Mrs M Wenlock

Ashfield House - Leominster

Inspection report

Bargates
Leominster
Herefordshire
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Tel: 01568614662

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashfield House is located in Leominster, Herefordshire. The service is registered to provide accommodation and care for older adults, as well as nursing care.No one living at the home was receiving nursing care at the time of our inspection. On the day of our inspection, there were 18 people living at the home, some of whom were living with dementia.

We previously inspected this service on 17 August 2015 and the rating was Good. At this inspection, we identified breaches of Regulation. These were in relation to person-centred care, dignity and respect and good governance. You can see what action we asked the provider to take at the end of this report.

The inspection took place on 30 October 2017 and was unannounced.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

People's medicines were not always stored in accordance with the prescriber's directions, or in accordance with current best practice. People's medicines were not always signed for by staff, which made it difficult to know whether some medicines had been given.

Staff were deployed as cleaners as well as carers, which sometimes impacted upon the care they were able to provide. People were not always treated with dignity and respect.

People could not always enjoy their individual hobbies and interests. People were not able to go out for day trips when they wanted to, unless taken out by family members. People's care plans were not always reflective of their individual preferences, likes, dislikes and interests.

Quality assurance measures were in place, but these were not effective in identifying shortfalls in the service. Care records were sometimes inaccurate or had not been completed.

People were protected from harm and abuse. Risk assessments were in place in regard to individuals' needs and these were known and followed by staff.

People's weight was monitored and where there were concerns, appropriate action was taken. People had access to healthcare professionals, and their changing needs were responded to. People enjoyed the meals provided.

There was a system in place for capturing and acting on complaints and feedback. Staff felt valued and supported in their roles.

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's medicines were not always stored as per the prescriber's instructions.

Care staff were also deployed as cleaners, which sometimes affected the care people received.

People were protected from harm and abuse. Individual risk assessments were in place which set out how to keep people safe, which staff adhered to.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not demonstrate an understanding of key legislation underpinning their daily practice.

People's health was maintained and they had access to a range of healthcare professionals, as required.

People were supported to eat and drink and any concerns about weight loss were acted on.

Staff's training was relevant to their roles and people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always maintained.

People enjoyed positive relationships with staff. People's independence was promoted, as much as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not always enjoy their individual hobbies and

interests. People wanted to go out more, but were unable to do so. People's care plans were not always reflective of their individual life histories and preferences.

People's changing needs were responded to.

There was a system for responding to complaints and feedback.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Shortfalls in the service had not always been identified or acted upon. The CQC had not been identified of all incidents where people had suffered harm or abuse.

The registered manager knew people well. Staff felt supported in their roles and that they could approach management.

Ashfield House - Leominister

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We made an unannounced inspection on 30 October 2017. The inspection team consisted of two Inspectors.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information helped us to focus our inspection.

We contacted the local authority and Healthwatch before our inspection and asked them if they had any information to share with us about the care provided to people.

We observed how staff supported people throughout the day. We spoke with seven people who lived at the home and two relatives. We also spoke with three healthcare professionals. We spoke with the registered manager, the provider; a nurse; the cook; and four members care staff. We looked at four care records, which included risk assessments, healthcare information and mental capacity assessments. We also looked at four medication administration records; comments and feedback received; medication audits; incident and accident records; and two staff pre-employment checks.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, we found that people received their medicines safely and as prescribed. At this inspection, we found that medicines were not always stored in accordance with the prescriber's and manufacturer's instructions. We found that medicines which required cold storage were stored in the main kitchen fridge, which also contained foods and liquids for human consumption; there was no separate receptacle within the fridge to store medicines. A senior member of staff told us that a recent inspection by the Clinical Commissioning Group had also identified the need for a secure medicines fridge. We saw a copy of this report, which clearly stated a secure, "designated medication refrigerator" was in use, as per best practice . However, there was no designated medication refrigerator at the time of our inspection. We raised this with the registered manager, who was aware the medicines were not being stored in accordance with their requirements, but did not offer an explanation as to why a secure medicines fridge was not in use. The provider information return (PIR) made no reference to forthcoming improvements to the safe storage of medicines, which indicated this had not been identified as an area of concern by the provider.

