had keys to their rooms.

Staff at the service worked with other agencies to ensure people's healthcare was maintained. People had access to community medical support. People told us "They get the GP for us. We have a regular eye test, hearing. I have a couple of hearing aids. The dentist comes. They all come here. If you have to go to the hospital they will take you." People had hospital packs or summary care plans in place in case of the need for a sudden admission. We saw evidence in people's files of visits from podiatrists, community nurses, GPs and other healthcare professionals. A visiting healthcare professional told us they felt the service had a 'very responsible approach' to the management of 'as required' medicines, and these were not over used.

People told us the meals were good and they ate well. People said "The meals are gorgeous, fantastic. You can ask them, but before lunch they will come and ask you what you would like. There's a choice of two different meals. Usually a couple of puddings. They would do you something else if you don't like it, but I have not had to do it". We saw staff showing residents both choices of meals, so they could make a choice.

We spoke with the home's cook, who had clear information about special dietary needs and textures to help people with difficulties in swallowing. Where needed people received diets that had been fortified with cream or other high calorie foods to help people's calorie intake up.

Is the service caring?

Our findings

At the last inspection we had rated this key question as good. We found this had been sustained.

People told us they were happy living at the service and found staff to be friendly, kind and supportive. People said "Yes, they are very good. They are very nice, pleasant. I have become very friendly with the boss, [name]" and "I can't think of anything to change."

We identified some concerns over a lack of confidentiality of information. A staff member was overheard talking on the phone to a GP surgery, discussing a person and their medication. This was audible to anyone in the quiet lounge (where a person was sitting), or in the corridor as the main door was not closed. Later, two staff members talked about a person in front of another person. We discussed this with the registered manager who said they would ensure staff were reminded of the need to ensure they could not be overheard when discussing people's needs.

People themselves told us they felt their privacy was respected. One said, "They always knock on the door". Visitors told us they were kept in touch with any changes in people's needs. One said, "When she fell down last time, they were very good at letting me know what's happening" and "They tell us everything. They have my number, they ring me immediately". People told us they could visit at any time. One person told us "I have two daughters who visit. The family can come in any time. No rules and regulations. They [staff] could not be more welcoming to them."

The relationship between people and staff was friendly and caring. Staff chatted to people as they carried out their tasks, asking if they were alright, and whether they would like a drink. They spoke to them by name, and knew them well. We saw staff laughing with people about the news and the weather. One person living at the service came into the handover to tell staff they were alright and see who was on duty. Staff showed affection towards them and chatted with them before returning to the handover.

When discussing people and their needs staff showed empathy and understanding, using respectful terminology and language. They demonstrated an understanding of the importance of recognising the significance of people's life history and personality. A staff member told us about their own personal experience of supporting family members with dementia, which had enhanced their understanding of how important it was that people were supported well. They told us they would feel happy their relation would be well looked after at the service. Staff also showed an understanding of the importance to people of maintaining their independence. This included a recognition of people's social, cultural and religious needs. One person told us "We go (to church) if we want. One of the staff would take us. We have had the vicar occasionally. We don't have a communion here in the home."

The service was open to people of all faiths and belief systems. There was no indication people protected under the characteristics of the Equality Act would be discriminated against. This is legislation that protects people from discrimination, for example on the grounds of disability, sexual orientation, race or gender. This was not explicit on the services website or documentation we saw, which might have discouraged people

from considering the service as a supportive environment to live or work. We discussed this with the registered manager who said they would consider reflecting this better on their website as it was due to be updated.

People could share their views on the service through regular residents and relative's meetings. People told us "I will go to that. I've not been before. I haven't been told about it, but I noticed it on the notice board."

Is the service responsive?

Our findings

At the last inspection in January 2017 we had rated this key question as good. On this inspection we have again rated this key question as good but have made some recommendations in relation to people's care.

Each person living at Ashfield had a plan of care, completed on a phone based software system. We found plans were not all up to date and one recently admitted person's plan was still in need of completion. The registered manager told us they completed plans in full after they had been able to spend time with the person assessing their needs fully, which could take up to three weeks. This was because they found the information given prior to the person moving in was not always an accurate reflection of the person and their needs and wishes. This person's plan was within the three weeks of their admission. Information about the person was available in sufficient detail to enable staff to respond to their needs prior to this being fully completed. One person at the service was living there for a regular period of respite care. The registered manager confirmed they updated the person's assessment details each time the person came for a short stay. A member of staff had already been allocated to update the care plans and resolve any conflicting information.

