Barchester Healthcare Homes Limited

Ashfields

Inspection report

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 2 and 4 November 2016. The first day was unannounced.

Ashfields is a service that provides accommodation and personal care for up to 44 people. During the inspection visit, there were 38 people living within the home, most of whom were living with dementia.

There was a registered manager employed at the home. 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 and associated Regulations about how the home is run.

At the last inspection on 13 January 2015, we asked the provider to take action to make improvements to the management of people's medicines, assisting people to eat and drink enough to meet their needs and to their processes to monitor the quality of care provided. At this inspection, we found that some improvements had been made. However, although effective systems were in place to monitor the quality and safety of the care provided in most areas, the provider had not effectively assessed and monitored that people received enough to drink to meet their individual needs. You can see what action we have told the provider to take at the back of the full version of this report.

The provider has assessed the number of staff required to provide people with safe care that met their needs. However, the required number had not always been reached resulting in less staff working on some days than there should have been. This placed people at risk of not receiving care in a timely manner or care that met their needs. The provider had recognised this and was making improvements within this area.

Risks to people's safety had been assessed and in most cases, actions had been taken to reduce any risks that had been identified. However, risks in relation to people developing a pressure ulcer required improvement.

Systems were in place to reduce the risk of people experiencing abuse. Risks in relation to the premises had been assessed and the home was well maintained. Equipment that people used had been tested to make sure it was safe to use and people received their medicines when they needed them.

The staff were kind, caring and compassionate. They treated people with respect and upheld their dignity. They provided people with choice so they could make decisions about how they wanted to be cared for. People's individual care needs had been assessed and they were encouraged to join in with a variety of different activities to enhance their wellbeing.

People had access to a good choice of freshly prepared meals and snacks. Staff sought advice from other healthcare professionals and acted in a timely manner when any concerns about people's health had been identified.

The staff requested people's consent before they provided them with care. Where people were not able to give consent, the staff made sure that they took any decisions they made on their behalf in the person's best interests.

Staff had the necessary skills and knowledge to enable them to provide people with effective care. The registered manager monitored the completion of their training to make sure it was up to date and appropriate.

The provider had identified that they wanted to improve the quality of care being provided to people living in the home, the ultimate aim of which was to improve people's quality of life and wellbeing. Improvements had commenced which involved staff receiving further training regarding supporting people living dementia and making changes to the environment.

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 consistently safe.

There were not always enough staff working on each shift in line with the provider's requirements.

Most risks to people's safety were being managed well. However, not all appropriate actions were being taken to reduce the risk of people developing a pressure ulcer.

People received their medicines when they needed them.

Systems were in place to reduce the risk of people experiencing abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received enough to eat. However, action had not always been taken to maximise the availability of drink to people and to encourage them to drink enough to meet their individual need.

Staff had the skills and knowledge to provide people with effective care.

Staff sought consent in line with the necessary legislation.

People were supported with their healthcare needs.

Is the service caring?

Good

The service was caring.

The staff were kind and compassionate and treated people with dignity and respect.

People and their relatives were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's individual needs and preferences had been assessed and were being met.

People were supported to access activities to complement their hobbies and interests.

The provider had a system in place to investigate and deal with complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Not all of the systems in place to assess and monitor the quality of care provided were effective.

Staff were happy working at the home but had mixed views regarding whether they received good leadership from all levels of management.

The provider was making improvements to the care people received to enhance their wellbeing.

Ashfields

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 home under the Care Act 2014.

This inspection took place on 2 and 4 November 2016. The first day was unannounced. The inspection team consisted of two inspectors, one of whom specialised in the management of medicines 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.

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 home, what the home does well and improvements they plan to make. We also reviewed other information that we held about the home. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams.

Most of the people living at Ashfields were not able to provide us with detailed feedback about the care and support they received. During the inspection visit however, we did gain the views of two people living at Ashfields and four visiting relatives. We also spoke with five care staff, the chef, the home's trainer, the deputy manager, the registered manager and a regional manager who represented the provider. As most people were not able to communicate their views fully to us, we observed how care and support was provided to some of these people. To do this, we 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.

The records we looked at included six people's care records, people's medicine records and other records relating to people's care, three staff recruitment files and staff training records. We also looked at records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in January 2015, we found that people's medicines had not been managed safely. This resulted in a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by April 2015. At this inspection, we found that the necessary improvements had been made and that therefore, the provider was no longer in breach of this regulation. People's medicines were managed in a safe way.

