Weston-super-Mare Free Church Housing Association Limited

The Links

Inspection report

7 Uphill Road North
Weston Super Mare
Somerset
BS23 4NE

Tel: 01934625869
Website: www.abbeycare.co.uk

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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

The inspection took place on 21 October 2016 and was unannounced. The service was last inspected on 02 August 2013 and no concerns were identified.

The Links is a small residential care home for older people and people living with a dementia. The home is registered to accommodate up to 13 people who require support with their personal care needs. The service does not provide nursing care. At the time of the inspection there were 9 people living at the home. People needed assistance from staff with some of their daily care routines but most of the people had relatively low dependency needs.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager told us their service philosophy was "For residents to feel this is their home without any restrictions. The staff have come into their home to help rather than feel they live in the place where staff work. And to encourage people to be independent as they are able to be".

People who lived in the home and the staff all said the registered manager was very supportive, accessible and responsive. One person who lived in the home said "The manager is very nice. I can talk to her if I have any problems. The home is well run". A member of staff said "The manager is very good. She bends over backwards for the staff and the residents. She's hands on and not just sat in the office".

Staff supported people in a caring and considerate way and had a good understanding of each person's needs and preferences. People who lived in the home told us they got on well together and considered the staff and the other people who lived in the home to be their friends. One person said "The staff are lovely. I think they are the best in Somerset".

People were also supported to access relevant healthcare practitioners when needed. The service worked closely with the local Residential Home Support Team, local GP practice, occupational therapy, falls team, and the incontinence team.

People and their relatives told us the service was responsive to their needs and people had choice about how they spent their days. People benefitted from individual engagement with the care staff as well as organised social and recreational activities. The registered manager said one of their priority areas was to continue to develop increased opportunities for people to engage in social activities.

People were supported to have sufficient to eat and drink and to maintain a healthy diet. One person said "They are very good cooks. The food is always lovely and always different". Another person said "We get more than enough to eat but you can ask for more if you want it".

There were enough suitably trained staff to keep people safe and to meet people's individual care needs. People were also protected from abuse and avoidable harm through appropriate policies, procedures and staff training. People received their medicines safely and were protected from the risk of acquired infections.

The service provided a homely and comfortable environment but the building was not suitable for wheelchair access. There were bedrooms on both the ground and first floors. Access to the first floor bedrooms was via a flight of stairs, with a stair lift for people with limited mobility. The accommodation was reasonably spacious and it was clean and well maintained throughout. People were able to decorate and furnish their bedrooms to suit their individual tastes.

The service had links with the local community and received regular support from a local church and chaplain.

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

The service was safe.

There were sufficient numbers of staff to keep people safe and meet their needs.

People were protected from abuse and avoidable harm.

People received their medicines safely and people were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

People received care and support from staff who were trained to meet their individual needs.

People were supported to maintain good health and to access external professionals when more specialist treatment or advice was needed.

People's nutritional needs were met, including any special dietary needs.

The service acted in line with current legislation and guidance when people lacked the mental capacity to consent to aspects of their care.

Is the service caring?

Good

The service was caring.

People were supported by caring, friendly and considerate staff.

People were treated with dignity and respect and were supported to be as independent as they were able to be.

People were supported to maintain continuing relationships with their family and friends.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their needs and took account of their wishes and preferences.

People were consulted and involved in decisions about their care.

The views of people, relatives, staff and other professionals were taken into account to improve the service.

Is the service well-led?

Good

The service was well led.

People were supported by an accessible and approachable manager and a motivated staff team.

The service had a caring and supportive culture focused on promoting the health and well-being of the people who lived in the home.

The provider had quality assurance systems to maintain and improve the quality and safety of the service.

The Links

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.

The inspection took place on 21 October 2016 and was unannounced. It was carried out by one inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The service was last inspected on 02 August 2013. At that time, the service was meeting essential standards of quality and safety and no concerns were identified.