Information on how to support people with specific health conditions or care needs was available, with guidance given to staff on how best to support the person. Relatives and people told us about improvements people had made since being at the service. One family member said of their relation "She was heavily medicated in hospital. The staff here phoned the GP who took her off strong medication and took the catheter out. She's back to normal and they [staff] have done a marvellous job. It has been difficult, but they have been brilliant."

Where people's plans contained guidance for staff on how to support the person, we saw they were being followed. For example, one person was being supported to receive personal care at their own pace. We saw discussions took place with the service's hairdresser who tried gently to persuade the person to have their hair washed and cut. This did not happen on the first day of the inspection, but due to the support from a carer the service's hairdresser was able to complete this on a later day. Staff celebrated this with the person, and complimented them on the changes to their appearance.

People told us their plans and daily choices were respected. For example, people were able to choose when they got up or went to bed. One person told us "If I am tired I go to bed and I usually go after the 10 o'clock news. I am usually up about 7 to 8 o'clock. Sometimes the staff waken me, but usually it's automatic" and another said "Yes, I normally go to bed by 9 p.m. and watch the news on TV. I always wake up 9-9.30 a.m. I press my bell when I am ready for breakfast." On the first visit we found five people up and dressed at 07:30am, which was their preference. Other people chose to remain in bed until later in the morning.

No-one living at the service was receiving end of life care, but people's care records contained information about people's wishes. Information from our records showed there had been a relatively high number of recorded deaths at the service in the last year. These were nearly all expected deaths and the registered manager told us these were due to general frailty of some of the people who had lived at the service for a

long time. One staff member told us how proud they had been over the care and support they had given one person to ensure their death was comfortable, pain and anxiety free, and in accordance with their wishes. They told us in these circumstances they realised they were "looking after more than just the resident", but had needed to provide support to family members as well.

All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. We looked at how the home shared information with people to support their rights and help them with decisions and choices. The registered manager told us they had not identified any additional ways in which people needed support to understand information about the service or their care. People's care plans included information on how their communication needs could be supported, including those people living with dementia.

The service had a programme on display detailing activities available, but the registered manager told us they were moving towards having more person-centred activities taking place, in line with people's needs and wishes. This had not yet translated into consistent practice. People told us there was not always much to do. One said "There's a back garden where we can sit out. We watch the telly a lot. There's not a lot to do. We can join the library. If I want a book my daughters will get me one. We regularly have a piano man every 3 weeks, another lady with a sing song. There's a lady who comes and does crayoning....I have never felt lonely here." Another person told us "It would be nice to have an excursion to town, to sit in a nice café, restaurant, shop. I like to look at the shops. I would like to do it more often. Maybe a drink in the pub." The registered manager told us the service was working on ensuring each person had a day a month where staff would support them to do as they pleased, including going out individually. The registered manager agreed this was 'work in progress'.

We recommend the service takes advice on the provision of person centred activities that meet people's interests, wishes and choices, including the implementation of activities for people living with dementia.

The registered manager told us they had plans to open a 'daily shop' in the quiet room. People would be able to take a shopping basket and choose what they wanted.

The service had a complaints procedure that ensured complaints were listened to and acted upon. People told us they would feel able to raise any concerns or issues with the service's staff or management. One relative told us they had raised a complaint and had received a positive response from the registered manager. Other people told us "They are all approachable" and "No complaint, haven't needed to." People who wanted to make a complaint could also raise this with the area managers who were regularly at the service.

We looked at the records held by the service in relation to complaints being made. These identified that not all concerns had been identified by the registered manager as complaints. This meant it was not possible to identify if there were any themes in relation to the concerns being raised or if issues were being raised repeatedly and not being resolved. The registered manager agreed to record all concerns and their outcome in future.

Is the service well-led?

Our findings

At the last inspection of the service in January 2017 we had rated this key question as good. On this inspection we have rated this as requires improvement. We identified a number of issues on this inspection needing improvement. We identified concerns over the premises such as the laundry, fire exits, an electric radiator, and complaints management. We have made good practice recommendations in relation to adaptation of the premises to meet people's needs, medicines, and the provision of person centred activities that met people's interests, wishes and choices.

