Chilterns Healthcare Limited

Chilterns Manor

Inspection report

Chilterns Manor
Northern Heights
Bourne End
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Tel: 01628528676

Date of inspection visit:
18 September 2018
19 September 2018

Date of publication:
17 October 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 18 and 19 September 2018. It was an unannounced visit to the service.

We previously inspected the service in August 2017. The service was not meeting the requirements of the regulations at that time. There were breaches of the regulations in relation to how it investigated and recorded complaints about the service, monitoring of people's care, recruitment procedures and ensuring staff received appropriate support and training. We asked the provider to submit an action plan which outlined the improvements they would make.

Chilterns Manor is a 'care 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 home is registered to provide care for up to 22 older people and people with dementia. Eighteen people were living there at the time of our visit.

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.

We received positive feedback from people about the staff who supported them. Comments included "All the staff are very nice," "(The carers) are all very good" and "They're nice people here." Relatives' and visitors' comments included "They know exactly where (my friend) is when I arrive and what she is doing" and "She's very well looked after here."

We saw improvements had been made to recruitment of staff and the support they received. This included staff training and supervision meetings, to discuss individual performance. However, we found the home had not enrolled new workers onto the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. We have made a recommendation about this.

There were systems for the safe management of medicines. We observed some areas where staff had not consistently followed good practice when they administered or recorded medicines. These were mentioned to the registered manager, in order for them to take appropriate action.

Risks to people's safety and welfare had been assessed, to prevent the likelihood of injury or harm. Measures were put in place where risks had been identified. Staff had received training in safe ways of working. This included how to move people safely.

Staff had received training to recognise and respond to safeguarding concerns. Staff told us they would report any concerns they had to managers or external organisations.

People were supported by sufficient numbers of staff. Staff were kind and caring towards people and knew their needs well. Care plans had been written, to record people's needs and their preferences for how they wished to be supported. These were up to date to reflect changes in people's needs.

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.

Staff followed good infection control practices, to help prevent the spread of infection. The home had been awarded a 'Good' rating by the Food Standards Agency, following their inspection this year.

Nutrition and hydration needs were being met. People were supported with their healthcare needs. Records were kept of any visits by healthcare professionals. The home had not established any links with community services who provided palliative care. We have made a recommendation about this, as a good practice.

The building complied with gas and electrical safety standards. Equipment was serviced to make sure it was in safe working order. Evacuation plans had been written for each person, to help support them safely in the event of an emergency. We found the garden was untidy and not in a suitable condition for people to use, as some preliminary building work had started. We have asked the provider to write to us about this.

Improvement had been made to monitoring of the service. The provider regularly visited and checked the quality of care at the service. Audits were also undertaken. Improvements had been made to the recording of people's complaints and storage of records.

We observed improvement could be made to handling of people's confidential information. Staff handover took place in an area where people could overhear what was being said. We have made a recommendation about this.

We looked at whether the service ensured people had access to the information they needed, in a way they could understand it. This was to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Whilst some work had been carried out, we have recommended further work is undertaken, to comply with this standard.

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.

People were supported by staff with the right skills and attributes because improvements had been made to the recruitment procedures used by the service.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures for staff to follow in the event of any abuse happening.

People were protected from the risk of infection as staff followed safe infection control practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements had been made to the support staff received, to ensure people were cared for by staff with the right skills. However, further work was needed to make sure staff induction followed nationally-recognised good practice.

People were unable to use the garden as it was not well-maintained.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in their best interests, in accordance with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were treated with kindness, affection and compassion.

People's privacy and dignity were respected when they received personal care. However, their confidentiality needed to be better safeguarded during staff handovers between shifts.

People were supported to express their views about the

standards of care they received.

Is the service responsive?

Good

The service was responsive.

People's preferences and wishes were supported by staff and through care planning.

Improvements had been made to the recording of people's complaints, so they could see these had been acknowledged and responded to.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care.

Is the service well-led?

Good

The service was well-led.

Improvements had been made to the monitoring of people's care, so that it met their needs.

People were cared for in a service which worked in partnership with other agencies.

People were cared for in a service which promoted a positive and inclusive culture.

Chilterns Manor

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 checked 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 18 and 19 September 2018 and was unannounced.

The inspection was carried out by one inspector 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. The expert by experience was present on one day only.

We used 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 reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted community professionals, such as the local authority commissioners of the service, to seek their views about people's care. We also took into account a report by Healthwatch, following their visit in April 2018.

We spoke with the registered manager and a range of other staff members. This included the deputy manager, senior care workers, care workers, the chef and activity organiser. We observed routines within the home and how meal times were managed.

