Care UK Community Partnerships Ltd

Foxbridge House

Inspection report

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Orpington
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Tel: 03333210926

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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 22 January 2019 and was unannounced. Foxbridge House is a residential care home that provides accommodation and nursing care for up to 84 older people. The home is located in Orpington Kent and is a large purpose-built care home. At the time of our inspection 74 people were living and receiving care and support at the home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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.

At our last inspection in August 2016, the service was rated 'Good'. At this inspection we found the service continued to support the rating of 'Good' and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection. We found the service remained 'Good'.

People continued to be supported and protected from the risk of abuse or harm. Risks to people were assessed and managed to ensure their well-being. Accidents and incidents were recorded, managed and monitored safely to assist in reducing the risk of reoccurrence. There were systems in place to deal with emergencies and protect people from the risk of infections. Medicines were stored, managed and administered safely. There were sufficient numbers of staff to ensure people were supported appropriately and promptly when required. There were safe recruitment practices in place and appropriate recruitment checks were conducted before staff started work to ensure they were suitable to be employed in a social care environment.

Staff received an induction and had on-going support, supervision and training. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to meet their nutrition and hydration needs and had access to health and social care professionals when required.

People told us they were consulted about their care and staff treated them with kindness and respect. Care plans and assessments considered the support people required with regard to any protected characteristics they had under the Equality Act 2010. People were involved in day to day decisions about their care and treatment.

People were supported to participate in activities that were meaningful to them and that met their need for social interaction and stimulation. The registered manager and staff were committed in ensuring people

received appropriate support and care at the end of their lives. The home had a complaints policy and procedure in place which contained guidance for people and their relatives or visitors on what they could expect if they made a complaint.

Staff told us the registered manager provided them with leadership and support. There were systems in place that ensured the registered manager and provider took account of the views of people living at the home and their relatives where appropriate. The service worked well with external organisations including health and social care professionals to ensure people's needs were safely met and to help improve the quality of the service provided. The provider recognised the importance of regularly monitoring the quality of the service and there were systems in place to ensure audits and checks were conducted.

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

Foxbridge House

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 22 January 2019 and was unannounced. The inspection was conducted by one inspector, an inspection manager, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service. This included details of notifications received from the provider about injuries and safeguarding allegations. A notification is information about important events that the provider is required to send us by law. The provider had also completed a Provider Information Return. We used the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority and other health and social care professionals to obtain their views of the service. We used this information to help inform our inspection planning.

We spoke with 14 people using the service and four visiting relatives. People living at the home had varying levels of communication so we therefore used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing the support provided to people in communal areas, at meal times and the interactions between people and staff.

We spoke with 12 members of staff including the provider's operations manager, registered manager, business manager, nursing and care staff, activity coordinators, the chef and kitchen assistants and housekeeping. In addition, we spoke with two visiting health and social care professionals. We looked at 14 people's care plans and care records, seven staff recruitment, training and supervision records and records relating to the management of the service such as audits and policies and procedures.

Good

Is the service safe?

Our findings

The care and support people received continued to be safe. People and their relatives told us they felt safe with the staff that supported them and the home environment felt safe. Comments included, "Yes, I do feel very safe", "Oh, the girls [staff] make sure everyone is safe", "It's very safe here. There are always people around", "I know my [relative] is safe here, staff are good at managing [relative's] needs", and, "There is always someone on the reception. I know [relative] is safe and well cared for."

People continued to be supported and protected from the risk of abuse or harm. There were up to date policies and procedures in place for safeguarding adults from abuse and systems in place to report and act on concerns or allegations. Safeguarding records included local and regional safeguarding policies and procedures, reporting forms and a safeguarding monitoring tool to oversee and learn from any on-going enquiries. The registered manager was the safeguarding lead for the home and they were responsible for managing safeguarding concerns and ensuring staff were appropriately trained. Staff we spoke with were aware of their responsibilities to safeguard people including the actions to take if they had any concerns and confirmed that they had received training. They were also aware of how to raise any concerns in line with the provider's whistleblowing policy. Information was displayed within the home informing people about safeguarding and how to raise any concerns. This information was also available for people in alternative formats such as large print or easy to read if required.

