Care Quality Commission

Barchester Healthcare Homes Limited

Atfield House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service responsive?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Atfield House is part of Barchester Healthcare Homes Limited and is registered for 68 people. It is a care home with nursing that accommodates people with dementia care needs and people with frail elderly care needs across three units. At the time of the inspection 63 people were using the service.

People's experience of using this service and what we found
People received a high level of person-centred care and were supported to have choice and control. Staff spent time identifying people's needs and wishes so they understood what a good quality of life might look like to the person. By identifying activities people could engage in, and that they were interested in, the service improved people's quality of life by developing their confidence and providing a sense of purpose. This motivated people to try new things which contributed to their independence, self-esteem and feeling good.

The provider received feedback from people using the service about what activities they would like to participate in, and a number of activities were available to help people choose an activity that was meaningful to them. People were supported to maintain links with family and friends, and we observed visitors during the inspection.

Staff were well trained in providing end of life care to help ensure people were cared for in a dignified and caring way. Families were also supported at this time so they could focus on being with their relative and not have to worry about the person's care.

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

The provider had systems in place to help safeguard people from the risk of abuse. Staff completed training on how to recognise safeguarding concerns and they knew how to respond appropriately. Risks to people's wellbeing had been identified and assessed. Medicines were managed and administered safely. Safe recruitment procedures were followed and there were enough staff to meet people's needs. Safe infection prevention and control procedures were followed to help protect people from the risk of infection.

The provider had processes to monitor, manage and improve service delivery and to improve the care and support provided to people. People using the service and staff reported the registered manager was approachable and promoted an open work environment. Clear leadership contributed to people and staff being positive about the management of the home and feeling valued and respected.

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

Rating at last inspection and update
The last rating for this service was good (published 6 March 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

This was a focused inspection, and this report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained good. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Atfield House on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Good**
Is the service responsive? The service was exceptionally responsive. Details are in our responsive findings below.	**Outstanding** ☆
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

Care Quality Commission

Atfield House

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by 2 inspectors, a nurse specialist advisor and an Expert by Experience who spoke with people living in the home. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Atfield House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Atfield House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 2 relatives. We spoke with 11 members of staff including the registered manager, deputy manager, nurses and care workers. We reviewed a range of records. This included 6 people's care records and various medicines records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. After the inspection we continued to seek clarification from the provider to validate evidence found and we spoke with a further four relatives for feedback about their experience of the service.

Good

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were protected from abuse and avoidable harm. People and their relatives told us they felt safe in the service. One person commented, "I feel safe. I'm seen to every day. There is always someone keeping an eye out for you. There is a call-bell in my room, but I've never used it, fortunately."
• The provider had systems and processes to ensure safeguarding concerns were investigated and reported to the appropriate agencies. This included up to date policies and procedures for safeguarding and whistleblowing.
• The staff received relevant training so they knew what to do if they were concerned about someone being abused.
• The home maintained a record of safeguarding concerns. We saw the home worked with the local authority to complete investigations and implement actions to safeguard people. The local authority confirmed that at the time of the inspection, there were no open safeguarding alerts.