Both of the people we spoke with and the visiting relatives told us that medicines were received when needed. One person told us, "Staff hand them (medication) over and I take them." A relative said, "I told the staff one day when I was visiting that [family member] had got a headache. They got [family member] something for it. The staff do all [family member's] medication."

We looked at how information in people's medication administration records and care records supported the safe handling of their medicines. We found that these records indicated that people received their medicines as intended by the person who had prescribed them.

Supporting information was available to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on people's preferences about having their medicines given to them. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines for the majority of medicines prescribed this way. At the time of the inspection visit, there were no additional charts to record the application and removal of prescribed skin patches. These are necessary to help staff ensure they do not place a patch in the same place which could result in skin damage. On the second day of our inspection visit, the registered manager confirmed that these had been put in place.

Medicines were being stored safely for the protection of people who lived at Ashfields and at the correct temperatures to make sure they were safe to use. Staff authorised to handle and give people their medicines had received training and had been assessed as competent to undertake medicine-related tasks. We observed part of the lunchtime medicine round and saw staff following safe procedures when giving people their medicines.

Some people received their medicines covertly (hidden or crushed in food or drink). Records confirmed that the person's GP had been consulted to ensure that these medicines remained effective when being given this way.

The two people we spoke with told us they felt there were enough staff available to meet their needs. One person told us, "They [the staff] are there if I need them." Three of the four relatives agreed with this. One relative said, "There are always enough staff in the lounge to see to residents and there is usually someone

around in the corridors." Another relative told us, "There is always someone [staff] floating about." However one relative disagreed telling us, "Sometimes there are not always enough staff. They are always so busy all the time."

Four of the five staff we spoke with told us that when they were fully staffed, they could keep people safe and meet people's care needs in a timely manner. One staff member did not agree with this. They felt that even when fully staffed, people did not receive support in a timely way. All of the staff told us that on a regular basis they had to work with less staff than they should. They told us this was due to last minute unplanned staff absence that was not being covered appropriately. When this happened, they said the care they provided was safe but that it was rushed and that sometimes, people had to wait for assistance from them.

During our inspection visit, we saw that there were enough staff to meet people's needs. Staff were always present in the communal areas of the home to keep people safe. They assisted people promptly when they requested support. However, in view of the feedback we had received about staffing levels within the home, we checked the staff duty rota's from 3 to 30 October 2016. This was to determine whether the number of staff the provider said should be working each day, had been achieved.

We found that the number of staff required to meet people's needs as determined by the provider had not been met on a regular basis. On 18 of the 28 days, there were less staff working than there should have been for a period of time throughout the day. This included five days where there were not enough staff in both the morning and afternoon. On other days, there was a shortage of staff in the afternoon or morning only. The required staff levels had been met during the night.

We spoke with the registered manager about our findings. They told us that when staff were unable to work at the last minute, they or their deputy manager would assist the staff with supporting people. They also said that the activities staff could also assist if needed and that they had asked staff at the provider's other homes if they could assist. Existing staff working in the home were also contacted to see if they could provide cover.

The registered manager had also recognised that at certain times of the day, the staffing levels needed to be increased to meet people's needs. In response to this, two new bank staff had been recruited who were due to start working at the home shortly. These staff would be used to cover unplanned staff absence. New rotas had also been devised to ensure that the required number of staff were working throughout the day as determined by the provider. We have concluded that improvements are required within this area. This is because it is too early for us to judge whether the actions taken by the provider will ensure there are consistently enough staff available to meet their requirements.

For those people who were at risk of developing a pressure ulcer, some equipment was in place to help reduce this risk such as a specialist mattress on their bed. The staff told us they regularly supported people to change their position to also help reduce this risk. Three people whose care we looked at had been assessed as either being at high or very high risk of developing a pressure ulcer. However, they were observed during the morning of our visit not to be sitting on a pressure cushion when sitting in a chair within a communal area. A senior member of staff told us the cushions should be used at these times. Improvements are therefore required to ensure that all appropriate actions are taken to reduce the risk of people developing a pressure ulcer.