We checked some of the required records. These included three people's care plans, medicines records, three staff recruitment files and six staff training and development files.

We spoke with ten people who used the service and three visitors. Some people were unable to tell us about

their experiences of living at Chilterns Manor because of their dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at the service. No one raised any concerns about how they were supported or cared for by staff.

When we visited the service in August 2017, we had concerns about recruitment practice. This was because the full range of required checks had not been obtained before staff commenced work. We asked the provider to make improvements. They sent us an action plan which outlined the measures they would put in place.

On this occasion, we were able to see improvements had been made. Each staff recruitment file we checked contained evidence of thorough checks. These included written references, a criminal records check and proof of identity. These checks helped to ensure people were supported by staff who were fit to work with vulnerable adults.

People's medicines were kept securely at the home. Staff had received training on safe medicines practice and were assessed before they administered medicines alone. There were medicines procedures to provide guidance for staff on best practice. We saw staff maintained appropriate records to show when medicines had been given to people, to provide a proper audit trail.

We observed part of the morning medicines round on one day. Safe procedures were followed in managing all but two people's medicines. We found the member of staff had potted out two people's medicines at the same time, in separate plastic pots. It is good practice to deal with one person at a time, to reduce the risk of errors occurring. There was a small piece of paper added to each pot, with the room numbers for these people. The member of staff knew people well and who was in which room but the practice they used could have led to errors. We mentioned this to the registered manager, in order for them to take action.

Some entries on medicines administration records had been handwritten. Where this is the case, it is good practice for a second person to check and sign to show the details have been transcribed correctly. This was also mentioned to the registered manager, for their attention.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored appropriately. When a controlled drug was administered, the records showed the signature of the person who administered the medicine and a witness signature. The balance recorded in the register for two drugs we checked matched the number in stock.

The service had systems and processes for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff had also undertaken training to be able to recognise and respond to signs of abuse. Staff told us they would report any concerns to managers or the owner, who regularly visited the home.

People's likelihood of being injured or harmed had been assessed. We saw risk assessments for people's risk

from falls, developing pressure damage and supporting them with moving and handling, as examples. Personal emergency evacuation plans had also been written. These outlined the support people would need in the event of needing to vacate the premises in an emergency. These risk assessments helped to ensure people were supported safely.

The building was maintained. There were certificates to show it complied with gas and electrical safety standards. Appropriate measures were in place to protect people from the risk of fire. Action had been taken to address issues identified by the fire officer when they visited in December 2017. Equipment to assist people with moving had been serviced and was safe to use. This included mobile hoists and stair lifts.

People were supported by sufficient numbers of staff. We saw staff responded to people's needs promptly. Busy times of the day, such as mealtimes, were managed appropriately. Staffing rotas were maintained and showed shifts were covered by a mix of care workers and senior staff. A new system had been introduced whereby staff were allocated named people to support on each shift. This helped to ensure everyone received the support they needed and that people received continuity of care during the shift.

Accidents and incidents were recorded appropriately at the home. At our last inspection in August 2017, we recommended the home followed good practice in the prevention of accidents, by recording actions taken when people had falls. We saw this was now being done. For example, one falls record showed the person had been referred to the district nurse for the injury they sustained.

Staff received training to ensure they followed safe practices when they supported people. This included first aid training, moving and handling and fire safety awareness. Staff told us they updated courses regularly, to keep these skills refreshed.

The registered manager took action where staff had not provided safe care for people. For example, where errors had occurred. Records were kept of meetings held with staff following incidents of this nature, to determine what had happened and to prevent recurrence. Disciplinary proceedings were used where necessary.

People were protected from the risk of infection. The kitchen was maintained in a clean and organised condition. A recent Food Standards Agency inspection resulted in the home being awarded a rating of "Good" for its food hygiene practices.

We saw staff wore gloves and disposable aprons when they supported people with personal care and put on fresh sets when they handled food. The laundry was in good order with dirty washing stored in skips according to what the item was and how soiled it was. Any washing that had the potential to spread infection was placed in a red, soluble laundry bag and remained in this until it was cleaned. Housekeeping staff were employed to keep the premises in a hygienic condition. Minor observations around the home were mentioned to the registered manager, for them to follow up.

People's records were accessible to care workers and managers. These were accurate and had been kept up to date.

Requires Improvement

Is the service effective?