Risks to people continued to be managed effectively to avoid harm. Risks to people's safety and well-being were assessed. Care plans were put into place to manage identified risks whilst ensuring people's individual independence was promoted and respected. Risk assessments documented identified risk factors for people and staff acted to manage them safely. Care plans included risk assessments covering areas such as nutrition, mobility and falls, behaviour, mental physical and emotional health and well-being, skin integrity and moving and handling amongst others. Where risks were identified, we saw there was clear guidance available for staff in supporting people to manage and reduce the reoccurrence of risks. For example, how staff were to support people when using equipment to mobilise to reduce the risks of falls; the use of bed rails and floor mats to ensure people's safety whilst in bed and the prevention, management and reduction of the risk of pressure sores. This enabled staff to provide care and support to people in a consistent and safe manner.

People continued to receive their medicines safely as prescribed. Medicines were stored, managed and administered safely. Up to date policies and procedures provided staff with guidance on managing and administering medicines safely. Records showed that staff responsible for medicines administration had received medicines training and had an assessment of their competency to ensure they were safe to administer medicines in line with best practice. Medicines were stored safely in a locked facility that only authorised staff had access to and records of medicines stock were completed accurately by staff. Temperature readings of medicines storage facilities were checked and recorded daily to ensure medicines were safe and fit for use. People had individual medicine administration records which we saw were completed accurately by staff. Medicines audits and checks were in place to ensure medicines continued to be managed and administered safely.

Staff continued to be recruited safely. Full employment checks were completed before staff started working with people, including gaining accurate references and a full employment history. A disclosure and barring service (DBS) check had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Nurse's registrations had been checked to be valid and in date with the nursing and midwifery council.

There were mixed views from people about the staffing levels within the home. Comments included, "There's nowhere near enough staff. They're very willing but there's not enough there to help you", "Yeh I would say there's enough, they always come when I need them", "The carers are always running around. They never seem to stop", "I think the staff are very good. Unfortunately, there is a shortage; the existing staff are run off their feet", and, "They [staff] are very busy but I think there is plenty of them."

Throughout our inspection we observed there were enough staff to keep people safe. Staffing levels were determined based on people's needs and the risks associated with their care and were regularly reviewed by the registered manager. The registered manager told us there were currently vacancies at the service but they were using regular agency nurses and care staff to ensure there was always enough staff available. Rotas showed that this was the case, and matched the numbers of staff on duty at the service when we visited. A 'twilight carer' was available when people were getting ready for bed to offer additional support, and ensure continuity if a staff member called in sick or became unexpectedly unavailable for their night time shift. Throughout our inspection staff were able to spend time with people. They responded quickly when people asked for assistance and did not appear rushed. Call bell logs showed that staff responded quickly when staff used their call bell to request support.

Accidents and incidents were recorded, managed and monitored safely to assist in reducing the risk of reoccurrence. Staff were aware of the provider's procedures for reporting accidents and incidents and we saw these were followed. Records demonstrated that staff had identified concerns appropriately, took actions to address concerns and referred to health and social care professionals when required. There was an up to date accident and incident policy in place and notifications were sent to the CQC where appropriate.

Staff continued to carry out regular health and safety checks of the environment and equipment to ensure it was safe to use. These included ensuring that electrical and gas appliances were safe. Equipment such hoists and lifts had been regularly serviced. Water temperatures were checked to make sure people were not at risk of scalding. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. People had personal emergency evacuation plans in place which contained information for staff and the emergency services on the support they needed to evacuate from the service in the event of an emergency. When people were at risk of developing pressure sores beds with air flow mattresses were provided to prevent this and special cushions were available for people to sit on. Staff regularly checked pressure relieving equipment to ensure they were set on the correct pressures. A visiting professional told us, "I have always found staff helpful and they follow any plans that are in place. They manage wounds well and there have been some positive results. They give me access to records needed and referrer appropriately to us when needed."

