Tonbridge Care Ltd

Chestnut Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Chestnut Lodge Care Home is registered to provide accommodation and personal care for 60 older people and people who live with dementia. There were 38 people living in the service at the time of our inspection visit.

People's experience of using the service and what we found
People and their relatives were positive about the service. A person said, "I like the staff as they're kind to me." A relative said, "The staff are absolutely brilliant with my family member, know their little ways and can get on with them better than I can."

Medicines had not always been administered in the right way. However, no one had experienced harm and robust steps had been taken to put things right. We have made a recommendation about the safe management of medicines.

People were safeguarded from the risk of abuse. People received safe care and treatment in line with national guidance from care staff who had the knowledge and skills they needed. There were enough care staff on duty and safe recruitment practices were in place. Lessons had been learned when accidents and near misses had occurred and infection was prevented and controlled. People had been assisted to obtain medical advice when necessary.

People were supported to have maximum choice and control of their lives and care staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice.

People were assisted to eat and drink enough and the accommodation was homely.

People were treated with kindness and their privacy was respected. People were supported to express their views about subjects important to them.

People were consulted about their care and had been given information in an accessible way. People were supported to pursue their hobbies and avoid the risk of social isolation. People were treated with compassion at the end of their lives so they had a dignified death.

Quality checks had been completed and people had been consulted about the development of the service. Good team work was encouraged and joint working was promoted.

For more details, please read the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Requires Improvement (published 22 January 2019).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

Chestnut Lodge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the registered provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by one inspector.

Service and service type
Chestnut Lodge Care Home is a care home without nursing. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the registered provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced and the second day was announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used information the registered provider sent us in the provider information return. This is information registered providers are required to send us with key information about their service, what the service does well and improvements they plan to make.

We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people living in the service and two relatives.

We spoke with four care staff, a team leader, a housekeeper and the chef. We also spoke with an activities coordinators administrator and maintenance manager. We met with the deputy manager, registered manager and regional director.

We reviewed documents and records that described how care had been planned, delivered and evaluated for six people.

We examined documents and records relating to how the service was run. This included health and safety, the management of medicines and staff training and recruitment. We also looked at documents relating to learning lessons when things had gone wrong, obtaining consent and the management of complaints.

We reviewed the systems and processes used to assess, monitor and evaluate the service.

In addition, 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 speak with us.

After the inspection
We spoke with a further three relatives to obtain feedback about the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
• People had not consistently been helped to safely use medicines in line with national guidelines. Since the last inspection there had been 22 occasions when medicines had not been administered in line with a doctor's prescribing instructions. This included occasions when medicines had not been given or given at the wrong time. Records showed each time senior care staff had quickly identified the mistake, obtained medical advice and monitored the people concerned to check they were not becoming unwell. Records of the daily care provided to the people concerned showed they had not experienced direct harm.
• The registered manager had carefully established why each mistake had occurred so action could be taken to put things right. Senior care staff who administered medicines had been given additional training. In addition, documents describing how medicines should be administered had been written in more detail with eye-catching reminders for staff to follow when dealing with particular medicines. More detailed and more frequent audits had been introduced to double check several times a day medicines were being given in the right way. Also, a new arrangement had been introduced involving two care staff rather than one member of staff administering medicines. This had been done so the second member of staff could check as medicines were being given to ensure it was being done in the right way.
• These steps taken had significantly reduced the frequency of medicines administration errors. However, the registered manager said no errors at all should occur in the administration of medicines. They assured us they would closely monitor the effectiveness of the new arrangements and would make further changes if necessary to ensure medicines were consistently administered correctly.

We recommend the registered provider consult national guidance about the safe administration of medicines.

• Medicines were reliably ordered so there were enough in stock and they were stored securely in temperature-controlled conditions.
• There were additional guidelines for senior care staff to follow when administering variable-dose medicines. These medicines can be used on a discretionary basis when necessary.