Our findings

People told us they were supported by effective staff. Comments included "They're very good (at looking after me). They do everything as well as they possibly could" and "(The staff) here have been doing it for a long time, so they know what to do best." One person told us "They take notice of what we want." We asked if staff always sought permission before they did things. The person said "Yes, they do. We might well say 'no' (to their request) and if we do, they respect that."

When we visited the service in August 2017, we had concerns about staff support. This was because there were inconsistencies in staff induction, training, supervision and appraisal. We asked the provider to make improvements. They sent us an action plan which outlined the measures they would put in place.

On this occasion, we saw improvements had been made to staff training, supervision and appraisal. A wide range of courses had been undertaken by staff. These included pressure area care, practical moving and handling, equality and diversity, falls awareness, whistleblowing (raising concerns about wrong-doing in the workplace) and dementia awareness. Staff said there was lots of training for them to undertake and keep their skills refreshed. Some staff had completed National Vocational Qualifications (NVQs) and Business and Technology Education Council (BTEC) awards, to further their development.

Supervision (one to one meetings with managers) took place to discuss how staff worked and to look at their development. This was now consistent for all staff in the sample of files we checked. Appraisals had also been carried out this year, to evaluate overall performance.

We saw records of completed in-house induction for new staff. At our last inspection, we commented that staff had not been assessed for the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, duty of care and working in a person-centred way. Last year we noted workbooks had been obtained for the Care Certificate but none of the staff had started to use these or been assessed whilst they carried out care. This was also the case on this occasion. We saw staff, including newer staff, worked well with people and appeared to know their needs and their preferences for how they liked to be supported. However, it is a nationally-recognised good practice for staff to complete the Care Certificate, if they do not already hold a relevant health and social care qualification which has assessed their competence.

We recommend the service seeks advice from Skills for Care regarding introducing the Care Certificate.

People's needs had been assessed before they received support. This included assessment of their health needs and personal care needs. Staff communicated information about people's needs using a range of methods. This included verbal staff handovers between shifts and use of hand-held electronic devises to record the care they had given.

People were supported with their nutritional needs and these were recorded in their care plans. Risk had been assessed for the likelihood of malnutrition. Food and fluid charts were put in place where necessary, to

monitor intake. Information about people's dietary requirements was communicated to the chef. This included likes and dislikes, allergies and texture of food, where people had swallowing difficulties.

We asked people about the meals provided for them. Most people said they enjoyed meals. Comments included "Good food comes my way when I'm (in the dining room) with the others" and "The food's not bad at all. I like the smells (of cooking) when you come in." One person told us "The food is average. Sometimes poor, sometimes reasonable." Another person said "People of my age want English food. Today on the menu it was curry for lunch," which they did not want. They told us the chef provided an alternative meal of their choice.

We saw lunchtime on both days was unrushed and gave people time to enjoy their food, at their own pace. People could eat in the dining room or their bedroom, if they chose. Staff provided appropriate support to help people with their meals. Equipment such as plate guards was provided, to help people manage meals independently. The daily menu was written on a large noticeboard by the dining room and there were pictures to show what the options were.

People were provided with drinks throughout the day and at meal times. Biscuits were offered to people with a mid morning hot drink and cake with an afternoon one.

People were supported with their healthcare needs and were referred to GPs, district nurses and podiatrists, as examples. Records were kept of visits from healthcare professionals, to ensure important information was noted and advice followed up. A visitor said the person they came to see received prompt medical attention, when needed.

Staff worked together within the service and with external agencies to provide effective care. This included the local authority.

The Mental Capacity Act 2005 (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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 were being met. The registered manager told us no conditions had been imposed on any authorised DoLS applications, so far.

We saw some care plans mentioned people who lacked capacity had a legally-appointed representative. This would enable the representative to make decisions on the person's behalf. There were certified copies of the Court of Protection documents to confirm this. This showed the service had satisfied itself it had consulted the right people to make decisions on residents' behalf.

The premises were not purpose-built to accommodate people with a range of disabilities and mobility needs. For example, corridors were quite narrow in places and there were small steps to negotiate. Stair lifts had been provided to enable people to move between floors. Adapted baths were in place. In one

bathroom, which had a specialist bath, it was too small to accommodate a mobile hoist. This restricted who could use the bathroom. We were aware the provider intended to refurbish the accommodation and they were liaising with the district council over planning permission. We saw some signage had been added around the premises, to direct people to key areas, such as the dining room.

The garden had not been kept in a well-maintained condition. The grass was overgrown and there were weeds growing between paving slabs. At the end of the garden there were sections where metal fencing had been put up as part of preliminary building works. These were potential hazards to people. We have asked the provider to write to us about the timescale for completing building works and how they intended to maintain the garden in the interim. In their response to the draft report, the registered manager told us people could still make use of the garden. They said events had been held, such as summer parties and barbeques.