The service was clean, free from odours and people were protected from the spread of infection. Staff had received training in infection control and had access to a range of personal protective equipment such as gloves and aprons, and we saw these being used throughout the inspection. The kitchen had been awarded a five star rating for food hygiene, the highest possible rating.

Good

Is the service effective?

Our findings

People were supported to have a balanced nutritional diet, however, their views about the food, menus on offer and meal time experience at the home varied. Comments included, "You get a nice dinner, but yesterday my dinner was practically cold; the pudding was hot. Very often I have to ask them [staff] to put it in the microwave", "At weekends you can wait for 15-20 minutes in the dining room waiting for food. It causes general irritation", "The food is very good and there's plenty of it", "Sometimes the food is not as good as it might be. It's a shame to waste food. It's not hot enough", "I enjoy the food here. It's pretty good. Yesterday they made me a special ham omelette which I like", and, "It's good food we get."

We visited the kitchen and observed it was clean and organised. We noted that the food standards agency visited the service in April 2018 and rated them five which is the highest rating. There were systems in place to manage risks in relation to people's nutritional and dietary needs. We spoke with the chef who showed us dietary and allergy information which was displayed within the kitchen to ensure catering staff were aware of people's needs and any dietary modifications or dietary and cultural preferences. They told us menus were discussed with people to take account of their wishes and the menus were seasonal and rotational. Food was cooked and placed in hot trolleys which were then delivered to each dining room for staff to serve.

We observed the lunchtime meal in two dining rooms and within lounge areas where some people preferred to eat their meals. The atmosphere in one dining room was relaxed and there was appropriate music playing in the background which people were seen to be enjoying. In another dining room we observed there was little interaction and the room was quiet. Staff supported people with meal choice by way of sample plates and with cutting their meals when required. We noted there were no menus displayed on tables or pictorial menus to aid comprehension and to promote choice. Kitchen hostess served food from kitchens located on each unit. We saw one hostess reheated some meals as they had identified that they were not hot enough to serve. People were offered a choice of drinks including juices, wine and sherry followed by tea or coffee after their meal.

Care plans documented people's nutritional needs, support required, known allergies and any nutritional risks such as swallowing difficulties and weight loss or gain. Snacks and drinks were available to people throughout the day and we observed staff regularly offered and supported people with these when required.

We spoke with the registered manager and drew their attention to the feedback received from people about their meal time experience and the observations we had made. They told us they would take immediate action to address these areas and to improve people's meal time experience in some parts of the home. We will check on this at our next inspection of the service.

Staff were knowledgeable about the people living at the home and had the necessary skills to meet their needs appropriately. Staff received training in a range of essential topics such as safeguarding, moving and handling, mental capacity and first aid. They had also received training specific to people's needs such as dementia and diabetes. Nurses had received additional training to keep their clinical skills up to date, and

we saw certificates relating to sepsis, catheter care and pressure ulcer prevention. The business manager told us they had responsibility for ensuring staff training was up to date, and they sent regular reminders to staff when their training was due.

New staff were supported through an induction and were given time to get to know people before working independently. The induction was based on the Care Certificate. The Care Certificate is an identified set of standards that social care workers work through based on their competency. Staff put their training into practice and were knowledgeable about people's needs. We saw staff assisting people to move in a calm and supportive way.

Staff received support and met regularly with their managers. Staff files showed that individual staff members had not had regular supervision, in line with the provider's policy. However, we discussed this with the registered manager and they showed us a range of group supervision meetings which had taken place. They agreed that individual staff supervisions had not been occurring as often as the provider's policy had stated, however, they could demonstrate that staff had multiple opportunities to reflect on their practice and discuss areas for improvement. Care staff had all received an annual appraisal. Staff we spoke with told us they felt well supported by the registered manager. One staff member commented, "I think they are visible and I know I could go to them [the registered manager] with any problems."