Medicines were not always stored in line with manufacturer's instructions. For example, one medicine required cold storage until it was opened. Once opened it should not be stored below 25 degrees Celsius. This medicine had been stored in the kitchen fridge, which meant it may have not been effective as it was stored at the wrong temperature. We raised this with the registered manager, who was unaware this medicines was being stored incorrectly.

The kitchen fridge temperature had been recorded daily. However, medication room temperature records were inconsistent and contained significant gaps where temperatures had not been recorded. The purpose of monitoring medication room temperatures is to ensure that medicines are stored in accordance with the prescriber's guidance. Storing medicines at the incorrect temperature can reduce their efficacy. We discussed this with the registered manager, who told us, "Staff should be recording those. " The registered manager was not aware there were gaps in the temperature records.

People and their relatives told us medicines were always administered correctly and on time. We observed the process of administering people's medicines. The senior member of care staff confirmed they had received training in the safe administration of medicines, and that they had received competence checks from the registered manager. We checked people's medicine records and they did not always record when people had their medicines. All the medication records we looked at had photographs of each person for whom medicine had been prescribed, and recorded people's allergies. This reduced the risk of medicines being given to the wrong person or to someone with an allergy, and was in line with current guidance. Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were stored as per legislation. We undertook a stock check and found the number of remaining tablets were correct.

We considered staffing levels at the home and whether there were enough staff, sufficiently deployed, to meet people's needs safely. We saw that people did not have to wait for staff assistance, such as help with mobilising. However, the first two hours of the morning care shifts were spent cleaning the home. This

meant that if people needed to request staff help, staff would have to fit that around the cleaning of the home. One member of staff was cleaning and then had to attend to a person's request for help. This meant they left potentially hazardous cleaning materials unsupervised and accessible for people when they went to assist the person who needed help. We discussed this with the member of staff, who told us they should have secured the materials first, but did not have time to do so. They told us, "Mornings are hectic here because we are cleaning as well as providing care."

Other members of staff told us about the difficulties in being deployed in the house-keeping role for part of their shift. One member of staff told us, " If somebody asked for a bath (in the morning), no staff would be available as staff are cleaning and the seniors are doing meds (medication). I think that needs to be improved." Another member of staff told us,"Evening staff should bath residents, but I know some people are not having regular baths." This was reflected in what people told us. One person we spoke with told us," I have been here for [time] and I have had three showers and one bath. I asked one member of staff for a shower and they said they had done all the showers for the night." A relative we spoke with told us their relative had a 'weekly bath', but they were not concerned by this and described it as "plenty."

We looked at bathing records for people, which contained gaps and it was therefore unclear as to how many baths and showers people did have. However, records did indicate this was around one a week per person. The registered manager told us that people were having more, but that staff were not always recording these. During our inspection, we did not have concerns about people looking unkempt or about their personal hygiene. However, staffing levels and the manner in which they were deployed resulted in a lack of staff availability to offer people daily baths or showers.

We discussed this with the registered manager, who told us that the home was in a transition period due to now being registered to also provide nursing care and that when there were more people living in the home, there would be resources available for separate housekeeping staff. However, this was not referenced in the provider's PIR when they set out forthcoming changes and improvements to the service.

People we spoke with told us they would like to go out more. One person we spoke with told us, "The home won't arrange any trips out, but it would be lovely to go." Another person spoke of their boredom within the home and how they would like to go out more. We did not observe any activities taking place for people during our inspection, although there was one scheduled on the displayed activities planner. We also saw that later that week, the daily activity was scheduled as, "One to Ones with people." However, staff we spoke with confirmed such activities did not always take place as there was not time to spend with everyone as a one-to-one.

