Ashfields Care Limited

Ashfields Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 June and the 6 July 2017. The first day was unannounced.

We carried out an unannounced comprehensive inspection of this service on 08 and 09 December 2016 and breaches of legal requirements were found. The provider was in breach of Regulations 09, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took action against the provider in relation to Regulation 12 and 17.

Regulation 12 was reviewed at the inspection in March 2017 (this report is available on our website) and we reviewed Regulation 09 and 17 at this inspection. We found the service was now meeting the requirements of these Regulations.

Ashfields Care Home is a nursing home which provides support and nursing care to up to 46 older people, some of whom live with a dementia related condition. Two beds in the service are designated enhanced beds for people who are nearing the end of their life. On the days of our inspection visits there were 42 using the service.
There was a registered manager at the service. 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.

People had good end of life care and the service worked well with other related health care professionals including Mc Millan nursing service. The provider had robust systems in place to review and update the service in a timely manner and in accordance with people's needs and wishes.

People's medicines were managed safely. There were procedures in place to ensure medicines were safely stored, administered and disposed of.
The provider had systems in place to keep people safe and staff were aware of their duty of care to people.

The provider had a system of ensuring new staff participated in an induction which included a period of shadowing an experienced staff member. New inexperienced staff completed The Care Certificate as part of their induction. All staff were offered the opportunity to achieve appropriate qualifications such as NVQ and specialised training.

Staff felt supported by other staff members. There were enough staff available to support and respond to people's needs in a timely manner. The provider had effective and safe recruitment procedures in place and employed new staff once appropriate checks had been completed.

People's care plans and records were updated and provided staff with the information needed to meet people's needs. People and their relatives were happy with the care and support provided and everyone felt

their individual needs were being met.

Staff and the provider were able to explain to us how they protected people's rights. Training was provided in relation to The Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS) and safeguarding. Appropriate referrals for authorisation to the DoLS team had taken place.

Staff supported people to maintain good health and have access to the appropriate health professional. Specialist end of life health care professionals attended the service on a daily basis. People's nutritional needs were met; special dietary needs were catered for.

Staff knew people well and were aware of the importance of treating them with dignity and respect. Staff were kind, caring and compassionate; people's self-esteem was promoted and staff supported and encouraged them to remain as independent as possible.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People felt the service was safe. Medicines were managed safely; records of medicines administered were complete. Pre-employment checks on staff had been completed prior to their employment. Sufficient staff were available to meet people's needs. Care plans and risk assessments were in place.

Is the service effective?

Good

The service was effective.

Where people lacked the capacity to make decisions, the staff followed the key principles of the Mental Capacity Act 2005 (MCA); applications had been made in relation to the Deprivation of Liberty Safeguards. People were supported by staff who had received training to meet their needs. People were supported to have access to healthcare professionals and services. People were provided with meals and drinks to suit their need, choice and preference.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and compassionate. People felt staff treated them fairly and provided choices in their daily routines and activities of daily living. People felt staff promoted their dignity and respected their privacy. People were encouraged to remain as independent as possible. Dignity was promoted at the end of life.

Is the service responsive?

Good

People and their relatives were confident to raise concerns or make a complaint. People had opportunities to take part in a variety of activities; people's independence was supported and encouraged. Care records held information about people and included their personal preferences, likes and dislikes; a pre-admission assessment was carried out to ensure people's needs could be met at the service.

Is the service well-led?

Good

The provider sought people's views and experiences and operated an inclusive approach to ensure people needs were recognised and met. The service was well-led by the registered manager and the provider both of whom were supportive and approachable, the staff team worked well together and staff's morale was good. Systems and processes were in place to check on the quality and safety of the service, audits of the service were taking place to monitor and review the service.

Ashfields Care Home

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.

This inspection took place on 21 June and 5 July 2017. The first inspection visit was unannounced. The inspection was carried out on the first day by one inspector and an expert-by-experience. On the second day by one inspector and a specialist in care of people at the end of their life. 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 our inspection visit we reviewed the information we held about the service including notifications the provider had sent us. A notification is information about important events which the service is required to send us by law for example, notifications of serious injuries or allegations of abuse. We contacted the local authority commissioning team, and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

During the inspection we spoke with eight people who used the service, and six relatives. We also received feedback from one health and social care professional. We spoke with two nurses, four care staff, the acting assistant manager, the registered manager and the provider. We looked at a range of records related to how the service was managed. These included four people's care records, medicines administration records (MAR) three staff recruitment and training files, and the provider's quality auditing system.