People were supported by staff that had good knowledge and understanding of gaining consent. Staff we spoke with demonstrated their knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) including people's right to make informed decisions independently, but, where necessary to act in someone's best interests. 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. 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 MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Care plans and records showed that where people lacked capacity to make specific decisions for themselves, mental capacity assessments were conducted and decisions were made in their best interests, in line with the requirements of the MCA. We saw that applications had been made to local authorities to deprive people of their liberty for their safety, where this was assessed as required. Where these applications had been authorised, we saw that the appropriate documentation was in place and kept under review and any conditions of authorisations were appropriately followed by staff.

Assessments of people's needs and preferences were completed before they moved into the home in order to ensure the service's suitability and that their needs and preferences could be met. Assessments covered areas such as contact information, personal history, preferences and wishes and consent. Care plans documented the involvement from people and their relatives where appropriate and any health and social care professionals involved, to ensure all individual needs were considered and addressed. Assessments and care plans showed that people were supported to maintain their health and well-being and when required were referred to health and social care professionals for intervention. Records from visiting health and social care professionals were retained in people's care plans to ensure staff were aware of people's presenting health and social care needs. A visiting health care professional told us, "I've seen the home in difficult times but now they are over this. Things have much improved. The nursing staff are very good and

always provide me with the information I need."

The home environment was maintained and adapted to meet people's needs. There were accessible toilets and bathrooms throughout the home and equipment was available for people who required it; such as walking frames, wheelchairs, hoists, hand rails and lift access to all floors.

Good

Is the service caring?

Our findings

People told us staff were kind and treated them with dignity and respect. Comments included, "This is a lovely place. They're [staff] looking after me very well. I can't grumble at all. If I ring my bell they do come in; even in the middle of the night. The night staff are very good", "They [staff] do try to listen to what I say", "The carers are very good. I've got no complaints. I'm grateful for the help", and, "The care is very good indeed. If you ask for anything they'll try and do it."

Throughout our inspection we observed staff supported people in a kind and caring manner. For example, where people showed signs of anxiety, staff provided them with support and reassurance in a calming manner. The atmosphere within the units at the home was relaxed and people appeared comfortable in the presence of staff. Staff we spoke with knew the people they supported very well. They were aware of their family history, the activities they enjoyed and their preferred daily routines. One member of staff told us, "It's important to know people well and for them to know us. That way we can care and support them better." One person told us that it was their birthday recently and after returning from being out with family they, "were warmly welcomed back with a cake with my name on it." A relative told us, "The staff have time to chat and are interested in the person."

We observed that staff had built trusting respectful relationships with people and valued their individualities. Staff addressed people by their preferred names and were friendly with their relatives when they visited. People's diverse and cultural needs were respected, assessed and documented as part of their plan of care. They included information about people's cultural requirements and spiritual beliefs which we saw staff were aware of. Staff had received training on equality and diversity to ensure people were not discriminated against in relation to any protected characteristics they had in line with the Equality Act 2010.

People and their relatives where appropriate were involved in day to day decisions about their care and treatment and they were provided with information about the service. One relative told us they were part of their loved one's care planning and they were aware of the plans in place to meet their needs. The registered manager told us that people received a copy of the 'residents guide' information book on admission. This provided people with information about the home including their philosophy of care, their values, the home environment including amenities and the complaints procedure amongst others. Staff told us how they promoted people's independence and empowered them to continue to make decisions wherever possible offering them choices; for example, in choosing what they wanted to wear or eat. One person told us, "I make my own decisions and staff respect that. I can do a lot for myself but when I need help staff are there."

Staff maintained people's privacy and dignity and described ways in which they worked to promote this. One member of staff said, "This is their home and I never forget that, I respect that and always ask before doing. For example, I always knock on people's doors before going in and always maintain people's dignity when helping them with personal care." One person told us, "Staff are very good and always ask my permission. They do close curtains and doors when helping me to wash and dress." We observed that staff sought permission before entering people's rooms and people were supported to personalise their rooms with pictures, photographs and furniture that was important to them. People were supported to maintain

relationships with people that were important to them. We observed relatives and visitors were made to feel welcome and there were no visiting restrictions placed upon them.