We spoke with the registered manager, who confirmed people did not go out, unless taken out by their families. They told us they did not have a mini-bus for trips out, and that there were staffing and financial resource considerations which prevented this. We spoke with the registered manager about other options they could consider, such as volunteer schemes. The registered manager told us they would look into these.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before staff members were allowed to start work, checks were completed to ensure they were safe to work with people. We saw that checks with the Disclosure and Barring Service (DBS) were completed and, once the provider was satisfied with the response, they could start work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care.

Staff and the registered manager understood their roles in regard to protecting people from harm and abuse. One member of staff told us, " If I thought a resident was being abused, I would tell the senior or the manager. I'm confident they would deal with it properly but, if they did not, I would report it to the police. People are safe here as they are never really on their own." We saw staff and the registered manager had acted on concerns about one person's self-neglect. These concerns had been raised with the local authority and the district nursing team in order to try and support this person and prevent the risk of harm.

Risks associated with people's individual care and support needs had been assessed and were known by staff. One member of staff told us, " One resident is at high risk of falls. We have pressure mats and we escort [person] wherever they go." Another member of staff told us, "There are risk assessments in place for people. We actively look to make the environment safe so people can't trip." We saw there were individual risk assessments in place for areas such as pressure care; weight loss; finances; and mental health. We saw how these risk assessments were followed to keep people safe. There were concerns about one person's mental wellbeing, so staff made sure they documented and escalated their concerns, which had resulted in the registered manager referring the person for input and support from the mental health team. People and their relatives told us they had no concerns about people's safety. One person told us, " I feel content and safe living here." A relative we spoke with told us, " I have no concerns, [Person] is safe and well looked-after."

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider upheld people's rights. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Although staff we spoke with told us they were not familiar with the key principles of the Act, we saw they acted within its requirements. For example, one member of staff told us, "I would always only do things with people's consent; I always respect their wishes." We mentioned MCA training to the registered manager, who told us this had taken place for staff.

Where people lacked capacity to make specific decisions, people had access to an Independent Mental Capacity Advocate (IMCA). An IMCA is someone who helps people with communication difficulties make their views known and represents people when decisions are being made about them. Additionally, where people lacked capacity to make certain decisions, meetings were held with the person, as well as relatives and health professionals where applicable, to ensure staff acted in that person's best interests. We saw that where there were capacity assessments in place, these were decision-specific. There was a recognition that people could have capacity to make decisions in some areas, but not others. There was also a recognition that people's capacity could fluctuate.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, everyone living at Ashfield House had been assessed and where DoLS were required, these were in place. Not all staff we spoke with were familiar with what these restrictions meant for people, or what the purpose of a DoLs was. One member of staff told us, " I know everyone is not allowed to go out without family." This demonstrated a lack of understanding of DoLS. However, staff were able to identify the individuals subject to a DoLS authorisation, although they did not know the associated individual conditions in place for people who had a DoLS. The registered manager told us they would discuss this with staff in the next staff meeting and in staff supervisions to ensure all staff were aware. We asked the registered manager to show us the system they used to monitor people's DoLS authorisations to make sure DoLS had not expired and people were not unlawfully being deprived of their liberty. The registered manager told us they would send this to us after our inspection as it was not readily available. However, this was not sent to us and as such, we could not be satisfied the registered manager and the provider had a system in place for monitoring DoLS.

Staff told us they received the training and support they needed to be effective in their roles. Staff described the training they had received during their induction, as well as the training they continued to receive. One member of staff told us, "I have had practical training from the manager in the use of hoists, handling belts, slide sheets and other aspects of moving and handling. I am currently doing my team leader training as well." We saw the registered manager had an up-to-date training qualification which enabled them to

provide manual handing training to staff. Another member of staff told us, "I do feel I have enough training for my role. I have supervisions every eight to twelve weeks, but the manager is always available." Staff told us they had received training in dementia care, which had also covered body language, and behaviours which challenge. Additionally, staff undertook the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily practice. We observed instances of staff being effective in their roles, such as defusing situations and tailoring their communication styles to individuals' needs.