Good

Is the service safe?

Our findings

The provider had systems in place to keep people safe. One person we spoke with said, "There is always someone here to make sure I am safe. They are paying attention to me all the time. They watch me walking for example but don't take over. If I can manage myself they let me, but by being there they give me confidence." Another said, "I know that all I need on a daily basis to keep me well will be provided and I feel secure here. No one can just walk in. It's like being on a luxury holiday." A third said, "I feel very safe here. If I need anything at all, there is someone to assist. Never alone like I was at home which worried me."

A relative said, "I entrust my [relative] to their care, trust every last one of them with her. It is a really good place for her." A second said, "She is totally safe here- not just about her physical welfare but also her psychological wellbeing. She trusts staff and feels safe which is very important." A third said, "Yes, without a doubt. There is always staff around and they respond quickly if there is any problems and ensure we are kept fully informed about everything. Only have to look at how she has progressed in the two years she has been here."

Discussions with staff and a review of records showed they received training in how to protect and safeguard people from potential harm and abuse; they all understood their duty of care to people. One staff member said, "We have a duty to keep people safe and I take that seriously." Another said, "I would have no problem calling the police if necessary." All staff agreed there would be no need to take drastic action as the ethos of the provider and the registered manager was to provide safe care and ensured staff kept people safe. All staff knew how and who to escalate concerns to.

Risk was assessed and risk assessments gave staff clear directions on how to keep people safe. For example one person suffered from motion sickness and this was clearly identified and staff had clear direction on how to move them slowly to avoid sudden movements that could trigger the sickness. We saw staff assisted people to move safely using equipment. Staff were observed to use best practice when assisting people to transfer using moving and handling equipment. In all cases they asked the person's permission before intervening and then talked them through the process, explaining what they were going to do next, offering reassurance and encouragement and focussing on the individual they were assisting. They ensured that their clothes were not displaced and that people's dignity was maintained throughout. People using the service and their visitors all seemed comfortable and relaxed with staff. People told me they felt they had enough help from staff both during the day and night and seldom had to wait for any length of time for staff to respond if they called for assistance.

People's medicines were managed safely and in accordance with professional guidance. We looked at seven people's records and we found where needed, the appropriate guidelines had been followed. For example, the multi-disciplinary team had been involved towards the end of life care and anticipatory medicines were in place. Medicines administration records (MAR) had clear photographs of people and how they like to take their medicines. There were systems in place to review medicines. There were no gaps in MAR and medicines were stored appropriately. One relative described medicines as, "Recorded and well organised."

Syringe drivers, these are used by people to have control of their own pain relief, were available to enable people to control their pain. The medicines for these were reviewed regularly by the visiting McMillan nurse and by the local hospital who provided the medicines. Medicines were review and changed on a daily basis if needed, to enable people to have optimum pain relief. Where people had allergies to medicines, these were clearly recorded. For example if a person was allergic to Penicillin, this was written on the care plan and also clearly recorded on the MAR.
We observed a medicines round and saw that staff were kind and patient when administering medicines. They took their time and explained to people what they were taking and gave the person ample time to take their meds at their own pace. Staff who supported people with medicines, told us they had received training to ensure this was done safely. People and relatives we spoke with felt staff safely looked after medicines. People and their relatives told us they were satisfied staff gave the correct medicines and they were on time. One relative described medicines as, "Recorded and well organised."

We were told by one person, "They help me to get up when I am ready, and then bring me down for my breakfast. This morning I had breakfast at about 10.15am. I also choose what time I go to bed. I just ask them when I am ready and they take me and help me get ready and put me in bed and then I watch my soaps" Another said, "They come in at about the same time every day as they know what time I like to get up but they still always ask me if I am ready to get up and if I want to stay in bed a bit longer they come back later." A third person said night staff responded in a timely manner also – we were told, "If I have to buzz in the night they come straight away. I have never had to wait and in the day you just have to call them over as usually someone around but often they are there before you need them because they notice."

People told us and we saw there were sufficient staff to meet their needs. The registered manager used a recognised tool to assess people's needs. We saw the service was staffed above these levels. A review of rotas, and our observations and discussions with staff confirmed there was always sufficient staff on duty. There was sufficient staff to respond to calls for assistance in a timely manner. The provider had recently installed a new call bell system. This went to emergency mode after four minutes. We noted during our visit that call bells were answered in a timely manner and within four minutes.