Good

Is the service caring?

Our findings

We received positive feedback from people about the staff who supported them. Comments included "All the staff are very nice." The person named one care worker who "Makes me laugh." They added "(The carers) are all very good. They don't really make any mistakes. That's the best part." Other people told us "They're nice people here" and "The carers are really very, very good. They'll do anything for you. They are extremely good. Their policy is to let you do as much (of your own personal care) as you can yourself." Further comments included "I think they look after me very well…there's always someone around if you need to talk to them. It's nice here, I feel comfortable. Nothing could be better, we've got it all here. We are lucky." Relatives' and visitors' comments included "They know exactly where (my friend) is when I arrive and what she is doing" and "She's very well looked after here."

There was a policy on confidentiality to provide staff with guidance. We saw copies of confidentiality agreements in each of the staff files we checked. At our previous inspection, we noted staff handover took place in the dining room. This was a verbal update about people's well-being for the next shift coming on duty. It was conducted within earshot of residents and visitors in the lounge. We had asked the registered manager to monitor this, as they said they were not aware of this issue. On this occasion, we found staff handover still took place in the dining room with the doors open. This had the potential to compromise people's confidentiality.

We recommend staff handover is conducted in private, to safeguard people's confidential information.

People said they felt listened to and their privacy and dignity were respected by staff. We observed bathroom and toilet doors were closed at all times when in use. People had been supported to look smart and wear co-ordinated clothes. A hairdresser regularly visited the service. We noticed they used part of the lounge to cut and dry people's hair. The registered manager told us this was usual practice as the home did not have another area or salon to use.

People were treated with kindness, respect and compassion. For example, we heard a member of staff ask someone who had felt poorly, "Are you feeling better now, (name of person)?" They took an interest in people, such as asking someone who had been out if they had enjoyed their time. This resulted in a conversation with the person about what they had been doing, with lots of smiles.

The service promoted people's independence, wherever possible. Risk assessments were contained in people's care plan files to support them with daily living tasks. People were supported to go shopping or into town. One person had been out to do some voluntary work on one of the days of our visit and had really enjoyed it. Another person liked to wipe down place mats after mealtimes and return the food trolley to the kitchen. We saw they were enabled to do this.

People were supported to express their views at the service. For example, residents' meetings were held at the home approximately every eight weeks, to ask for people's views and to inform them about significant events. People were also able to express their views in annual quality assurance surveys. The findings from

these surveys were analysed and displayed in the hallway. Ninety percent of people had rated the service as 'good' or 'very good' during this year's surveys.

Good

Is the service responsive?

Our findings

When we visited the service in August 2017, we had concerns about the recording and management of people's complaints. This was because records were not kept of issues people raised with staff about their care. We asked the provider to make improvements. They sent us an action plan which outlined the measures they would put in place.

On this occasion, we saw improvements had been made. Records were kept of any matters raised by people. We saw action was taken to put matters right. For example, complaints about food or the kitchen were addressed with the chef.

There were complaints procedures people could use. People were also asked if they had any concerns or feedback as part of residents' meetings.

People's needs were assessed before they came to live at the service. This information was then used to formulate care plans. Care plans contained sections which included how people communicated, any behavioural issues, emotional support, health, personal care and pain control. The care plans we read took into account people's preferred routines and how they liked to be supported. Each care plan we read had been kept under review, to make sure information was up to date.

Technology was used to provide person-centred care, which was responsive to people's needs. For example, sensor mats were in place where people were at risk of falling at night time. These mats alerted staff to any movement, so they could check the person was alright. External doors were fitted with alarms. These had previously just been switched on at night time but were now operational 24 hours a day. This was in response to an incident where someone had left the building unnoticed. We saw staff were quick to check each time the alarm was activated.

People were supported to meet their religious needs at the service. Holy communion was held each month. We saw a nun visited to meet with people and Jehovah's Witnesses came into the home to discuss stories from the Bible. One person went out to church each Sunday.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care. A 'future wishes' document had been completed, to record what people would like to happen. We saw copies of any funeral plans were also in people's files, such as where a funeral had been pre-paid in advance. The registered manager told us no one was currently at the end of life stage. We asked about links with services in the community who provided end of life care, such as the local hospice. The home had not established any links yet.

We recommend contact is made with the local hospice or other palliative care services, to establish links between the two services and to promote good end of life care.