Assessing risk, safety monitoring and management
• The provider had systems and processes in place to help keep people safe including risk assessments, risk management plans and appropriate reviews that were used to update care plans. For example, we reviewed the records of a person who had recently had hospital treatment. We found that upon return from the hospital, the care plan was rewritten promptly, and the tissue viability nurse, dietician and GP were informed.
• Staff completed relevant training to help make sure they could care for people safely and in line with best practice.
• There were procedures in place for dealing with emergencies. Personal emergency evacuation plans (PEEPs) were in place for people. These contained information for supporting people in the event of a fire or other emergencies.
• The environment was safely maintained through maintenance and the monitoring. Records indicated a range of maintenance and safety inspections had been carried out.
• Incidents that might affect the functioning of the service had been identified and planned for in the provider's business continuity plan. This was part of new staff members' induction, so all staff were aware of the emergency procedures and who to contact.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
• The service had adequate staffing levels to meet the needs of people. People told us, "I think there are enough staff. There is always someone on the desk. I don't feel isolated here" and "You can always find a staff member. There's always someone around." A staff member said, "I think we have enough staff. We can get busy, but we work well together. It gets quieter in the afternoon and then we can spend time talking to our residents, then it gets busy again for teatime and residents getting ready for bed."
• People were attended to promptly and staff were not rushed. Most people confirmed call bells were answered in a timely manner. One person told us, "They're brilliant. If I use the call-bell a staff member normally arrives quite quickly. It depends how busy they are really."
• The registered manager told us they had a full staff team and were able to retain staff. They also had enough bank staff to cover permanent staff being off, which meant they did not have to use agency staff and there was continuity of staff for people using the service.
• The provider followed safe recruitment practices to help ensure only suitable staff were employed to care for people using the service. These included checks on their identity, eligibility to work in the United Kingdom, references from previous employers and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
• Staff completed an induction when they began working at the home. Regular training and supervision were provided so staff had the required knowledge to care for people.

Using medicines safely
• Medicines were managed safely, and the provider had a medicines policy and procedure in place.
• Staff had appropriate training and medicines competency was tested to help ensure they were managing and administering medicines safely.
• Records we viewed were completed appropriately. This included medicines administration records (MARs). The MARs folder contained details about what condition painkillers were prescribed for, as well as the dose instructions and signs or symptoms to look out for in people being supported with end of life care. Reasons for administering medicines was well documented.
• Appropriate protocols were in place. Where people were in receipt of covert medicines, capacity assessments and best interest meetings were undertaken and plans for regular reviews were in place.
• Monthly medicines audits had been carried out to help ensure procedures were followed, and improvements made as required.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely. A staff member told us, "We are told by management to be vigilant and protect people and protect ourselves. We have personal protective equipment (PPE) and make sure surfaces and equipment is cleaned. We have infection control training every year and managers talk about it in our meetings."

• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• Government guidelines were followed and there were no restrictions around visiting people in the home. During the inspection, we observed visits taking place.

Learning lessons when things go wrong
• The provider had systems for learning lessons when things went wrong. Incident and accident forms described the incident, treatments, who has been informed, the cause, actions taken and long term actions required to prevent reoccurrence. For more complex incidents, a root cause analysis was completed to help determine why the incident happened and to identify what action to take to prevent it happening again.
• Additionally, if there were a high number of falls, the falls policy was reintroduced on the policy of the month board to help raise staff awareness around falls.
• The provider told us after the last inspection they began completing a lessons learned file. The registered manager said the lessons learned file was part of new staff members' induction so they could see relevant lessons learnt. The lessons learned information was also shared at a monthly nurses' meeting to help ensure good practice was followed and preventative measures were in place.

Outstanding ☆

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to outstanding. This meant services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• The provider ensured people received care that was highly person centred and met their individual needs and preferences. People's care was planned in a way to achieve realistic goals from the time the person was admitted to the service to when they required end of life care. People and their relatives were involved in every step of the process.
• For example, records showed two people were admitted to the home who needed to be cared for in bed at all times. The staff team worked with the people on setting goals to help both people to become more confident and physically active to develop more mobility and independence.
• One of the people stated their wish was to be able to dance again. Staff patiently worked with the person to achieve this by setting goals to incrementally increase the person's physical strength and motivation and now the person participates in a dance class arranged by the home.
• The other person was very distressed when they arrived at the home and not engaging. Now, they have regained their mobility and can undertake their daily routine with minimal supervision. This has improved their quality of life as they were now more cheerful and motivated and seized every opportunity to engage with others and take part in social activities.
• Staff were proactive in supporting people in the way that worked best for the person. One person found it difficult to focus or engage with others, so staff introduced a doll as part of the strategy to care for them. Caring for the doll provided the person with purpose, and it was a useful way for staff to engage the person in conversation. This helped to raise the person's mood and confidence and they became more involved in other activities. Staff were aware if the doll was removed, for example, to be laundered this would cause the person distress. Consequently, staff made the decision to buy more dolls so the person did not ever have to be without their doll and which helped to avoid causing any distress to the person.
• As part of promoting dignity, 14 words were chosen from a survey completed by people living in the service, and these were displayed on a dignity tree. This helped to promote a greater understanding between people and staff, including a better understanding of people's cultural and religious needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The service encouraged and promoted social interaction. People were supported to identify activities and interests that were meaningful for them by completing a 'Getting to know me' booklet.
• One person who did not like to participate in activities wrote a poem on an occasion. The praise the person received from staff and other people for their work encouraged them to come out of their room and write about things they saw in the home. This was the beginning of the poetry club. With staff support, other