The recruitment process ensured staff employed were of good character and suitable to work with people who needed to be protected from harm or abuse. Staff told us potential new employees did not start working at the service until checks had been received from the Disclosure and Barring Service (DBS) and references had been returned. A review of staff recruitment records confirmed the appropriate pre-employment checks had been made and where appropriate qualifications verified.

Good

Is the service effective?

Our findings

People told us staff were trained to care of them. One person said, "I think staff are very well trained and are very skilled. I have seen some of the training taking place when I have been here. Some staff have been here a long time but the younger ones are all coming along nicely." Another said, "It was a real wrench to hand the safe keeping of[relative] over to anyone as I had been doing it for so many years and [relative] was so dependent on me for everything. It's not just providing the physical care which I can no longer do because of my own health it's coping with [relative] behaviour. Staff here are well trained however difficult the behaviour becomes but they are also never slow to seek specialist advice if necessary."

The provider ensured people were cared for effectively as staff had been trained. All staff new to care underwent the Care certificate. All mandatory training was completed and staff had the opportunity to, and were encouraged to complete NVQ Staff told us and records confirmed they participated in training deemed necessary by the provider. Staff were able to list a selection of courses they had attended, for example, safeguarding, moving and handling and medicines administration.

New staff completed a period of induction and shadowing more experienced colleagues. We saw new staff also worked through the Care Certificate as part of their induction. The Care Certificate identifies a set of care standards and introductory skills non regulated health and social care workers should consistently adhere to. The provider had a system in place which identified when staff were due refresher training. This showed us the provider recognised the need to ensure staff were provided with appropriate training to meet people's needs.

Staff understood the need to obtain consent from people before they provided care. The provider and staff understood the requirements of the Mental Capacity Act 2005 (MCA). 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. For example, a multi-disciplinary team, including a pharmacist, was involved in decision making when a person refused to take their medicines. The decision taken in the person best interests was for their medicines to be given covertly. This was clearly documented.

The provider understood their responsibilities to ensure applications were made for those people whose freedom and liberty had been restricted. People can only be deprived of their liberty so that they can 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).

When required, the provider had made applications for assessment to the local DoLS team. The provider had policies and procedures in place for staff to follow in relation to the MCA. The provider and staff understood the importance of acting in people's best interests and the key principles of the MCA. One member of staff said, "If someone has capacity, they are able to make their own decisions – if not then we

need to make sure they are safe." Another member of staff said, "People are supported with decision making; at times people can make good and bad decisions."

A staff member was able to tell us which people had DoLS in place and explained, "A DoLS is in place to protect people and keep them safe." Another staff member said, "It's all about consent and if a person has not capacity the DoLS are there to protect them. We saw documentation which supported applications for DoLS being made and reviewed, in a timely manner. This meant the provider was working within the principles and requirements of DoLS and MCA.

The provider ensured people were provided with nutritious meals which met individual needs and preferences. Meal times were protected from unnecessary interruptions. A relative said, "If we come at meal times there are lounges where we can go or sit in people's rooms or the garden in good weather while they have their meal."

People told us that the food at Ashfields was good with plenty of choice. There was a weekly menu on display in the dining room and there was a hot option at each meal. We were told if people did not like the choices, then alternatives were offered. Apart from breakfast, meals were at set times and although encouraged to use the dining room people were able to choose to eat in their rooms if they wished. One person said, "If you don't like or fancy what's there you tell them and they ask what you would like or suggest something they know you do like and try to oblige.

The registered manager ensured people had optimum nutrition. People who were at risk of poor nutrition had their intake monitored. For example, we saw one person who was very unwell had their fluid intake noted and staff were encouraged to ensure they had at least the suggested amount of fluid. The chef had recently attended training on how to make pureed food more attractive and appetising for people. We saw the mould they used to achieve maximum impact.

Food and fluid charts were maintained for people who were at risk of poor nutrition. These gave details to staff on the amount of nutrition the person was usually capable of taking. For example one person in poor health was able to take 350 mls of liquid in 24 hours. Staff were directed to ensure they gave the person the time to take at least this amount. There were several people who needed full assistance to eat and there was enough staff to ensure people were not waiting for long periods for assistance.

We saw staff understood and supported people who required a specialist diet. Care plans we looked at showed where it was necessary, people had been referred to health care professionals such as Speech and Language Therapists (SALT) for support and guidance. We saw changes to people's dietary requirements had been documented and passed on to the kitchen staff, to ensure people received meals prepared to the correct consistency. This ensured people had optimum physical and mental health.