We spoke with the cook, who was familiar with people's individual dietary requirements. We saw that one person had needed an iron supplement when they moved into Ashfield House, but were no longer deficient in iron and did not take the supplement now. The cook attributed this to the healthy diet the person had, with all food being freshly prepared and home-cooked. Although there was only one lunchtime option available, people told us they were happy with the range of meals provided. One person told us about their lunch," It's lovely, good pastry here. It's a big plate of dinner." At the time of our inspection, no-one living at Ashfield House required a specialist diet. However, the cook and the registered manager ensured that people's needs were kept under review and understood that people's eating and drinking needs may change.

The lunchtime dining experience was relaxed and calm. Staff encouraged and assisted people to eat, where necessary. Drinks and snacks were provided to people throughout the day, in -between meals. At the time of our inspection, no one living at Ashfield House required input from the Speech and Language Therapy team in regard to their eating and drinking needs, but the registered manager told us referrals would be made should people's needs change.

People's weights were monitored and where there were concerns, referrals had been made to the relevant healthcare professionals and their guidance followed, such as putting in place a daily food and fluid chart. Staff knew whose weights needed monitoring on a weekly basis, and people whose weight could be taken on a monthly basis. We found that people's weight records were clear and had been regularly updated.

People had access to a range of healthcare professionals. On the day of our inspection, people had their feet treated by a chiropodist, who told us they visited the home monthly. We saw in people's care plans details of other healthcare input. This included district nurses, GPs, dentists and opticians. People and relatives told us staff always ensured people saw health professionals when they needed to.

Requires Improvement

Is the service caring?

Our findings

During the morning of our inspection, eight people were sitting in the communal lounge as the visiting chiropodist treated people's feet. This included cutting people's toenails and filing their feet. We asked the chiropodist if people's feet were usually treated in this manner, and they told us they would expect the use of a 'dignity screen', but there was not one available. A dignity screen is a partition which is used during personal care so that other people cannot see that personal care is taking place. We discussed this with the registered manager, who told us there was not room in the communal lounge for a screen, but that the new nursing wing had a treatment room which could be used for this purpose. The registered manager confirmed that people would now be given the option of the treatment room so that they did not have to be placed in an undignified situation.

People and relatives spoke positively about the caring approach of staff. One relative told us, " Staff have a laugh and a joke. They are incredibly kind and respectful." During our inspection, we read recent positive feedback received about the care Ashfield House had provided. One comment stated, " My mother is clearly well looked-after. The patience and caring attitude they show her is wonderful." We observed caring interactions between staff and people throughout our inspection, with staff being particularly soothing and reassuring to people who became distressed or anxious. However, staff told us they would like to have more time to spend with people, which they told us would further improve the care people received. One member of staff told us, " Having to clean does restrict the amount of time we can spend with people. Where I do have time, I will sit and spend this with people and have a chat. People love it when we are able to do that."

Staff we spoke with told us about the importance of promoting people's independence, as much as possible. One member of staff told us, " We have a few people who are independent. With others, if they can wash themselves or feed themselves, we will always encourage them to do so. I think it is very important as they (people) like being able to do things themselves." We saw instances of where staff respected people's wish to be independent, but that they also monitored them to ensure they were safe. For example, one person wanted to walk without their frame, even though they needed the frame's support. Staff respected the person wanted to walk unaided, but stayed near them so they could ensure their safety. One relative remarked, " It is the little things like using [person's] own cutlery, having toast with the marmalade and butter provided separately which helps [person's] independence."

Requires Improvement

Is the service responsive?