people became interested and the club now has seven members, providing much happiness and opportunities for the members to enjoy discussing and writing poetry.
• Activities such as 'Namaste Care', were organised in a way that recognised initiatives used to promote people's wellbeing in care settings. The programme was developed for people living with the experience of dementia and provides sensory stimulation, particularly through touch.
• The registered manager regularly invited children from a local school to visit. The children engaged in interactive activities with people such as singing, dancing, crafting and storytelling. It helped people to reminisce about their own childhoods and the interaction with children has brought smiles and laughter to people living in the home. They always look forward to their time with the children when they visit.
• People confirmed they were happy with the range of activities offered in the home and told us, "There are plenty of things to do. They organise events. There's an exercise class. Something is on every day and at the weekend too. We have the odd outing too, to local places" and "We do go out to places like Syon Park. We have been to the airport recently. It was so interesting to see how the airport is run. It was a good trip."

End of life care and support
• The provider had effective arrangements to ensure people received high quality end of life care according to their wishes and preferences. Detailed care plans were in place addressing this aspect of people's care which were developed with the local palliative care team when this was required.
• Staff received appropriate training and were supported to care for people with end of life care needs. Nurses completed a three month course and the service had end of life care champions to ensure care could be delivered to a high standard. All staff in the home irrespective of their roles have some understanding of end of life care as the service had a 'whole home' webinar for all staff. This ensured all staff were able to support people when they develop end of life care needs, and support their loved ones, in a sensitive way according to their role. The registered manager confirmed to us that following a specific incident staff had received additional training to provide them with the confidence to challenge a decision which contradicted the wishes of people using the service regarding their end of life care.
• One person being supported with end of life care refused medical intervention and made the decision to remain in the home. Their wishes were recorded in their care plan, and explained to all care staff to ensure their needs and wishes were met in a dignified and caring manner. Support was sought from other healthcare professionals and the family were supported. This helped ensure the person was cared for in a dignified way, according to their wishes and was able to spend their last moments in a familiar and friendly environment with their loved ones.
• Where relatives wanted to stay with the person towards the end of their life, they were provided with a 'care basket' that contained toiletries, snacks and reading material. They were also provided with a resting area so they could rest and spend time with their loved ones. A butterfly placed on the persons' door after their death, discretely communicated this to others.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

• Care plans recorded detailed information about people's communication needs, including how they liked to be addressed, their first language, if they had assistive aids such as glasses or hearing aids and guidance for staff about how best to communicate with them.
• Staff understood the need to communicate with people effectively and people received information about the service in different formats according to their needs, for example large print and pictures. English was

not the first language of several people living in the service and the staff took this into account. One person was anxious on admission as they were moving to a new place where they were afraid they might not be understood. The use of the communication cards translated in the language the person spoke helped them to settle to the point the one to one support they had initially required on admission was no longer necessary.
• Another person using the service had limited use of their limbs due to a medical condition. The provider contacted the organisation that provides support with this condition to better understand how they could enable the person to communicate. As a result, the person now has a communication aid that they can use independently which helps them to maintain relationships with family and friends while maintaining their independence and privacy. This has made them happier and has considerably improved their quality of life.
• Staff confirmed they used different communication methods to meet people's needs and promote positive relationships. A staff member said, "[Person] doesn't speak but can write. We give them pen and paper. We ask them and they nod yes or no. We also use sign language like gesturing 'would you like a drink' and they will reply with a thumbs up or a thumbs down." Another staff member gave an example of person with a disability who is not able to speak following a stroke, "I use eye to eye contact and speak slowly and clearly. We have built up ways of communicating and understanding individual needs."