People's physical and mental health was promoted. One person told us, "They always phone for the GP if needed. I was unwell at the weekend and was sent to hospital to be checked over. I have also been seen by the chiropodist this week." Another said, "The home are excellent at getting the GP to call if needed and we have a very good relationship with the GP." A relative said, "I was here the other day and GP called in to have a look at [relative] to see if [relative] was alright and say hello to us when visiting someone else." A second relative said, "I feel very much that [relative's] health needs are being met. [Relative] has long standing mental health issues and the home is working with both the community psychiatric nurse (CPN)who calls regularly and have had a meeting here with a psycho-geriatrician and together are working out care plan to try and manage her psychotic behaviour."

Good

Is the service caring?

Our findings

The registered manager and staff ensured people were treated with kindness and had their dignity promoted at all times. Discussions with people and our observations supported this. One person told us "They close the door when they are helping me with any personal care. When they me to shower the girls encourage me to do what I can for myself, like wash my privates and they do what I can't reach."

We observed staff discreetly ask people if they needed the toilet. This was done with sensitivity and kindness. A relative told us, "They [staff] provide the physical care I can no longer manage because of my own health problems, but more than that, they give her affection. I can't compete, they give care, attention and devotion 24/7. I never want [relative] to go anywhere else."
Relatives told us they felt cared for by staff as well. One person said, "Everyone is so kind. When I came here I felt terrified as I did not know what to expect. But they were immediately so friendly towards me. So welcoming, clean spoken with no naughty words. They are brilliant." Another said "There is nothing that is too much trouble. My husband comes every day and is also made to feel welcome. If I can't be at home, which I know is the case, then this is the next best place." A relative said, "They take a real interest in us as well. Make us welcome and always ask how we are, offer us a drink, make sure we are informed about things."
Another relative said, "Staff have said, "You look terrible today, [relative] is fine and try to persuade me to have a day off from coming." They have told me, "We are here for you as well you know as [relative] you know." A third relative said, "This is the only home I know that is so family orientated. Everyone knows everyone and families are involved with everything that goes on. It's still all very professional, but they [staff] are like a family. They [people] know facts about staff and vice versa, but still retain that professional approach."

People were served their meals in pleasant surroundings; people were given the choice of using clothing protectors. Meals were served quickly, but not hurried, and by table. This gave people the opportunity to eat together and to have uninterrupted conversations. People said they liked this.
Independence was promoted through the use of equipment. For example people had adapted drinking utensils and although small, this encouraged people to do as much as they could for themselves.

A relative said "I stayed over for a couple of nights last week sleeping in a chair in [relative's] room as she was unwell. [Relative] gets very anxious and I thought it was that which was affecting [relative] breathing and I was worried about leaving [relative]." They continued and said, "The staff were lovely. They were fantastic. Kept coming to check if I was alright. GP has now prescribed anti-biotics and [relative] seems more settled."

A second relative said, "We have been involved all along in [relative's] care plan and [relative] is a different person from the one who came here thanks to the care she has received. The staff are excellent. She has never had a bed sore in all the two years she has been here despite her lack of mobility."

People who were at the end of their life were cared for by staff who were caring and kind. The service worked closely with McMillan Specialist Nurse to ensure people had optimum pain relief. We saw from care plans

that staff were aware of what was important to people and endeavoured to ensure this was provided. For example the provider ensured families could stay overnight and had provided double beds so the person could be comforted by loved ones. Families and children were also welcomed and where needed, safe areas were made for children to play. This showed the staff and the provider made reasonable adjustments and encourage family members to remain involved in their relatives care.

People who were at the end of their life had a separate care plan. This also allowed relatives to input into their family members care. Communication with the person, their loved ones and external professionals was recorded in detail. It was clear within the care plan that the person and those important to them have been listened to and their needs had been respected.

Care was taken to ensure people received the appropriate care. There was a system in place to highlight those people who were close to the end of their lives, (48 hours). Care and professional collaboration was taken to make sure people were comfortable and pain free. All staff within the service were involved in end of life care so they knew the importance of the last day's care. One person told us of staff, "They are quick to respond and kind when they do."

Families and staff were also supported at this difficult time. Part of this support was to hold a service to remember those who had died. This gave people who were not able to attend the funeral service, families and staff the opportunity to reflect on the person and to say good bye.