The majority of these were areas the service had become aware of during their internal audits, and where they had not previously identified the concerns, the service took immediate action to address them. The registered manager told us and we saw evidence that plans were under way to address the other concerns. However, we could not be assured at this time other improvements would be completed quickly, be comprehensive or sustained as they remained "work in progress". Some of these, such as the free-standing radiator had not been identified as a risk. These concerns told us governance and associated action was not always reliable and effective, because needed improvements or risks were not always identified or managed in a timely way.

We also requested the service make a referral to the safeguarding team about the failure to seek medical advice for a person following a fall. This could have led to the person receiving poor health outcomes.

We have therefore rated this key question as requires improvement.

People and visitors told us "I can't think of anything to change", "I don't know what we would do without it", "The meals here are good, it's clean, the staff 100%, people are very friendly", and "It's brilliant. I find it all amazing, the job they do here. I can't thank them enough."

The service had a registered manager in post. The provider organisation had recently increased the level of oversight and management of their services with the recruitment of a new area manager and deputy area manager. They both regularly visited the service to support development and assess and improve the quality of services provided. They could tell us about changes they were making and new processes they were implementing. These included new documentation to ensure falls were escalated appropriately, and additional new quality monitoring systems and audits. The registered manager told us "My office door is never shut. I like to spend a lot of time (working) on the floor" which they said kept them in touch with people's changing needs. This was confirmed by a visiting healthcare professional who said the registered manager and deputy were not the type of managers to 'hide in the office'.

The service had a clear management structure. The Nominated Individual visited the service regularly, and the area manager and registered manager had clear oversight of day to day issues. Staff meetings were being held at the service every month. Staff told us they worked well as a team, there was not a high staff turnover and that they were clear about their and other people's roles. One told us "I think that's why I'm still here – the staff team – everyone's lovely." Senior staff worked alongside people modelling positive care.

Regular audits were being carried out at the service. These included a three-monthly audit of health and safety issues, medicines, the environment, care planning, people's 'dining experience', and weekly environmental audits including cleanliness carried out by the registered manager. Feedback from these was linked to an action plan which the registered manager signed off when completed. For example, it had been identified people could benefit from staff wearing name badges and these were on order. The registered manager told us they were appreciative of the support they were receiving in improving standards.

People and their relatives/supporters could have a say about the operation of the service both through regular meetings and the completion of questionnaires. These had last been sent out and analysed in March 2018. The registered manager was planning to introduce "You said, We did" boards to give visual feedback to people about their feedback and actions taken. Prior to this any developments had been discussed in resident's meetings. New questionnaires were being introduced which included easy read versions, supported by pictures to help people with their completion. Some new picture frames were also on order to frame people's art work.

New policies and procedures had just been sent in an updated format to all services. Staff told us they were proud of the work they had been doing at the service and the developments they had made in the last few years. Staff told us they would be happy for their relatives to receive care at Ashfield.

The registered manager told us they strived to have an open and honest relationship with staff, people living at the service and others and tried to operate a 'no blame culture' for example with medicines errors. They told us they felt this meant staff were not afraid for example owning up to a medicines error, thereby reducing risks to people because they could receive swift treatment. Staff and people living at the service told us the registered manager was approachable. People told us "The boss lady [name], she's lovely. It's just a happy place", "I see [manager's name], she lets me know about things", "excellent leadership" and "She's very helpful. I would not be afraid to go and see her." People, relatives and staff were pleased to tell us about improvements that had taken place at the home and of planned changes ahead.

The registered manager told us they updated themselves on any developments in the care sector by using the internet. The service was about to start having regular meetings with other managers within the organisation and connect with the online "outstanding manager's" forum. In addition, the service was going to work with the Local Authority Quality Improvement team to test out quality assurance systems in care services.

The service had ensured notifications had appropriately been sent to the Care Quality Commission as required by law. These are records of incidents at the service, which the service is required to tell us about.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The failure to ensure the premises were properly maintained, standards of hygiene were maintained and services met people's needs was a breach of Regulation 15 (1) (a) (e) and 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014