Improving care quality in response to complaints or concerns
• The provider had procedures in place to respond to complaints. We saw these were investigated and responded to appropriately.
• People and their relatives knew how to make a complaint and felt comfortable raising concerns.
• People we spoke with indicated senior staff were available and told us, "If I wasn't happy with something I'd see the person on the desk as they're very good. I don't really have any complaints" and "I would speak to a nurse initially. Then the deputy manager. Anything I've had a problem with generally gets followed up."

Good

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The service promoted a positive and person-centred culture.
• Promoting a positive culture began at the induction stage for staff when the provider began supporting staff to embed the provider's values and through to best practice sessions with staff.
• As an example of how the service supported staff, the registered manager told us about a member of staff who did not have a background in care and had English as a second language. To support them in their new role, the provider doubled their induction time and gave the staff member written phrases they may require as part of their job. Additionally, they started the staff member in a role with less responsibility and as they became more confident moved them to their permanent position.
•The registered manager conducted reviews and sought feedback about staff performance, and where appropriate, identified relevant health and social care, and care practitioner training as part of staff members' ongoing development of their skills and career progression. This helped to achieve good outcomes for people. The registered manager told us, "The main aim for the management team was driving improvement through nurturing our staff and developing their skills."
• The provider celebrated an employee of the month and if the registered manager witnessed a particular piece of good practice, the employee was given a thank you card in recognition of their good work. Additionally, there were staff appreciation days. For example, a day to recognise the nurses' contributions, and birthdays were celebrated.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood their responsibility around the duty of candour. They were aware when they needed to share information with other agencies including the local authority and CQC.
• People and their relatives felt they could raise concerns. One relative said, "If I've had any worries there has always been someone around to talk things through. I'd feel comfortable to mention something I wasn't happy with."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Managers and staff were clear about their roles and kept themselves up to date with relevant guidance and legislation. The registered manager and deputy manager were appropriately qualified and worked well together to support people using the service and staff.