The service had also produced their own 'Bereavement Leaflet' to give to relatives, after the death of their loved ones. This included details on actions people needed to take such as what you need to do to obtain a death certificate and how to register a death. The leaflet also provided details of local bereavement support service. This showed the provider and the registered manager were aware of the effects of bereavement and endeavoured to assist bereaved people.

Good

Is the service responsive?

Our findings

All people had an assessment of care prior to being admitted to the service. A care plan was drawn up to ensure their needs were identified, recognised by staff and met to people's satisfaction. All relatives we spoke with said they were fully involved in care planning. A relative told us "[Relative] cannot talk much now but you can "read her face" and tell if she is comfortable or wants something such as going to the toilet and I think staff do their best to do that and respond."

A second said regarding involvement in care planning, "Yes I was involved and they [staff] still make sure I know what is going on with it." A third said, "I was very involved in planning her care before she came and still am."

People and their relatives were clear the care was person centred. We were told, "When [relative] came [relative] could not talk hardly, but they have got [relative] speaking by keeping on talking to them and you can have a conversation now. [Relative] has never been a great mixer but [relative] is asking to come out of her room now and go to activities, even if they cannot always fully participate. [Relative] is taking a pride in her appearance and they all work hard to encourage [relative] to get even more independent. Not bad for someone who two years ago was end of life following a bleed?"

We saw care planning was detailed and person centred. All aspects of people's care were identified and clear directions on how staff should care for people. For example one person had motion sickness and there were directions on how staff should move them. Staff we spoke with were aware of this. One person liked to smoke and details of how this was supported were included.

Care planning included details of the conditions people were living with and how this affected them. Care was taken to include people's wishes. For example, we saw one person, whose was receiving palliative care, their care plans reflected the persons' wishes. For example, we saw documented, a 'nurse will support your wish to have a pain managed death.' Information also included who the person wanted to be kept in touch with and who to contact at the end of life. The funeral arrangements were included, where possible. This ensured the person had the opportunity to express their wishes.

There was a system in place to assess pain. This included sites of pain, shortness of breath and if the person suffered from nausea, vomiting, restlessness, confusion, urinary retention, dry mouth and breathing problems. There were directions on what staff should do should they recognise any of the symptoms. If people needed a syringe driver for pain control there was a separate care plan for this. Skin Integrity was monitored and body maps were drawn up as appropriate.

As well as full details on health care, people's preferences were identified, for example a person liked to wear a particular item of clothing. This was recognised and directions included (name) likes to wear item of clothing most of the time, care staff will support you to put them on if you wish to wear them'.

Each care plan had a front sheet this contained a summary of people's needs. This was kept separately in

the nurse's office. As care planning was electronic this hard copy was available so agency staff could have a quick over view of people's needs and wishes. This was also taken with a person should they be admitted to hospital.

The service was supported by Macmillan nurses, who visited people on a daily basis. The service also held bi-monthly meetings around end of life care. These were minuted and available to staff. We were also told that the 'in-house' end of life team meet every six weeks to discuss progress and reflect on lessons learned, to ensure a continued development on care planning.

The service was working towards certification with Derbyshire End of Life Quality Award. The criteria for which requires a number of actions which were linked to NICE Quality Standards. The evidence folder demonstrated that the work the service have done towards this accreditation was of a high quality and well recorded. This showed the staff and the provider looked for ways to continue to improve the quality of care for people.

The provider had a system in place for people to make complaints or raise concerns. We saw records to support this. A relative told us "I can honestly say I have never had any major concerns but would be comfortable raising issues if they arise with any of the staff and feel sure they would be sorted." Others we spoke with felt concerns had been dealt with in a satisfactory manner and were satisfied with the outcome. For example a second relative said, "I mentioned a smell in [relative's] bedroom to the owner last week. It is to do with drains and we experienced this problem once before and it was sorted but the work took time through no fault of the home. The owner suggested [relative] moved rooms, which was quickly arranged. It is a far nicer room and although [relative] needed persuading, they have since said they prefer it as it's on a busier corridor and they can see what is going on."

The registered manager recognised the importance of offering people occupation. Care plans explored people's interests. The service had two dedicated activity workers covering seven days of the week. We saw this worked well and people were occupied. For example one staff member was looking at a scrap book of the 1950's with someone and using this to engage them in conversation and memories about their life and that period of time. Others were seen to sit and actively talk to individual people. The service also had an extensive range of DVDs and books and there were group and individual games around.