Most of the people who lived in the home were able to tell us about their experiences. We also spent time talking to staff and observing the care and support practices in the home. During the inspection we spoke with five of the people who lived in the home, the registered manager and four other members of staff. We also looked at records which related to people's individual care and to the running of the home. These included three care plans, medication records and some of the provider's quality assurance records, including staff training, complaints and incident files.

Good

Is the service safe?

Our findings

People who lived in the home told us the staff looked after them well and they felt safe. One person said "They are very kind. I don't think you will find anything wrong here". When asked if they had ever witnessed anyone treating people badly they said "No, nothing like that". All of the people we spoke with said they felt safe and had no problems with any of the staff.

Care plans included risk assessments outlining measures to ensure people received care safely. The risk assessments included issues such as mental capacity, mobility and falls, medication, use of the home's stair lift, bathing, and access to the home's external key fob. There was equipment available to meet people's individual needs. This included assisted bathing equipment and a range of mobility aids. For example, we observed staff supporting one person who was at risk of falling to use their walking frame. We also saw staff patiently assisting a person with dementia, who appeared a little disorientated, to the dining room for their lunch. Care plans contained records of the daily care provided and any observations or concerns about people's health and well-being.

The service protected people from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff told us they had no concerns about any of their colleagues' practices but would not hesitate to report something if they had any worries. Staff were confident the provider would deal with any concerns quickly to ensure people were protected.

The risks of abuse to people were reduced because there were effective recruitment and selection processes for new staff. Staff described their recruitment which included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks a person's criminal history and their suitability to work with vulnerable people.

Records showed incidents and accidents were investigated and action plans put in place to minimise the risk of recurrence. As far as we could ascertain from the records, the service met its statutory obligations to inform the local authority safeguarding team and the Care Quality Commission of all notifiable incidents.

Staff knew what to do in emergency situations. There were emergency evacuation plans which described the measures staff had to take to support people to remain safe. For example, in the event of a fire. Staff said they would call the ambulance service and/or the person's GP in the event of a medical emergency. External specialist contractors were employed to carry out fire, gas, and electrical safety checks to ensure the environment was safe. The registered manager carried out regular health and safety checks and the service had a comprehensive range of health and safety policies and procedures for staff to follow.

There were enough staff to keep people safe and to meet their needs. The registered manager was on duty most mornings, plus a senior care worker, two care workers and a cook. In the afternoons, staff were replaced by an afternoon senior care worker and two afternoon care staff. At night there were two care staff, one waking night staff and one sleep in member of staff. The registered manager said they could be

contacted by staff out of hours at any time. They said the staff were competent to deal with any emergencies but they would always call and let her know in line with their operating protocols.

The registered manager said they always aimed to start each shift with the required number of care staff. They organised the staffing rotas and then posted a notice of any shifts that still needed covering on the staff notice board for any staff to pick up, if they wished. Similarly, for short notice staff absences they would see if any staff wanted to work overtime, do extra shifts, or could contact the provider's other two larger homes for additional staff support. Staff told us there were always sufficient staff numbers to meet people's needs and keep them safe.

People received their medicines safely from staff who had been trained and assessed as competent to administer medicines. We observed people were given their medicines in a safe, considerate and respectful way. Medicine administration records (MAR) were accurate and up to date. Staff assisted the majority of people to take their medicines and completed the MAR sheets in these circumstances. However, in some cases, people were assessed as safe to administer their own medicines. Staff were still able to check if these people were taking the right doses. Staff did so by recording all medicines on arrival from the pharmacy and then carrying out monthly stock checks to verify their usage.

We observed the home was well maintained and appeared clean and tidy throughout. There were clear house cleaning schedules, appropriate laundry processes and sufficient supplies of personal protective equipment for staff to use. These measures helped ensure people were kept safe by the prevention and control of infection.

Good

Is the service effective?

Our findings

People told us the staff were effective in meeting their care needs. One person who lived in the home said "I'm very well looked after. You couldn't wish for better staff". Another person said "The staff are excellent".