We looked at whether the service ensured people had access to the information they needed, in a way they

could understand it. This was to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. There were no examples of information routinely provided in large print for people who required this, although the registered manager said they would provide it if asked to. A recommendation from Healthwatch to introduce pictorial menus had started to be addressed, although their suggestion to introduce pictorial activity schedules had not been noticed by the registered manager when we asked them about it. Healthwatch had also recommended use of technology to assist people in making choices. For example, laptops or tablet devices, to show people pictures of food and other options. This would help people to be involved in making decisions.

We recommend further work is undertaken to make sure the service ensures people have access to the information they need, in a way they can understand it, to comply with the Accessible Information Standard.

The service supported people to take part in social activities. We met with the activity organiser and observed activities taking place. A wide range of activities or events were available to people. We saw festivals and events throughout the year were celebrated. These included Chinese New Year, Easter, Diwali and Christmas. Other occasions such as Mothers' Day and Fathers' Day were celebrated, as well as royal occasions including the Queen's birthday and the marriage of Prince Harry. There were board games, jigsaws and crafts people could participate in. Entertainers were booked to visit the home. These included musicians and singers. Two staff were due to start a course to be able to offer gentle exercise sessions at the home, to help keep people active. There were links with the community. Some people liked to go into town for a coffee, visit the library or do their shopping. A local school put on an annual musical production, such as 'Grease', which people were invited to.

Good

Is the service well-led?

Our findings

When we visited the service in August 2017, we had concerns about the quality of monitoring of the service. This was because audits and observations by the provider and registered manager had not identified the issues we found during the inspection. We asked the provider to make improvements. They sent us an action plan which outlined the measures they would put in place.

On this occasion, we saw improvements had been made. Requirements to improve the service had been responded to. We saw the provider's representative visited the service. Staff told us this was a regular occurrence. Reports were written of their findings and shared with the registered manager. Various audits were undertaken at the home. These included audits of infections, accidents, people's weights, falls and pressure wounds. Checks were also made of care plans, standards of catering and housekeeping.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. The registered manager had informed us about incidents and from these we were able to see appropriate actions had been taken. However, we had not been notified of the absence of the registered manager for 28 days or more, as required. This was attended to after the inspection.

The home had a registered manager in place. They were assisted by a deputy manager and other senior care workers. Both the registered manager and deputy manager had undertaken a level 5 qualification in health and social care. The registered manager was part of a local 'My Home Life' project, which aimed to promote and share good practice in care homes.

Staff knew their responsibilities and lines of accountability within the service. People received care in a service which had improved since our previous inspection. This enabled then to receive safer, more effective and better co-ordinated care. One member of staff commented to us "We've definitely improved here."

Staff were now supported through regular supervision and received appropriate training to meet the needs of people they cared for. We observed staff, visitors and people who used the service were comfortable approaching the registered manager or other staff. Staff told us they could speak with the registered manager or the deputy manager any time and said their door was always open. They were encouraged to contribute to staff meetings and their ideas were listened to. For example, staff were asked what training they would like from the local authority's Quality in Care Team. We observed the staff team worked well together to meet people's needs.

The provider had ensured people were cared for in a service where there was an open culture. Staff were advised of how to raise whistleblowing concerns and report safeguarding matters as part of their training. Equality and inclusion were promoted within the staff team by managers.

Information technology was used effectively to monitor and improve the quality of people's care. For example, the electronic care plan system provided a live account of any support people received. There was

also a 'family hub' option on the computerised system. This enabled families to view their relative's care plans and see photographs of them undertaking activities, with their permission.

The provider had also looked at a computerised medicines system which they planned to introduce. Managers we spoke with said this would bring in additional checks for staff, to improve people's care. For example, where medicines were prescribed to be given several times a day, it would alert staff to the time the previous dose had been given. This would help prevent medicines being given too soon in these circumstances.

The service worked with other organisations to ensure people received effective and continuous care. For example, healthcare professionals and the local authority.

People's views were sought about the service through questionnaires and residents' meetings. They enabled people to be engaged and involved in developing the service.

The home had links with the local community, for example, local schools and churches. This helped people to keep in touch with the community and to feel part of it.

People's records were kept safe. The records we looked at were well maintained. At our last inspection some records could not be located by the registered manager. On this occasion, records were located promptly. There was secure storage for personal and confidential records, such as staff recruitment files and supervision records. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, end of life care, equality and diversity and missing persons. These had been reviewed to make sure they were up to date.

We found there were good communication systems at the service. Residents' meetings were held regularly. These provided an opportunity for communication between people who use the service and staff about concerns or improvements that were being made. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in staff meetings.