Risks to people's safety had been assessed. These included risks in respect of people, falling, developing a pressure ulcer, not eating and drinking and choking. In most cases, we saw that the provider managed these risks well and that actions had been taken to reduce the risk of people experiencing harm. For example, one

person who was at risk of falling out of their bed, had a bed low to the floor and a crash mat in place to reduce the risk of them experiencing injury. Another person who had been assessed as being at risk of choking on their food, was receiving a pureed diet to reduce this risk.

Risks associated with the use of bed rails on people's beds had been assessed. This was to make sure they were safe for the person to use. We discussed the use of bed rails for one person with the registered manager. It had been recorded within the person's care record that on one occasion in the past, they had trapped their leg in the bed rails which had resulted in an injury. More recently, they had been found with some bruising to their body which the staff had concluded had been due to the bed rails.

The registered manager told us that they had re-assessed the risk of using bed rails since this latest incident and had concluded that the bed rails were safe. The latest risk assessment in the person's care record confirmed this. The registered manager said they believed the person had been able to remove the bed bumpers (soft coverings on the bed rails) which had contributed to their latest injury. In response, the registered manager said that new bed bumpers had been purchased which could not be removed by the person. They also told us they had considered alternative ways of protecting the person from the risk of injury if they fell out of bed but had concluded that bed rails were the most appropriate method to do this.

Risks in relation to the premises had been assessed and actions taken to reduce any identified risks. We saw that fire doors were kept closed and that the emergency exits were well sign posted and kept clear. The staff we spoke with confirmed that testing of the fire alarm had taken place to make sure it worked correctly. Staff demonstrated to us that they knew what action to take in the event of an emergency such as a fire or finding someone unresponsive within their room. Lifting equipment used to assist people to move such as hoists, had been regularly serviced to make sure they were safe to use.

The required checks had been completed when recruiting new staff to the home. These included obtaining references about the staff member's character and checking with the Disclosure and Barring Service that the staff member was deemed safe to work with people living in the home. This reduced the risk of employing staff who were unsuitable to work within care.

Systems were in place to reduce the risk of people experiencing abuse. Both of the people we spoke with said they felt safe living at Ashfields. One person told us, "I feel safe living here. As long as they are there to give me my food I am happy." Another person said, "I feel safe very safe here." All of the relatives we spoke with agreed with this. One relative told us, "[Family member] is safe here, that was the main worry taken away for us." Another relative said, "[Family member] is absolutely safe here I don't think I have seen anything unsafe. All the residents seem happy. I think I would know if [family member] was unhappy."

Staff had received training in safeguarding adults and were able to demonstrate to us that they understood what constituted abuse. They were clear on the correct reporting procedures if they suspected that any abuse had taken place. This included who to report concerns to outside of the home if this was needed. We saw that any safeguarding concerns had been reported to the relevant authorities by the registered manager and fully investigated by them, with action taken as appropriate.

The staff told us that some people could become upset which could pose a risk to themselves, the staff and others living in the home. The staff were able to demonstrate to us they understood what strategies to use to calm the person. This information was clearly documented within people's care records to guide staff if this scenario occurred.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2015, we found that a number of people did not receive enough to eat and drink to meet their individual needs. This resulted in a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by 30 April 2015. At this inspection, we found that some improvements had been made and that therefore, the provider was no longer in breach of this regulation. However, further improvements are required to ensure that people receive good effective care in relation to eating and drinking.

Both of the people we spoke with told us they received enough to eat and drink to meet their needs. One person said, "The food is satisfactory, I have plenty to eat and tea or coffee." Another person told us, "I have enough to eat, the food is good." The relatives we spoke with agreed that their family member received good support to eat and drink. One relative said, "The food is wonderful from what I saw of it. The chef is brilliant. [Family member] has their food pureed and the staff help her to eat it." Another relative told us, "The food is very good here and [family member] gets plenty."

We observed the lunchtime meal. Most people who required support to eat their meals received this. However, we did see that one person did not receive timely support. Their meal sat in front of them for some time. There were a number of staff in the dining room available to assist people but one was observed writing in people's records rather than providing assistance to this person. Eventually, the registered manager recognised the person requested support and therefore started to assist them with their meal at which time it may have been cold. We also saw that people who sat on the same table received their meals at different times. This meant that some people had finished their meal before others had started. This may have been unpleasant and uncomfortable for some people if they were hungry.

We observed that people in their rooms had access to a drink at all times. People who spent most of their time in the communal areas of the home received a drink at regular intervals along with prompting from the staff to drink. However, people were not observed to have a full glass of drink near them at all times which meant that people did not always have access to drinks.