Our findings

We looked at whether people were able to enjoy their individual hobbies and interests. One person's care plan said, "[Person's name] is a very intellectual lady. [Person] still completes crosswords and puzzles regularly and this will need to be maintained and that [person] has plenty of stimuli." We asked staff and the registered manager if the person was given the opportunity to do these puzzles still, and we were told the family did this when they visited. However, this was not something staff did with the person as a matter of course. During the course of our inspection, we did not see this person have access to any crosswords or puzzles. We spoke with this person, who told us about their interests and skills, which included dress-making and playing the piano. Their care plan also reflected the fact the person, "Loves to sing, so these activities would be of particular interest." This person did not have access to any stimuli, such as dress-making patterns or a keyboard. They told us, "There is not very much for me to do here." We found there was limited dementia-friendly and dementia-specific activities for people. For example, there was no evidence of any activities such as reminiscence work with people to help them stay active and stimulated. The provider told us there was a selection of books for people, including large print books and 'talking' books, and that people had the choice of using the quiet lounge area if they wanted to listen to music or read.

One person told us, " I came here with great positivity, but experienced great disappointment. There are no activities at all. No books, no papers, no piano, no keyboards; absolutely nothing. The TV is on from 9 a.m. in the morning to 9 p.m. at night." There was no designated activities coordinator in place, which meant that activities had to be led by care staff. However, staff did not have the time available to dedicate to this role. We spoke with the registered manager, who told us there were resource implications in employing an activities coordinator, but this role would be considered again once the service had grown and began to accept people who require nursing care.

One health professional we spoke with told us, " My main criticism would be the lack of stimulation for people. The television is always on. It would be good for a change if some music could be played instead and so that people could have a sing-a-long." We spoke with the registered manager and provider, who told us that people had previously enjoyed watching musicals, but these were no longer shown at the home as the provider had been told they needed a special licence to show these. We looked into this matter during our inspection and found the provider was able to show these films. The provider told us this would be reinstated. However, a period of months had passed where people had been unable to enjoy watching films they liked and wanted to watch, with no action taken by the provider to investigate this matter further until our inspection.

People's care plans did not always contain information about their preferences, life histories and background. Out of a sample of three care plans we looked at, none had detailed personal information. People living with dementia are reliant on staff knowing them and being able to recognise their individual preferences, needs and communication styles. Without detailed records, staff did not have access to this information. Life history information is important for staff when supporting people with dementia as it can aid them in conversations with people, as well as reminiscence work with people to stimulate their memories. We spoke with the registered manager, who told us that some people's plans contained 'life

story' books, but some did not as family members had not completed these. We spoke with the registered manager about ensuring people's individual preferences, likes and dislikes were captured and reviewed to ensure all staff knew how to provide person-centred care.

People did not always receive the care they wanted or needed at the times of their choosing. This was particularly in relation to their personal care needs, as people had to fit around designated times where staff helped people to have a bath or a shower. As staff were deployed as cleaners in the mornings, this meant that they were unavailable to assist people with baths or showers during this time. This resulted in the evening staff being given the duty of helping people with baths and showers, but they did not always have enough time to attend to everyone. This approach to personal care did not reflect people's individual needs or preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's changing health and wellbeing needs were responded to. Staff were vigilant to any changes in people's health or mood and made sure they communicated these concerns with the staff team and the registered manager. We saw examples of where concerns had been responded to, such as involving other healthcare professionals and reviewing people's individual care needs. One health professional we spoke with told us, " They are very good at letting me know about any changes to people's needs and if they need to see me."

There was a system in place for capturing and responding to complaints, concerns and feedback. At the time of our inspection, no formal complaints had been received and so we could not consider whether these had been responded to appropriately. The complaints procedure was displayed in an accessible format for people and visitors, and people and relatives we spoke with told us they were aware of how to complain, if the need arose. The registered manager had gathered feedback from people about any improvements they wished to make, and they had requested a summer house in the garden. The registered manager had started fundraising in order to generate enough money in the residents' fund to buy a summer house for people.

Requires Improvement

Is the service well-led?