People's needs were assessed prior to moving to the home to ensure the service was able to meet the person's individual needs. People's needs were reviewed each month to make sure any change in their care needs was understood and met. Appropriate equipment was also in place as needed. For example, assisted bathing facilities were available for people with mobility needs.

People were supported to maintain good health and wellbeing. People were relatively independent but needed staff support with some of their personal care needs. People's care records also described their individual health needs and provided information on any action needed to maintain their health, including regular access to external health care professionals when needed. People were supported to access relevant healthcare practitioners through the Residential Home Support Team, local GP practice, occupational therapy, the falls team, and the incontinence team.

Staff kept notes of how people were feeling in their daily care records and also noted any changes in people's needs, risks or care. The information was discussed at each shift hand-over to ensure all staff were aware and up to date with people's current needs.

Staff received training to ensure they had the knowledge and skills to provide effective care in line with current best practices. This included general training, such as: safeguarding, Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, first aid, infection control, fire safety, moving and handling. Person specific training was also provided to meet people's individual needs, including: dementia awareness, skin care, diabetes, and end of life care. Staff told us most of the training was face to face classroom style training. Often external specialists visited the home to provide training, such as, healthcare professionals from the Residential Home Support Team, and staff from the Dementia Action Alliance and the Alzheimer's Society.

Newly appointed staff completed an induction programme and worked alongside more experienced staff to gain confidence and knowledge about their roles. During their induction, staff completed a range of generic and service specific training. The new Care Certificate had been introduced as part of the induction programme. The Care Certificate covers an identified set of standards which health and social care workers are expected to adhere to in their daily working life.

The registered manager maintained a training matrix to check staff were up to date with their training and to identify when refresher training was due. The provider also supported staff with continuing training and development, including vocational qualifications in health and social care.

Staff said they felt very well supported by their colleagues, senior care staff, and the registered manager. They received individual staff supervision from the registered manager every couple of months, attended

monthly team meetings, and had annual performance and development appraisals. These meetings provided opportunities for individual performance review and to discuss any staff training or development needs.

In addition, people's individual care and support needs were discussed at each shift hand-over. Important events or messages were also noted in a staff communications book. The registered manager circulated a monthly 'Toolbox Memo' to highlight or update staff about any key issues.

Staff received training and had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found staff knew how to support people to make decisions and knew about the procedures to follow where a person lacked the capacity to consent. This ensured people's rights were protected. Care plans recorded discussions with people's relatives and any decisions made in their best interest.

The registered manager had recently submitted a new DoLS application for a person who lived in the home, as certain restrictive practices were necessary to keep them safe from harm. They were currently awaiting a decision from the authorising authority. This showed the service followed the requirements in the DoLS. We observed there were associated risk assessments and best interest decisions documented in the person's care plan.

People were supported to have sufficient to eat and drink and to maintain a healthy diet. One person said "They are very good cooks. The food is always lovely and always different. They read out the menu and ask what you would like but will make something else for those who don't want it". Another person said "We get more than enough to eat but you can ask for more if you want it".

The cook told us they worked to a four week rolling menu of meal choices based around people's expressed preferences and this was reviewed regularly at residents meetings. For example, people had decided they wanted to be offered salads in the summer but not in the winter. Also alternatives were always available if people did not want the daily menu choices. The cook said the people who lived in the home mostly liked traditional meals, although occasionally she also tried to introduce some new options.

People's nutritional needs were assessed and staff were knowledgeable about each person's dietary needs and preferences. The cook said they did not have any special dietary needs but one person was borderline diabetic. They watched what they gave them to ensure it contained low sugar content. They said they knew who liked to eat more and who liked less and adapted the portion sizes to suit each individual. For people with dementia, the cook kept a written record of whether they liked or disliked particular meals, as people couldn't always remember their previous experiences and preferences.