The registered manager told us that some people living in the home were at risk of not drinking enough. Where people were at risk, the staff recorded the amount of drink each person consumed. Each person had an individual target in respect of how much they drank. The amount they drank was totalled at midnight each day. Where it was below the target, it had been recorded on the form that staff were to 'push' fluids the following day. However, we saw that the frequency that the staff offered drinks the subsequent day did not always increase to make sure the person received more fluid.

The four staff we spoke with about this told us they could offer regular fluids when they had enough staff. However when they were short of staff, two told us they did not always have sufficient time to encourage people to drink more and two said that they tried to encourage fluids as much as possible but probably

didn't offer them as often as they should. The staff gave us different opinions as to whether the records were being completed correctly. Some said they gave an accurate reflection of what they had offered people whilst others said they knew staff sometimes forgot to complete them. Improvements are required to ensure people receive enough to drink to meet their needs.

People had a choice of eating their meal in either the dining room, their own room or within a communal lounge. We observed the lunchtime meal within the dining room. Here, the tables were set out nicely with tablecloths, napkins and condiments. Written menus were in place and a three course meal was on offer which had a different choice of meal. We saw that alternative dishes were made for people who didn't like the choice of main meal. People were also offered a choice of drink that included an alcoholic beverage. The atmosphere was pleasant with background music playing. The chef had a good understanding about people's individual dietary requirements and these were catered for.

The chef took actions to increase the calorific intake of people who were at risk of not eating enough. They were aware of these people and told us they fortified their food with extra calories and prepared milkshakes for them to drink on a regular basis. The staff we spoke with told us they offered these people regular snacks to encourage them to eat more. When concerned about people not eating and drinking enough, a referral had been made to a GP for specialist advice. People's weight was also monitored. Five of the people whose care we looked at had been weighed regularly and in line with the requirements stipulated within their care plan. However, one person who the registered manager had deemed needed to be weighed weekly from August 2016 had not been weighed for two weeks on two occasions. We saw that they had not lost any weight but brought this to the attention of the registered manager. The weighing of people had therefore not consistently occurred at the frequency it should have done.

The staff had the knowledge and skills to provide people with effective care. Both people we spoke with and the visiting relatives told us they felt the staff were well trained. One person told us, "The staff are good they do everything for me." A relative told us, "Staff appear to have enough training. They explain to [family member] what is going to be done." Another relative said, "Very often when I come in training is going on in the little lounge."

The staff told us they had received enough training to provide people with effective care. Training had been completed within a number of areas such as infection control, first aid, dementia, the Mental Capacity Act 2005 and assisting people to move. The home had a trainer who delivered all of the training for staff. They told us this was delivered in both an e-learning and classroom format.

Some of the staff told us they had commenced further dementia training that was being rolled out across the provider's homes. The aim of this training is to enhance the skills of staff to enable them to provide excellent care to people living with dementia. The staff we spoke with who had started this training told us it was good and was increasing their knowledge about the condition. During our visit, we observed staff interacting well with people who lived with dementia and using safe care practice.

The staff we spoke with told us they felt supported in their role and said they could talk to the senior staff at any time who offered them guidance and advice. Some staff told us that their care practice had been observed by senior staff to make sure it was safe and effective. We found that the home's trainer had assessed new staff working in the home as being competent before they started working with people on their own. However, limited checks had taken place in relation to the ongoing competency of existing staff. We saw that some checks had been completed in relation to their moving and handling practice but that other aspects of their care had not been formally assessed. We spoke with the home's trainer about this. They told us the provider had recently rolled out a programme of formalised competency checks for staff.

They said that these were being implemented to give the provider assurance that the staff continued to be competent to perform their role effectively.

People's consent was sought in line with the relevant legislation and guidance. People told us they were asked for their consent before the staff performed a task. One person told us, "I haven't found anybody here dictatorial. They don't tell you what to do they ask you." We observed staff asking people for their consent throughout the inspection.

The staff told us that there were some people who lived at the home who lacked capacity to consent to their care and treatment. This means that the provider has to comply with the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 are called the Deprivation of Liberty Safeguards. We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager and the staff we spoke with had a good understanding of the MCA and DoLS. They were able to tell us how they supported people to make their own decisions and when they made decisions for people in their best interests. People's care records contained information about what decisions people could make and those that required support from the staff. Where there was doubt that the person could make a specific decision themselves, an assessment of their capacity had been made. For example, regarding whether people were able to understand why it was important for them to take their medicines regularly.