Assessing risk, safety monitoring and management
• At the last inspection suitable arrangements had not been made to ensure people were kept safe and only left the accommodation when it was safe for them to do so. This was because a patio door in a communal area was broken and could not be shut properly. At this inspection the door had been repaired and had been fitted with an alarm to notify staff if opened so they could check if a person needed assistance to safely leave the accommodation.

• People's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. A person said. "The staff keep an eye on me at night to make sure I'm safe and I like that. I don't have to worry because the staff are around." People who needed extra help due to having reduced mobility were assisted to transfer in the right way. This included care staff assisting people to transfer by using hoists and supportive handling belts.
• People were helped to keep their skin healthy. When necessary people were provided with special air mattresses. These mattresses reduce pressure on a person's skin making it less likely they will develop pressure ulcers. Also, care staff used special low-friction slide-sheets when a person needed to be helped to change position in bed. Slide sheets reduce the risk of a person's skin being chaffed.
• People were helped to promote their continence. They were discreetly assisted to use the bathroom whenever they wished. People were supported in the right way to use continence promotion aids and care staff regularly checked to ensure people had not developed a urinary infection.
• Hot water was temperature-controlled and radiators were guarded to reduce the risk of scalds and burns. Windows were fitted with safety latches to prevent them opening too wide so they could be used safely.
• The accommodation was equipped with a modern fire safety system to detect and contain fire. The fire safety system was being regularly checked to make sure it remained in good working order. Care staff had been given guidance and knew how to quickly move people to a safe place in the event of the fire alarm sounding.

Staffing and recruitment
• At the last inspection a small number of people and relatives thought there were occasions when there were not enough care staff on duty. Although we found the service was adequately staffed we recommended the registered manager review staffing levels. At this inspection people who lived in the service and relatives told us there were enough care staff on duty to quickly provide people with the personal care they needed. A person said, "When I use my call bell the staff come pretty much straight away." A relative said, "The staff are very busy but they're organised and very attentive. I've not seen people waiting unduly for care."
• There were enough care staff on duty. Since the last inspection the registered manager had increased the number of care staff on duty at busy times of day and records showed planned shifts were being reliably filled. Call bells were answered quickly and people were promptly assisted to undertake a range of everyday activities. These included washing and dressing, using the bathroom and receiving care when in bed.
• Safe recruitment and selection procedures were in place. Applicants were required to provide a full account of previous jobs they had done. This was so the registered manager could identify what assurances needed to be obtained about applicants' previous good conduct. References from past employers had been obtained as had disclosures from the Disclosure and Barring Service. These disclosures establish if an applicant has a relevant criminal conviction or has been included on a barring list due to professional misconduct. All these checks helped to ensure that only trustworthy and suitable people were employed to work in the service.

Systems and processes to support staff to keep people safe from harm and abuse
• People were safeguarded from situations in which they may be at risk of experiencing abuse. Care staff had received training and knew what to do if they were concerned a person was at risk. A person said, "The staff are lovely to us all." A relative said, "I find the staff to be genuinely compassionate and I think the manager has high expectations and the staff know it."
• There were systems and processes to quickly act upon any concerns including notifying the local safeguarding of adults authority and the Care Quality Commission. This helps to ensure the right action is taken to keep people safe.

Preventing and controlling infection

• There were suitable measures to prevent and control infection. Care staff were correctly following guidance about how to maintain good standards of hygiene. A relative said, "The home is clean. When we came to look around at the start we were struck by the fresh atmosphere and the general standard of cleanliness."
• Care staff wore clean uniforms and used disposable gloves and aprons when providing people with close personal care.
• There was an adequate supply of cleaning materials. Fixtures, fittings and furnishings were clean as were mattresses, bed linen, towels and face clothes.
• Audits had been completed to check suitable standards of hygiene were being maintained.