Good

Is the service responsive?

Our findings

People's care and support continued to be assessed, personalised and reviewed to meet their individual needs appropriately. One person told us, "They [staff] check with me to make sure I'm happy and ask if I want anything changed." Assessments of people's individual needs were completed prior to admission and contained details about individual's physical, mental, social and emotional care needs. This information was used to create care plans, which provided guidance for staff on how best they could support people to meet their identified needs and preferences. On admission people were also given a nominated a member of staff to be there keyworker to coordinate their care and ensure their preferences were respected and met.

Care plans contained information regarding people's physical and mental health, life histories and choices and people and things that were important to them. Care plans were recorded and stored on the provider's electronic computer system and paper pictorial care plans were also available to help promote and aid better understanding for some people living with dementia. Care plans were reviewed on a regular basis to ensure they remained up to date and reflective of individual's needs. Staff we spoke with were knowledgeable about the contents of people's care plans. One member of staff told us, "We have access to the computer system and can update people's care plans constantly which is good as people's care can change from day to day."

Staff supported people at the end of their lives, in line with their wishes and preferences. One relative told us, "They [staff] looked after my [relative] at the end of their life. They looked after [relative] extremely well." People's end of life care wishes was recorded where people had wished to and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision were in place where appropriate. Nursing staff told us and we saw within people's records that they worked closely with GPs and palliative care teams to ensure people received appropriate care at the end of their lives and in line with their individual wishes.

People's diverse needs, human rights and independence was supported and respected. Care plans and assessments considered the support people may require in regard to any protected characteristics under the Equality Act 2010. For example, in relation to age, race, religion, disability, sexual orientation and gender. Care plans reflected individual's preferences, social and cultural diversity and values. Staff demonstrated an understanding of individual's needs and listened to people, their relatives where appropriate and health and social care professionals to meet their identified needs and wishes.

The home ensured good communication and we saw information was displayed around the home for people in accessible formats in line with the Accessible Information Standard. The Accessible Information Standard ensures that services must identify, record, flag, share and meet people's information and communication needs. The registered manager told us they had access to different communication formats to ensure everyone's needs were met. One relative told us, "They [staff] provide me with an enlarged printed version of home's newsletter because I have poor eyesight." The home environment and equipment in place assisted in the promotion of people's independence and staff worked well with people to maximise their independence. For example, with the use of pictorial signage to aid orientation and wheelchairs and walking aids to support safer independent mobility. The registered manager told us that they recently changed the

lighting on the dementia unit after identifying patterns in which a number of people suffered falls. They said evidence based guidance and research suggested that appropriate lighting supported and aided people living with dementia to see and mobilise safer.

There continued to be appropriate arrangements in place to respond to people's concerns and complaints. People and their relatives told us they knew how to make a complaint and had confidence that any issues would be dealt with appropriately. The provider's complaints policy included information on what people could expect if they raised any concerns, details of the timescale for responses and actions to take if they remained unhappy with the outcome. Complaints records we looked at showed that when complaints were received these were responded to timely and appropriately in line with the provider's policy.

People were supported to engage in a range of activities that met their need for social interaction and stimulation. Activities on offer within the home and which were observed during our inspection included reading daily news using them as a tool to branch off into discussions with people and completing the puzzles and quizzes as a group, reminiscence activities which included the use of props that acted as visual and scent aids to remember how things were in the 50's and 60's and baking activities.

People we spoke with told us they were aware of the variety of activities on offer every day and were aware of the activities happening that day. People spoke positively about the activities on offer, comments included, "The activities are good", "There's plenty for me to do. We have a wall opposite the canteen door covered with notices about activities. We get a paper with puzzles and singers also come in, it's like a party effect", and, "There's always something going on. We have quizzes, we went to the cinema last week. We're doing cooking this afternoon. I try to join in when I can. The gardens are very extensive. There's easy access and there's chairs and tables." We spoke with the two full time activity co-ordinators in post. They told us how they aimed to deliver a varied and full programme of meaningful activities for people. They said they engaged with local schools and made regular trips to the local cinema as well as showing films in the in-house cinema room. They held a poetry club and encouraged people to write their own poetry. They also told us they were proud of the sensory room which they had helped designed with people. One commented, "We actually love what we do. We do parties for every occasion. It's one big party here."