Where people had been assessed as lacking capacity to make certain decisions, records were in place to show that the relevant healthcare professionals and those close to the person had been consulted. This was so their views could be sought so the staff could ensure any decision they made on behalf of the person was in their best interests.

The registered manager had assessed people living at Ashfields to see if they were depriving them of the liberty. Where it was felt they were, applications had been made to the local authority for authorisation to deprive some people of their liberty in their best interests. The registered manager advised that these were kept under regular review and that the least restrictive options were being taken. Therefore, the provider had acted in accordance with relevant legal requirements.

People were supported with their healthcare needs. One person told us how they had seen the doctor the previous day for a painful condition that was now healing. A relative told us, "The optician visits [family member] and they have had a couple of pairs of glasses." Another relative said, "A doctor visits two to three times a week. If [family member] needs to be seen the staff put [family member] on the list to be seen. Like today, I think [family member] is getting a cold as their throat seemed husky so the staff have put [family member] on the list to be seen. They see the chiropodist."

The staff told us that the GP visited often and the records we saw confirmed this. We also saw that other healthcare professionals such as dentists, chiropodists and district nurses provided care to people when

needed. We were therefore satisfied that the staff supported people with their healthcare needs.

Good

Is the service caring?

Our findings

Staff had developed positive and caring relationships had been developed with people who lived in the home. Both of the people and all of the visiting relatives we spoke with told us the staff were kind and caring. One person told us, "I can't grumble about anything they are nice, quite kind." A relative said, "Everything I have seen is caring. I have never seen anyone be disrespectful to anyone." Another relative told us, "All the girls are good and patient. I have never seen anybody who isn't. [Family member] can become upset sometimes but they [staff] are always so patient."

Throughout the day, we observed staff interacting with people in a kind and compassionate manner. The staff spoke to the people respectfully and made eye contact when speaking with them. Some staff and people were heard laughing and joking with each other. We saw other staff were seen offering comfort and gentle encouragement to people when needed. The atmosphere within the home was vibrant and the staff were friendly and open. When staff assisted people to move with equipment such as a hoist or stand aide, we saw that they fully explained to people what they were doing. They also encouraged people to do as much as they could for themselves and gave people reassurance throughout.

The relatives we spoke with told us the staff knew their family members well. They said they understood their family member and knew their individual likes and dislikes so they could tailor the care provided to their individual needs. One relative we spoke with told us how they had been impressed with the staff when their family member had run out of their favourite sweet treat. They told us, "[Family member] likes chocolate buttons and I couldn't visit for a week so [family member] had ran out. So one of the girls went and bought some from the shop. They [staff] didn't have to do that."

The staff we spoke with demonstrated they knew people well. People's life history had been explored and staff told us this helped them facilitate conversations with people and helped them get to know them as a person. Staff celebrated people's birthdays with them if they wished for this to happen. On the day of our inspection visit, two people were celebrating their birthday. We saw the staff singing happy birthday to these people and a cake was presented to them.

People and/or their family were involved in making decisions about the care that was received. Before people moved into Ashfields, they and/or their family member had been asked for their opinion on what care they needed and how they wanted it to be provided. One relative told us the staff always kept them up to date with the health and welfare of their family member which was important to them. The people living at Ashfields and their relatives had been asked to participate in regular reviews of the care and support that was being received.

We observed staff offering people choice throughout the inspection. This included whether people wanted to be in their own rooms or within a communal area, what food and drink they wanted to receive and whether they wanted to join in with activities. Staff supported people who found it difficult to verbalise their choice in different ways. For example, staff showed people the meals that were on offer at lunchtime so they could make their own choice.

Both of the people we spoke with and the visiting relatives said the staff treated people with dignity and respect. One relative told us how they had witnessed the staff supporting their family member in a respectful way with personal care. During our inspection visit, we saw staff talking to people in a respectful manner. They addressed people in the way they preferred and knocked on people's doors before entering into their room. Doors were kept closed when they provided people with personal care. All of the staff we spoke with understood the importance of treating people with respect and of maintaining their dignity.

Good

Is the service responsive?

Our findings

At the last inspection in January 2015, we found that improvements needed to be made to ensure that people received care to meet their individual needs. At this inspection, we found that the necessary improvements had been made.