Learning lessons when things go wrong
• Accidents and near misses were analysed so lessons could be learned and improvements made. An audit tool identified what had happened and what needed to be done to reduce the likelihood of the same thing reoccurring. An example was identifying the times of day when people had fallen so the reasons for this could be identified.
• When things had gone wrong suitable action had been taken to reduce the likelihood of the same thing happening again. This included consulting with a person's relatives and requesting assistance from healthcare professionals. An example was arranging for a person to see their doctor if they appeared to have become unsteady on their feet due to being unwell.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Adapting service, design, decoration to meet people's needs
• At the last inspection one of the lounges was being redecorated and was not a homely and welcoming space. At this inspection the redecoration had been completed and the lounge was well presented. There was a refurbishment plan to update some corridors and bedrooms in the older part of the building.
• There was a passenger lift giving step-free access around the accommodation. There were bannister rails in hallways, supportive frames around toilets and an accessible call bell system.
• Each person had their own bedroom which they had been encouraged to personalise by decorating and furnishing them as they wished.
• There was enough communal space. Signs on communal doors and bedroom doors and different wall-colours helped people to find their way around.
• The grounds were neatly maintained and there was enough car parking for visitors.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The registered manager and/or deputy manager met each person before they moved into the service. This gave people the chance to ask questions about the service. The assessment also established the care a person needed to ensure the service could meet their needs. An example was arranging for any special medical devices a person needed to use to be available as soon as they moved into the service.
• The assessment also established how to respect a person's protected characteristics under the Equality Act 2010. An example was respecting a person's cultural or ethnic heritage. Another example was asking a person if they had a preference about the gender of the care staff who assisted them.

Staff support: induction, training, skills and experience
• New care staff received introductory training before they provided people with care. Care staff had also received refresher training in subjects including the safe use of hoists and how to support people to promote their continence. Care staff regularly met with a senior colleague to review their work and to plan for their professional development.
• Care staff knew how to support each person in ways right for them. An example of this was a member of care staff responding appropriately when a person became upset and was at risk of placing themselves and people around them at risk of harm. The person was anxious because they could not recall when their lunch time meal was due to be served. A member of care staff quietly pointed to a nearby clock and reassured the person they would assist them to go to the dining room in plenty of time for their meal.
• Care staff supported people to maintain good oral hygiene. An oral hygiene assessment had been completed for each person following guidance received from a dental professional. The assessment

described what assistance needed to be provided. Care staff provided practical help such as noting when a person needed to buy a new toothbrush or renew their supply of denture cleaning products. People had also been supported to attend dental appointments.

Supporting people to eat and drink enough to maintain a balanced diet
• People were helped to eat and drink enough. Kitchen staff prepared a range of meals that gave people the opportunity to have a balanced diet. People had been consulted about the meals they wanted to have. A person said, "The food is pretty good and certainly there is more than enough."

• People were free to dine in the privacy of their bedrooms and those who needed help to eat and drink enough were assisted by care staff.
• People's weights were monitored so significant changes could be noted and referred to healthcare professionals for advice. When necessary care staff also recorded how much people had to eat and drink to check enough nutrition and hydration was being taken.
• Speech and language therapists had been contacted when people were at risk of choking. Care staff were following the advice they had been given including blending food and thickening drinks to make them easier to swallow.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to receive coordinated care when they used or moved between different services. Care staff offered to accompany people to doctors' and hospital appointments so they could pass on important information to healthcare professionals.
• People were also assisted to see other healthcare professionals including chiropodists and opticians.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 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 with appropriate legal authority. In care homes and some hospitals this is usually through the Act's application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the Act and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People had been supported to make everyday decisions for themselves whenever possible. Examples of this were people being asked about what drinks they wanted to have and when they wanted to be assisted to rest in their bedroom.
• When people lacked mental capacity the registered manager had ensured that decisions were made in each person's best interests. This included consulting with relatives and healthcare professionals when a significant decision needed to be made about the care provided. An example was the registered manager liaising with a person's relatives when it was necessary for bed rails to be fitted to reduce the risk of the person rolling onto the floor.
• Some people had made advanced decisions about the care they wanted to receive. Others had given their relatives the power to make decisions on their behalf when they were no longer able to do so for

themselves. This included making important decisions about whether a person should be resuscitated. There were suitable records to describe these arrangements and care staff knew about the decisions that had been made.