We observed the lunchtime experience. Six people sat together at two tables in the home's dining room and three people chose to have their meals in their rooms. The main menu choice was fish and chips but people had a choice of cod, scampi, or cod in butter sauce, plus homemade chips or mashed potato and beans or

peas. Arctic roll or cake was served as the dessert. We observed people were able to eat their meals independently but staff checked regularly to ensure everyone was OK. For example, we heard a senior care worker ask "Are you alright ladies, are you enjoying lunch?" The meals looked very appetising and there was no waste left on people's plates at the end of the meal. The cook came in to check if people had enjoyed their meal which everyone clearly had.

The premises were clean and tidy and it was well furnished and decorated in a comfortable and homely style. The registered manager told us the building was not suitable for wheelchair use due to the narrow and bending hallways. All of the people who lived in the home were independently mobile, although some used walking aids for assistance. There was a stair lift to the first floor where there was six bedrooms, a communal bathroom and a bath hoist to assist people with mobility needs. People were risk assessed for their suitability to use the stair lift if and when required. There were five more bedrooms on the ground floor, a communal WC and a wet room with assisted shower facilities. All bedrooms had their own ensuite WC and wash basin and some rooms had their own shower facilities.

Good

Is the service caring?

Our findings

People who lived in the home told us they got on well together and considered the staff and the other people who lived in the home as their friends. One person said "The staff are lovely. I think they are the best in Somerset". Another person who told us they had struggled to cope in their own home said "I'm very happy here and I want to stay here to live". The registered manager said everyone was treated like a member of the family as it was a small home and "All of our staff are patient and kind".

Staff displayed a friendly, kind and caring approach toward the people in the home. For example, we observed a person with dementia who was waiting for a lift to go out. They told a member of staff they wanted to wait outside by the road. The member of staff was concerned for their welfare and safety and tried to gently coax them to wait inside the home and to watch out from the window. The member of staff said "If I were you I'd stay here and keep warm". It was clear the person was still not convinced. We then heard the registered manager intervene and say to the person they would let them know when their lift arrived and, "In the meantime, do you want to play a game with staff while you wait". This successfully diverted the person's attention.

We observed there were cuddly toys and games in the lounge to provide sensory interaction for people who wanted to rummage around or hold on to them. People with a dementia sometimes find this kind of activity calming and comforting.

We heard staff speaking with people in a polite and caring manner. Staff bent down to be on the same eye level as people when they spoke with them. We heard staff consulting people about their daily routines and preferences and no one was made to do anything they did not want to. We observed staff were patient and persevered, without rushing people, to ensure they understood people's wishes, particularly people who had limited understanding or communication skills.

People were encouraged to make their own decisions, as far as they were able to. We observed staff offered people options to choose from and then acted on the person's wishes. For example, choices of food and drinks, and whether people wished to join others in the communal areas or return to the privacy of their own rooms. We could see staff had a good understanding of each person's individual needs and preferences but they still asked people for their views rather than making assumptions.

Staff respected people's privacy and dignity. For example, personal care was only provided in the privacy of people's bedrooms or in the home's assisted bathrooms. Staff also ensured doors were closed and curtains or blinds drawn, as necessary. Staff respected people's privacy by knocking on people's doors and waiting until they were invited in. Throughout the inspection, we observed staff assisted people in a discrete and respectful manner.

Staff spoke warmly and respectfully about the people they supported. They were careful not to make any comments about people of a personal or confidential nature in front of others. They also made sure people's care plans were not left unattended for others to read. One member of staff said "People's care

plans contain confidential information and no one else needs to know". This showed staff respected people's confidentiality.

However, we observed there was a whiteboard on the wall in the registered manager's office containing confidential personal information about people. Although the office was mostly used by staff, it was adjacent to the entrance hallway and the office door was open much of the time. This ensured the registered manager was accessible to people but it was also possible for people, relatives or other visitors to view the whiteboard if they approached the office. We discussed this with the registered manager who said they would take action to address this straight away. They said they would either anonymise the names or alternatively use a cover to hide the information from the view of unauthorised people.