• People and their relatives gave positive feedback about the management team. Comments included, "The manager seems very nice. We do see him out and about", "[The registered manager] does attend the residents' meetings, which is positive" and "[The deputy manager] is a fount of all knowledge – extremely helpful."
• Staff felt supported by the registered manger and deputy manager. They told us, "Our managers are very good listeners, they listen and try to find a solution. We have in the past raised about the need for more staff and staff was increased" and "Yes, I feel fine about telling my manager if I have a concern. They want us to do a good job and will listen to what we have to say as we all want to give our residents good care."
• The provider had processes to monitor the quality of services provided and make improvements as required. They used things going wrong in the service as a learning opportunity and shared the learning with the staff team to improve care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider engaged with people using the service and other stakeholders. A sign in the reception in rainbow colours read that everyone was welcome in the home.
• Cultural days such as Pride were celebrated as well as religious days such as Christmas.
• The provider asked for feedback and views, and kept people informed of changes in the service. This included a three monthly newsletter. One relative confirmed, "I am happy with the feedback and they tell me what's going on. I can ask questions."
• Care plans considered people's protected characteristics and provided information about how to support these. For example, identifying people's communication needs and providing the right support.
• People confirmed residents' meetings were held but noted none had been held recently.
• Team meetings were held to share information and give staff the opportunity to raise any issues. Group supervision for staff included discussions about protected characteristics to help embed best practice. One staff member confirmed, "Every 3 months there is a big staff meeting. It is useful. They (management) ask us if we have any concerns. We are told about any improvements needed. We get updates if families have commented, and they tell us about any new policies."
• The service had 'speak up' champions who were available to staff to encourage them to speak up and raise concerns if they had them. They ensured that people who spoke up were thanked, the issues they raised responded to and that the person speaking up received feedback on the actions taken.
• Additionally, staff had the option of using 'cause for concern' forms which they could leave in a comments box only the registered manager had access to. There were also 'wellbeing' champions available to support staff.
• The registered manager told us in 2021 for World Mental Health Day the service invited an external organisation to the home to discuss the wellbeing of people using the service and staff. Following on from this the registered manager began a monthly surgery for the staff and created a well being board. They informed us as a result of their investment in staff wellbeing, sickness has reduced by 80% in 2023.
• The registered manager showed us a number of surveys they had completed to obtain feedback from people and their relatives. A resident survey was completed in October 2022 and where people could not communicate verbally, staff used photos to receive feedback. Other surveys included feedback around menus and activities.
• To get feedback from people who did not communicate verbally, the registered manager introduced a pictorial feedback form with colour coded emoji faces so people could indicate how they felt about the activities they were offered.
• There were also suggestion boxes around the home and the registered manager reviewed any comments weekly. These processes supported people and their relatives to give feedback in a variety of ways so the provider could make improvements.

Continuous learning and improving care
• The provider had systems for assessing, monitoring and mitigating risk and improving the quality of the service which included checks and audits to help ensure continuous learning and improving care. Audits were analysed to identify issues, learn lessons and action plans were implemented where these were needed to make improvements.
• The provider used a 'dignity in care' assessment tool to assess the effectiveness of dignity in the service.
• The provider supported staff to develop their practice. For example, through case studies for staff to see examples of real life scenarios and how improvements had been made.
• A monthly staffing review and planning meeting discussed staffing and recruitment. This included observations and feedback of staffing levels, and help to make sure there were enough, competent staff to meet people's needs. Through supervision and appraisals, the registered and deputy managers were able to support staff to progress into key senior roles
• For more senior staff, monthly clinical governance meetings included actions from the previous meeting, a review of people's clinical needs, a review of safeguarding alerts, an analysis for incidents and accidents, clinical policy and training statistics. This gave the senior team an overview of what was happening in the service and helped them to plan and improve service delivery.
• The registered manager told us they were a 'dignity' champion and they had dignity cards people could complete to give feedback. A respite resident advised they did not know where things such as the dining room and hairdresser were when they first arrived. In response the provider created an orientation pack for new residents to show them where everything is in the home.

Working in partnership with others
• Records indicated the provider worked with other professionals to maintain people's wellbeing. These included the GP and community nurse which had improved how referrals to other services were made.
• Where appropriate they shared information with other relevant agencies, such as the local authority, for the benefit of people who used the service.
• The provider attended local authority forums to share best practice. For example, the registered manager told us they had raised the issue of not receiving safeguarding outcomes from the local authority. This has improved communication with the local authority, and the home now receives written outcomes from the safeguarding team.
• To help reduce the number of falls in the home, the provider worked with The Royal Society for the Prevention of Accidents (RoSPA).
• The provider had engaged with Kingston University to look at research around the sensory needs of people living with dementia and as a result has purchased more sensory activities for the service.
•As part of the provider working in partnership with other agencies to improve care, they used guidance from the National Institute for Health and Care Excellence (NICE) and implemented a programme to reduce urinary tract infections which included a 6 monthly evaluation to provide oversight and to be used in discussions with the GP.
• The provider had created relationships within their community. In addition to religious leaders visiting the home, people were supported to attend their place of worship. At Easter the service hosted an Easter egg hunt for children in the community. They worked with the British Legion to fund raise for their poppy appeal and have participated in other fund-raising events such as cancer research.