• Applications had been made to obtain authorisations when a person lacked mental capacity and was being deprived of their liberty. There were arrangements to ensure that any conditions placed on authorisations were implemented. These measures helped to ensure that people only received care that respected their legal rights.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that people were supported and treated with dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• At the last inspection a person had not been supported to wash and comb their hair. Also, two people told us care staff did not always consult with them about the clothes they wished to select from the wardrobe to wear each day. At this inspection suitable arrangements had been made for people to style their hair and to dress as they wished.
• People were positive about the care they received. A person said, "I'm treated very well here and have everything I need." A relative said, "The staff are first class and I know my family member likes the staff and is treated with real kindness."
• Care staff provided care promoting equality and diversity. They had received training and guidance in respecting the choices people made about their identities and lifestyles. An example was a person who only wanted their close personal care to be provided by a female member of care staff. This preference was highlighted in the person's care plan and the person told us their request was always honoured. A religious ceremony was held in the service each month.

Promoting people's privacy, dignity and independence
• People's right to privacy was respected and promoted. People could choose to lock their bedroom door if they wished.
• Care staff did not intrude into people's private space. People could use their bedroom in private whenever they wished. When providing close personal care staff closed the door and covered up people as much as possible. Communal bathrooms, toilets and bedrooms had working locks on the doors.
• Private information was kept confidential. Care staff had been provided with training about managing confidential information in the right way. Electronic care records were password-protected so only authorised staff could see them. Paper records were stored securely when not in use.
• People received compassionate care. This included having personal keepsakes with them to provide comfort.
• People were encouraged to be as independent as possible. An example was a person who liked to help care staff laying tables for lunch. A person said, "I like to do things myself and the staff leave me to it."

Supporting people to express their views and be involved in making decisions about their care
• People were supported to be actively involved in making decisions about things important to them as far as possible. An example was a person choosing where to sit in a communal area so they could look out over the garden. A member of care staff noticed this and accompanied the person into the garden to get some fresh air.

• People had family, friends, solicitors or care managers (social workers) who could support them to express their preferences. The registered manager had developed links with local lay advocacy resources. Lay advocates are independent of the service and who can support people to weigh up information, make decisions and communicate their wishes.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people's needs were met through good organisation and delivery.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• At the last inspection some people who did not want to join in group activities had not always been given the individual support they needed to avoid the risk of social isolation. At this inspection there were two activities coordinators who were present in the service for an increased number of hours. Records showed and we saw people receiving one to one assistance to enjoy activities such as reading and solving puzzles.
• The activities coordinators also invited people to enjoy small group events including armchair exercises, parlour games, crafts and film-shows. People had also been invited to contribute to imaginative themed events such as posting messages of gratitude on poppy day to servicemen and women.
• There were outside entertainers who called regularly to the service and trips out to places of interest. People were supported to celebrate seasonal occasions such as Easter and Christmas and personal events such as birthdays.
• People had been supported to keep in touch with their families. With each person's agreement the registered manager and deputy manager contacted family members to let them know about any important developments in the care being provided. A relative said, "I like how the service lets me know straight away if there's a change in my family members' care needs."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People with mental capacity were consulted about the care to be provided. The results were recorded in an individual care plan for each person describing the care they needed and wanted to receive. People who did not have mental capacity were supported to review their care by relatives and/or social care professionals.
• People received personalised care responding to their changing wishes. An example was people being asked when they wished to take a bath or a shower rather than there being fixed days and times. Another example was people choosing when they got up in the morning and went to bed in the evening. A person said, "It's up to me. Sometimes I go to bed early and sometimes not – depends how I feel at the time."
• Some people needed or chose to have most of their care provided in bed or while they were sitting in their bedroom. Care staff regularly called to each person to make sure they were comfortable and had everything they needed.

Meeting people's communication needs
Since 2016 onwards all organisations providing publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with adaptive needs or sensory loss and in some circumstances to their carers.

• People had information presented to them in an accessible manner. Parts of care plans were written in a user-friendly way using an easy-read style with pictures and graphics. A person with hearing-loss said, "The staff know I'm a bit hard of hearing and speak close to my ear."
• There was a written menu and care staff had show-meals to help people decide which meal they wanted to have.
• Important documents presented information in an accessible way. There was a leaflet that explained the role of the local safeguarding of adults authority and which gave the authority's contact details.