One person said they participated in, "Group games such as bowls, skittles or other floor games; there is usually a prize and one of the residents is the score keeper. Group activities like bingo, it's taken very seriously here- we have a laugh as well as quizzes, card and word games. We have arts and crafts, baking, gardening, painting, knitting, reading, jigsaws to name but a few."

One activity staff member told us when people moved to the service, "I introduce myself and then give people time to settle and go back after a few days to speak to them. We have a sheet about what their life experiences have been so we can find something to talk about that they can relate to and get to know them. If they are confused or have communication difficulties, I involve their families. I do this as a conversation to find out what they would like to do but make sure that all activities are risk assessed." Records we saw supported this. Another staff member said, "I just want to make people happy and for them not to be bored and I think I have good relationship with most residents and their families. I have to be professional as well but I know who to be 'daft' with." We saw staff had a good relationship with people.

Good

Is the service well-led?

Our findings

At our inspection in December 2016 the provider's quality assurance process was not fit for purpose and we issued a warning notice to the provider. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the provider sent us their action plan to tell us about the improvements they were going to make. At this inspection we found improvements to the care of people at the service had been made. A review of documentation and discussions with people and staff supported this.

The service had a registered manager. 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.

People and their visitors told us they felt the service was well led. They felt there was clear leadership in the service and were full of praise for the registered manager and the provider. People felt they could talk to both the registered manager and the provider and they said they found them both to be very approachable. Two relatives sought us out to express their views of the service and the shock they felt following previous inspections. One said, "The manager runs a very well organised ship. She is experienced, but is always approachable and a good role model for the staff. I think the staff to have enormous respect for her." A second said, "In my opinion, the manager herself is the major asset to the place. Sort of person who would say no matter how well things were going, there is always something you can do better." A third said, "Based on the principle of equal value I believe every resident here is treated the same and I am sure they all feel specially looked after. We chose this home as my [relative] was a health professional and had seen it in the past." They continued and said I have, "No regrets [relative] came here as 'end of life' two years ago and they have done wonders. Other homes don't hold a light to this one."

It was evident the staff and the provider were known to people and relatives. A relative said the provider was, "Easy to talk to." We were told they listened and acted on issues, for example one person was a sports fan and was missing watching sport on television. The provider installed a sports channel in their room.

The registered manager ensured end of life care was person-centred and was linked to NICE guidance and they made sure people and their relatives were included in all decisions and plans of care. The registered manager had good relationships with health care professionals and this was confirmed by those professionals we spoke with. One of whom said they would choose this service for a loved one.

We saw a variety of records required for the running and management of the service were maintained and safely stored. The provider and staff told us they carried out a number of checks and audits to ensure people were provided with a quality and safe service. Examples were audits of medicines, care plans, how staff delivered care and a number of checks carried out to ensure people were safe. For example they installed a new call bell system to ensure people were responded to in a timely manner. The provider recognised the

need to assess, evaluate and reduce potential risks relating to the health, safety and welfare of people.

The provider and the registered manager understood the need for continuous improvement and monitoring of the service they provided. We saw analysis of incidents and accidents took place. The provider looked for any emerging patterns or trends to help reduce the likelihood of such incidents happening again. The provider understood their role and responsibilities and sent us written notifications to inform us of important events that had taken place. For example, when someone died or was admitted to hospital for treatment.

The registered manager had an open door policy so staff and people could talk through any concerns or worries. We were told this worked well. People's views and experiences were also gathered by completing questionnaires designed to identify where the service was doing well and where it could improve. The outcomes of the questionnaires were positive. In addition, staff meetings and resident's meeting took place and provided staff with opportunities to share views and work as a team. The provider sought people's views and experiences and operated an inclusive approach. One way of doing this was appointing a 'resident's' spokesperson who attended meetings with the management team on a monthly basis. We saw the minutes of these meetings and it was clear people's concerns and worries were aired and addressed.

The provider had an on-going programme of staff training and supervision for all staff. Staff told us they were aware of the need to complete training and keeping their knowledge and understanding updated. Staff told us that they received effective support and supervision from the registered manager. Nursing staff received clinical supervision. Supervision is a process where staff meet with their manager to discuss their work performance and any training and development needs. This showed us the provider was aware of promoting the need for continuous training and this was recognised by the staff.

Staff we spoke with said morale was high and they enjoyed working at Ashfields Care Home. Our observations and discussions with people supported this. We were told there was a core of established staff member and that staff turnover was low. All the staff we spoke with felt appreciated by the registered manager and the provider and all said they were very proud of the care they provided.