Both of the people we spoke with and all of the relatives told us the staff provided care that was based on their or their family member's individual needs. One person told us how the staff helped them to have a bath when they wanted one. A relative told us how the staff had adapted their approach so they could assist their family member effectively with personal care. They told us, "[Family member] doesn't always want their personal hygiene done so they [staff] have found a way of dealing with it. Just one carer now sees to [family member] as they are better with one to one." They also told us how the staff respected the fact that the person sometimes didn't want to sleep in a bed as they had not done this in their own home. Another relative said, "Every time I come in it is a calm environment, you don't see anyone sitting around. If they are, they are talking to the people."

Four of the five staff we spoke with told us they were able to provide people with care that met their individual needs and preferences. They said that occasionally when they had less staff than planned this could be difficult but confirmed that people received the care they required. They told us that people's preferences in respect of what time they wanted to get up in the morning and go to bed at night were respected. They also said they could support people with a bath or shower at a frequency of their choosing. The records we looked at confirmed this. The registered manager told us that people's preference in respect of the gender of carer providing them with support was also respected.

During our inspection visit, we observed staff being responsive to people's individual needs. People received support with their personal care in a timely manner. One person had slumped to the side in their chair. The staff quickly noticed this and helped them to re-position themselves so they were more comfortable. Another person said they felt cold and so a staff member fetched their cardigan and helped them put this on.

Before people went to live at Ashfields, the registered manager carried out an assessment of their individual needs to make sure that these could be met. The information took into account the care that people wanted to receive and some preferences about how they wanted their care to be given. Spiritual and cultural information was also captured. There was information documented within people's care records about what actions staff needed to take to meet people's needs and preferences. This information was clear and regularly reviewed to help staff provide them with the care they required. However, we did see that three people's care plans in relation to pressure area care was incomplete. This was because it did not include information that people needed to be sitting on a pressure cushion when seated in a chair. The registered manager agreed to add this information to the care plan so staff had accurate guidance regarding these people's care needs in this area.

Both of the people we spoke with and the visiting relatives said they felt there was enough stimulation for

them/their family members to enhance their wellbeing. One relative told us, "The staff try and involve [family member] in activities. [Family member] likes it when the music is on. They have had the balloon man come in to the home, exotic animals. I came in one day and [family member] was sat with a lizard in their hand. They [staff] also encourage you to bring your dog in for the people." Another relative said, "[Family member] likes to join in the dancing, and football where they pass the ball to each other, throwing the ball, and skittles. [Family member] likes all of these because they used to play bowls. [Family member] likes to go down the corridor and sit quietly on the sofa. In the summer we had Pimms on the lawn. The home had organised it, it was really lovely."

Four of the five staff we spoke with told us they felt people received enough stimulation to enhance their wellbeing. They told us that they were able to take people outside the home for walks. One staff member explained how they had supported some people to go blackberry picking and to hang some washing out. Another staff member said that some people had been taken out on trips on the river and recently to a firework display at one of the provider's other care homes. One staff member did not agree and said that at times, people lacked stimulation when the number of staff working was reduced.

Two staff members were employed by the home to support people with activities they enjoyed. There were activities going on throughout the morning of our inspection visit. This included colouring and painting artwork which some people were observed to enjoy. At other times of the day, staff put on DVD'S of different musicals and movies that some people enjoyed listening to and joined in the songs.

There were a number of sensory items that people who were living with dementia could touch, look at and feel. This included different types of materials, dolls and toys. Coats, hats and handbags were also available for people to use if they wished to. We observed people walking around communal areas accessing some of these items. There were also items around the home that could stimulate memories of the past. Religious figures from various faiths visited the home to assist some people who wished to continue to practice their religion or for whom this was important.

Both of the people we spoke with and the visiting relatives told us they did not have any complaints about the care being provided. They all told us however, that if they were concerned about anything that they would have no hesitation in speaking to the staff about this. Information about how to make a complaint was provided to people and their relatives when they moved into the home.

The registered manager had received one complaint within the last 12 months. Records showed that this had been fully investigated and that feedback had been given to the person who raised the concern. We were therefore satisfied that people's complaints were investigated and responded to effectively.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in January 2015, we found that the provider did not have effective quality assurances in place to monitor the quality of care that people received. This had resulted in a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by 30 April 2015. At this inspection, we found that sufficient improvements had not been made.