Our findings

We looked at how the registered manager and provider monitored the quality of care provided to people living at Ashfield House. Whilst there were audits in place for areas such as medication; infection control and health and safety, these audits were not always effective in identifying shortfalls. For example, we found that Medication Administration Records (MARs) were not always complete, which meant that medicines had not always been signed for. Although a stock-take showed us that people had received certain medicines, it was not possible to determine whether liquid or cream medicines had been given. Staff and the registered manager told us that all medicines had been given, but not always signed for. This is contrary to guidelines on safe administration of medicines. The Clinical Commissioning Group's medication audit from the previous month had found gaps in the MARs which had not been investigated. We found three gaps for this month which also had not been investigated. This demonstrated that the provider's quality assurance systems were not always effective in identifying risks to people, or shortfalls in the quality of people's care. It also demonstrated to us that action was not always taken promptly when concerns were brought to the provider's attention.

The provider's audits had failed to identify that people's care records were not always completed. Registered providers are required to maintain accurate, complete and contemporaneous records in respect of every person using their service. We found that people's care records were not always completed, with the registered manager being unaware of this. For example, the one person's bathing records showed two instances of where they had not had a bath or a shower for 10 days. We also found gaps of up to eight days in one person's skin health records. In total, there were five gaps in this person's daily checks during September 2017. The registered manager told us, "I have told staff to complete those. Have they not been doing so?" Although people did not look unkempt or in need of personal care during our inspection, the lack of accurate records meant we could not be satisfied that people had their bathing needs met.

One person's weight records were in the bathing records file. We asked the registered manager about this, who told us the weight record should be in a separate file and did not know why it had been filed incorrectly. Whilst the registered manager was correct to say that individual care staff should ensure accurate record keeping, the ultimate responsibility for maintaining accurate records is with the registered manager and the registered provider. Care records should be regularly audited and monitored to ensure they are an accurate, complete and contemporaneous record in respect of each person and the care they receive.

The registered manager told us one way the provider monitored the quality of care provided to people was through questionnaires. They told us they had questionnaires from this year to show us, but they then discovered were from the previous year. We saw that staff feedback in the questionnaire said there were not enough activities for people and that too much time was spent by care staff on cleaning the home. At the time of our inspection, these concerns raised by staff had not been acted on and remained a concern a year later. Therefore, we could not be satisfied that staff and people's views were given due regard and that people and staff were involved in the running of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Registered providers are legally obliged to send the CQC notifications of incidents, events or changes that happen to the service within a required timescale. Statutory notifications ensure that the CQC is aware of important events and play a key role in our ongoing monitoring of services. During our inspection, we discovered the registered provider had not made us aware of a safeguarding concern regarding one person and had not submitted the relevant notification to us, We spoke with the registered manager, who told us, "That was an oversight on my part, and I fully apologise for that." The registered manager submitted this notification to us after our inspection so that we had a record of the matter.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We looked at how the registered manager promoted a positive culture within the home. We saw the registered manager spent time speaking with people throughout our inspection and that they knew everyone well as individuals. There was an ease and a familiarity between people and the registered manager, which assured us that people felt comfortable with the registered manager and knew who they were. One relative commented, " [Registered manager] is excellent and a trooper. They have the ability in engaging the residents and winning their trust." The registered manager and the provider has established links with the local community for the benefit of people living at Ashfield House. For example, a recent cake sale had taken place for members of the local community, which was in aid of raising funds for the Alzheimer's Society. We spoke with the registered manager about further local links they could develop to further benefit people living at the home.

Staff we spoke with told us they felt supported in their roles. One member of staff told us, " The manager and the seniors are very approachable." Another member of staff told us, " I do feel we are valued and that our roles are important." Staff were aware of how to raise concerns, including the provider's whistle-blowing policy. Staff told us they would escalate any concerns to the provider or the CQC in the event they were concerned about any aspect of the care provided to people.

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 17 HSCA RA Regulations 2014 Good governance Whilst audits were in place to monitor the quality of care provided, they were not always effective. Not all the issues we identified during our inspection had been identified by the provider. For example, medication audits had not identified the shortfalls in regard to safe storage of medicines. Where the provider was aware of the shortfalls, such in regard to dignity and respect, action had not been taken to remedy this. The provider had not acted on feedback from people and staff about people wanting to go out of the home more, nor about wanting more to occupy them throughout the day. Feedback had also been giving about staffing levels and the deployment of staff, with no changes made.