People were supported to maintain relationships with their families and friends. People told us they received regular visits from their families and friends and they could invite them for lunch if they wished. Families were also invited to attend the resident and families meetings. The service did not operate set visiting times or place unreasonable restrictions on visiting. Several people also told us they visited their relatives' homes during holidays and festivities. These contacts helped people to maintain relationships with the people who cared most about them.

Information about people's advanced care preferences and any spiritual or religious beliefs was recorded in their care plans. The provider supported people to practice their spiritual and religious beliefs where this was important to them. For example, people were supported to attend local church services and the local chaplain visited the home each week to provide pastoral care for people who wanted this.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs and they had choice about how they spent their time. One person said "I can go out if I ask, it's my choice". Another person who preferred to remain in their own room said "I'm OK, I've got no complaints. I like it quiet. I don't bother with the others". They said their relatives visited and took them out when they wanted.

People told us the staff responded promptly when they needed assistance. One person told us "I have a call bell and they come quick". On the day of inspection, we observed staff were available whenever people needed support and the call bells were responded to without undue delay.

Each person had an individual care plan based on their assessed needs. People's needs were assessed prior to moving to the home to ensure the service could provide the necessary care and support. Care plans described people's individual care and support needs and the things they enjoyed or disliked. This information helped staff to respond to people's needs and preferences.

Care records included information on managing identified risks, such as: the safe use of the stair lift, medicines administration, and risk of falls. Any accidents or other incidents were recorded and analysed. If changes to the way care was provided were needed the person's care plan was updated accordingly.

Staff demonstrated a good knowledge of people's care plans. Care plans were reviewed by a senior member of care staff with the person concerned, on a monthly basis, and were updated to reflect any changes in people's needs or preferences. At a person's request, or if they lacked the mental capacity to make certain decisions about their care, their next of kin was also consulted and involved in the care plan reviews. We found the monthly care plan reviews were up to date. Care plans included details of people's communication and decision making profiles, mental capacity assessments and any best interest decisions made on their behalf. Care records showed people also received support from a range of appropriate external health and social care professionals.

People were encouraged and supported to make their own decisions to the extent they were able to. People told us they could choose when they wished to get up or go to bed, what they wished to eat at meal times, where they wished to spend their time, and what activities to participate in. The service also responded to people's preferences regarding their rooms. People's rooms were decorated and furnished to suit people's individual tastes and choices. Each room was personalised with the person's own belongings including flowers, family photographs, entertainment equipment and arts and crafts.

Structured activities took place two or three times a week including: flexercise, arts and crafts, hairdresser, knitting club, nails, clothing, and visits/services by a chaplain. There was a coffee morning every Thursday at a local church and other activities, such as visits from an animal sanctuary, were arranged on an ad hoc basis. Staff also engaged socially with people on a group and individual basis as time permitted. People told us they sometimes went out on shopping trips in the home's minibus, or to the garden centre, or visited the theatre, cinema or other places of interest. Some liked to sit out in the home's small patio garden area or to

visit the nearby park. People also entertained themselves in their rooms by reading, watching TV or listening to the radio. There were also various board games and toys available in the lounge for people's use.

The minutes of the last residents and relatives meeting recorded a person's comment that, "Staff were too busy cleaning to spend enough one to one time with them". In response, the registered manager had reviewed the cleaning schedule and the staff rota to free up more time for staff to spend with people. She had also requested additional funding for an allocated cleaner and an activities co-ordinator and was awaiting a decision from the provider. The registered manager said when they first started there were not many activities available for people. This was one of their priority areas for development and they now organised a monthly activities plan. They were also looking into organising group activities with the provider's other two homes.

People told us the care staff, seniors and the registered manager were all very approachable and responsive. They said they could go to the registered manager or any of the staff and they would resolve any issues or complaints appropriately and promptly.