The record of people's food and fluid intake were inaccurate. We found that records we looked at for three people from the last week in October 2016, had not detailed the exact amount of food and fluid consumed. We saw that this issue had been identified by the provider in August 2016 during an audit they had conducted but this had not improved. Staff had recorded fluid intake however this was not consistent. The day staff recorded the amount of fluid consumed but the night staff did not. This made it impossible for the registered manager to ascertain from the records, whether people were receiving enough to meet their individual needs.

The registered manager told us that the purpose of these records was to help them ascertain whether people were eating and drinking enough and to see if they needed to change their approach when supporting people with this. For example, by looking at the times people preferred to eat or the types of food they enjoyed. However, as the records were not capturing all of the required information accurately, they were not able to do this. In addition, they told us that they did not monitor or audit the completion of the records to either ensure their accuracy or to help them assess whether people had received enough to eat and drink to meet their needs. Due to this lack of monitoring and inaccurate recording, there was a risk that people had not received the care they required within this area.

Communication and guidance to staff was not always effective. It had been recorded in the minutes of the October 2016 nutritional meeting that for one person, 'all staff to be aware that someone needs to sit with them and prompt them'. However, during the lunchtime meal, we saw that this did not happen and that staff were not given appropriate guidance at the time to ensure the person received timely assistance with their meal.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regular audits had been conducted to assess the quality of care that had been provided in relation to medicines management, the environment, infection control, care record documentation and the safety of the premises. We saw from these audits, that where any shortfalls had been identified, action had been taken to improve the quality of care people received within these areas going forward. The registered manager monitored the completion of staff training and we found that the majority of staff had received the training they required.

The provider had identified some of the issues we found during this inspection and were taking action to improve these areas. These included ensuring the correct number of staff worked on each shift and having more effective contingency plans in place to cover unplanned staff absence. Formal competency assessments of staff's performance were also about to be introduced.

The registered manager regularly analysed accidents and incidents. Action had been taken to reduce the risk of the incident or accident happening again. For example, we saw that one person had been referred to a specialist falls team for advice following a number of falls they had experienced.

Feedback from people and their relatives about the care being provided was regularly sought. This was in the form of meetings or formal questionnaires. We saw that suggested improvements from people had been made. For example, in response to feedback about food, the chef had increased the choice of food available.

Both of the people we spoke with and all of the visiting relatives told us they were happy with the support and care that was provided, that they felt that the home was well-led and that it had an open culture. One relative told us, "I recommend it to lots of people. My neighbour has come with me to visit [family member] in preparation for her husband. I try to attend the residents meetings. When I have been I have thanked them for doing such a wonderful job." Another relative said, "I find [registered manager] approachable. I could go to any one if I was unhappy with anything. The cleanliness of the home is very good. The laundry lady embroidered [family members] initials on his/her socks. I can't fault any of the staff I would definitely recommend this home." A further relative said, "The manager is approachable the staff are friendly there is interaction between the staff, the carers have become our friends. Over the last nine months things have changed, everything is cleaner, better generally."

All of the staff we spoke with were happy working within the home. They said they all worked well as a team to provide people with care and support. All of the staff said they received good leadership from most of the senior staff within the home. However, we received mixed views from the staff as to whether they thought there was consistently good leadership and an open culture within the home. Some staff said they felt there was a disconnect between them, the registered manager and the provider. They said they did not always feel the registered manager or provider listened to them. They told us this was because nothing had changed in response to the concerns they told us they had raised about inconsistent staffing levels. They also told us they did not regularly see the registered manager out on the floor and did not feel they could raise any concerns with them if they had any. Some other staff however, told us the registered manager was highly visible and they could approach them if needed. During the inspection visit, we regularly saw the registered manager within the home, talking to staff, the people living there and their visitors.

The provider was conducting a project with the aim to provide outstanding care to people living with dementia. Ashfields had been chosen as a pilot home in the second phase of this project. The project included making improvements in staff knowledge and care practice in relation to dementia and to the environment. Latest research and best practice in caring for people living with dementia was being used. Some staff had commenced this training and we saw that improvements were being made to the environment at the time of our inspection.

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 Not all current systems in place were effective at assessing and monitoring the quality of care provided or to reduce the risk of people receiving poor quality care. Some records in relation to people's care were not accurate. Regulation 17, 1, 2 (a), (b) and (c).