Improving care quality in response to complaints or concerns
• The complaints procedure reassured people about their right to make a complaint and explained how complaints would be investigated. It was written in an accessible way using larger print, pictures and graphics making it easier to read.
• A person said, "I've not had to complain about anything really but if I did the manager would sort it for me." A relative said, "The manager is down-to-earth and approachable. You see her around the place and I would feel confident speaking to her if there was something I wasn't happy about."
• There was a management procedure for the registered manager to follow when resolving complaints. This included establishing what had gone wrong and what the complainant wanted to be done about it. The regional director who supervised the handling of complaints said no complaint would be closed until the complainant was satisfied with the outcome.
• Records showed the service had received a small number of complaints since our last inspection all of which had quickly been resolved.

End of life care and support
• People were supported at the end of their life to have a dignified death. Relatives were welcome to stay with their family member to provide comfort.
• The service liaised with the local hospice who gave advice about caring for people approaching the end of their lives.
• At this inspection the service was holding comfort medicines. This was so they could quickly be given in line with a doctor's instructions to provide a person with pain relief if necessary.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care, supported learning and innovation and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Continuous learning and improving care
• At the last inspection quality checks had not always been completed quickly and thoroughly to address limited shortfalls in the running of the service. At this inspection quality checks were being completed in the right way. An example was the steps taken to reduce the risk of further errors being made in the administration of medicines. Other checks had ensured the provision of safe care and treatment, learning lessons when things had gone wrong, health and safety and obtaining consent to care.
• People and their relatives considered the service to be well run. A relative said, "I think the service is very well run. It's organised without being formal."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People had been invited to comment on their experience of living in the service. There were regular residents' meetings at which people had been supported to suggest improvements to the service. People had also been invited to give feedback on an individual basis. Suggested improvements had been implemented including changes to the menu.
• Relatives and members of staff had been invited to give feedback by completing questionnaires. Action had been taken to implement suggestions. An example was the creation of a quiet secluded lounge in which relatives could relax with their family member while enjoying a cup of tea.
• There was a newsletter giving updates about social events to be held in the service, staff changes and other points of interest. Copies of the newsletter were available in the service and on request could also be sent to relatives and health and social care professionals.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Care staff had been supported to understand their responsibilities to meet regulatory requirements. They had been provided with up-to-date written policies and procedures to help them to consistently provide people with the right assistance. This included updated information from the Department of Health about the correct use of use of equipment, medical devices and medicines.
• There was a member of the management team on call during out of office hours to give advice and assistance to support staff.
• There were handover meetings between to update care staff about developments in the care each person needed. Care staff also attended regular staff meetings to further develop their ability to work together as a team.

• Care staff said there was an explicit 'no tolerance approach' to any member of staff who did not treat people in the right way. They were confident the registered manager would quickly address any 'whistle-blowing' concerns about a person not receiving safe care and treatment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager had established a culture in the service that emphasised the importance of providing people with person-centred care. A relative said, "I'm confident the residents come first in the service. The place is relaxed and in general the staff seem to get on with each other and work as a team."
• The registered manager and regional director understood the duty of candour requirement. This requires the service to be honest with people and their representatives when things have not gone well. They had consulted guidance published by the Care Quality Commission and there was a system to identify incidents to which the duty of candour applied. This helped to ensure that people with an interest in the service and outside bodies could reliably be given the information they needed.
• It is a legal requirement that a service's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The registered persons had conspicuously displayed their rating both in the service and on their website.
• Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is so that we can check that appropriate action has been taken. The registered manager had submitted notifications to Care Quality Commission in an appropriate and timely manner in line with our guidelines.

Working in partnership with others
• The service worked in partnership with other agencies to enable people to receive 'joined-up' support. The registered manager subscribed to some professional publications relating to best practice initiatives in providing people with nursing and personal care.
• The registered manager attended a registered managers' forum to share and learn from examples of best practice in the provision of residential care for older people.