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. Each person had a service user guide in their room which included details of the complaints procedure. In the last 12 months the service had managed two complaints under their formal complaints procedure. Both complaints had been resolved to the satisfaction of the complainants.

Good

Is the service well-led?

Our findings

People who lived in the home and the staff all said the registered manager was very supportive, accessible and responsive. One person who lived in the home said "The manager is very nice. I can talk to her if I have any problems. The home is well run". A member of staff said "The manager is very good. She bends over backwards for the staff and the residents. She's hands on and not just sat in the office". Another member of staff said "She is the best of the best. She is so giving and so respectful and she knows her stuff".

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The registered manager told us their service philosophy was "For residents to feel this is their home without any restrictions. To feel the staff have come into their home to help them rather than they live in the place where staff work. And to encourage people to be as independent as they are able to be". Staff training and development was used to promote these values and they were reinforced at staff meetings, shift hand-over meetings and one to one staff supervisions.

Staff said the registered manager adopted an open door policy and was very accessible, approachable and supportive. One member of staff said "She is very approachable. She's a good manager and always has time for you. She is always on the floor. All the staff are hard-working and help each other out". Staff also said the provider's general manager visited the home from time to time and they could talk to them if needed.

The service had a clear staffing structure, with clear lines of reporting and accountability. The registered manager was very visible around the home and provided clear and supportive leadership. The senior care staff worked closely with the registered manager and all staff clearly understood their respective roles and responsibilities. Decisions about people's care and support were made by the appropriate staff at the appropriate level. The whole staff team appeared motivated and focussed on meeting people's personal support needs.

The provider had a quality assurance system to ensure people received good quality care in a safe and homely environment. This included monthly in-house audits by the registered manager of all key aspects of the service, such as: medicines, care plans, significant incidents, health and safety and the environment. A member of the provider's management committee visited the home regularly and prepared a quarterly 'house report' on the quality of care and other significant issues. The provider's general manager also visited the service on a regular basis to carry out quality assurance checks.

As far as we can ascertain, the registered manager has notified the Care Quality Commission of all significant events and notifiable incidents in line with their legal responsibilities. We observed the service kept records and investigated incidents. Where appropriate, action plans were in place to minimise the risk of recurrence. For example, following an incident where a person fell while getting off the home's stair lift, new guidelines, risk assessments, and instructions were issued to staff to prevent similar incidents happening again.

The registered manager said they and the provider promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The

duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

People were encouraged to give their views on the service through routine conversations, care plan review meetings, residents and relatives meetings and an annual satisfaction questionnaire. The minutes of a recent residents and relatives meeting showed they were attended by the majority of people who lived in the home, plus a relative, the registered manager and a representative from the provider. Items discussed included: the annual survey results, which were predominantly positive; menu choices; activities; maintenance issues; staffing and care.

The registered manager participated in forums for exchanging information and ideas and fostering best practice. These included Skills for Care meetings, North Somerset Provider Forums, Residential Home Support Team meetings for home managers, and multi-disciplinary meetings with health and social care professionals. The registered manager also accessed service related training events, conferences and relevant online resources for obtaining information and advice.
For example, the service had achieved a dementia friend status in recognition of the work they were doing with the Dementia Action Alliance.

The managers of the provider's three homes had a monthly meeting with the provider's general manager and then their own monthly meeting with their senior care staff. These meetings were used to discuss and disseminate information and ideas and then to cascade information to the other care staff. A meeting of the whole staff team took place twice a year, or when major service issues or developments were being considered. These meetings and events helped the service to keep up to date with the latest care practices.

People were supported to engage in the community. Staff supported people to go out into the community, to visit places of interest, and visit relatives or friends. The service had strong links with a local church which arranged coffee mornings and other activities. The chaplain visited the home twice a week to socialise with people and take them out on trips.

The service worked in partnership with local health and social care professionals. More specialist support and advice was also sought from relevant professionals when needed. We saw records of multi-disciplinary meetings and support in people's care plans. This cooperation helped to ensure people's health and wellbeing needs were met.