Good

Is the service well-led?

Our findings

People, their relatives and visiting professionals we spoke with were complimentary about the home, staff and the management of the home. Comments included, "The care is pretty good. It's a very pleasant atmosphere; quite jolly", "Staff are patient and kind", "The place is nice and clean and it's well managed", "When I came here they brought me back to life to be honest", "I do feel management listen", "Staff provide good care and follow any recommendations made", and, "It's a nice home. The manager is approachable and the staff are very friendly."

At the time of our inspection there was an experienced registered manager in post. They knew the service very well and were aware of their registration requirements with CQC. They knew the different forms of statutory notifications they were required to send the CQC by law and had completed their CQC Provider Information Return, as required. They were aware of the legal requirement to display their CQC rating. They demonstrated an in-depth knowledge of people's needs and the needs of the staffing team. During our inspection we saw that the registered manager put people's needs first and was visible and available to people, their relatives, visitors and staff.

Staff told us the registered manager provided them with leadership and was available to them offering guidance and support to them in their roles when required. One member of staff said, "The manager is very supportive and helps us to care for people when needed, they get stuck in. We have a good team and work together well." Regular staff meetings continued to take place to engage and involve staff in the running of the home. Meetings of different disciplines were used to provide staff with updates, to share learning and good practice. These included clinical flash meetings, daily staff meetings, activity feedback meetings, monthly health and safety meetings and medication reflection meetings amongst others. Staff were clear about their roles and responsibilities; and were committed to providing good care and improving people's well-being.

There were systems in place to ensure the home sought the views of people and their relatives through regular residents and relative's meetings, annual surveys and through the use of a comments and suggestions box located in the reception area. We looked at the results of the survey conducted in September 2018 which were positive. Results showed that 100 percent of respondents said that they felt the home was a safe place to live, 100 percent said the staff provided the care they needed, 100 percent said staff treated them with kindness, dignity and respect and 89 percent said they felt they had a say.

People and their relatives told us they also had the opportunity to give their feedback at resident and relatives meetings. We saw a range of topics were discussed and people and their loved ones were able to give their thoughts on the service. When areas of improvement were identified, such as more regular changing of water jugs, to ensure water was fresh, these were placed on an action plan and an update was given at the next meeting. One person told us, "I am the chairperson of the resident's meetings and I think it performs a very useful purpose." A relative told us they were sent questionnaires to complete and attended relatives' meetings frequently. They said they felt listened to and had raised the issue of the coffee shop area being so popular that there was not always enough space to accommodate people. They told us

management had taken their comments on board and there were plans to enlarge it. The home also produced a quarterly newsletter which provided people and visitors with information about the home, dates for the diary, staff news and puzzles amongst other areas of interest.

The service continued to work well with external organisations including health and social care professionals to ensure people's needs were safely met and to help improve the quality of the service provided. The registered manager told us that they communicated and worked with local authorities who were commissioners of the service, GPs, district nurses, community mental health teams, palliative care teams and other health and social care professionals when required.

There continued to be well-led governance arrangements in place to monitor, assess and improve the quality of the service. Records demonstrated that regular checks and audits were conducted in a range of areas to ensure the home was managed well and that people received good standards of care. Audits undertaken focused on areas such as care plans and records, medicines, health and safety, the home environment, accidents and incidents and safeguarding amongst others. Records of actions taken to address any highlighted concerns, issues or planned improvements were documented and recorded as appropriate. The provider's operations manager also completed checks and visits to the home on a regular basis to ensure any actions required were taken promptly and the home continued to be well-led.