

Majesticare Blenheim Limited

Blenheim House Care Home

Inspection report

27 Shurnhold
Melksham
SN12 8DD

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05 November 2019

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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

About the service

Blenheim Care Home is a care home and can accommodate up to 85 people across four separate units, each with separate shared space. One of the units specialises in providing care to people living with dementia.

People's experience of using this service and what we found

We saw many examples of positive engagement between people and staff. However, there was an over use of endearment terms by staff during conversations with people. The registered manager must take the opportunity to assess the overuse of terms of endearment by staff during conversations and when delivering personal care.

Individual risks were assessed, and action plans were developed on the risk reducing measures. Records were not consistently maintained where there were actions to monitor food and fluid or repositioning.

We recommended the provider seek from a reputable source guidance on the monitoring of food and fluid intake and on record keeping

Care plans overall were person centred and reviewed as people's needs changed. We found daily reports were generic, but this could be the system that does not allow for more information to be documented.

The registered manager acted on our observations to ensure people were protected from potential harm.

People felt safe living at the home and relatives were confident their family members were safe with the staff. Relatives felt informed about important events.

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.

People's comments reflected their views of staff being kind and caring. We saw many examples of good interactions with staff. People were asked about their care and relatives said they were invited to reviews. The opinions from people was they felt valued most of the time. People's rights were respected.

There was a full programme of events which included group and one to one activity. People were having virtual reality experiences such as visits to places of interests.

There were systems in place to support staff with their roles and their responsibilities. New staff received an induction when they started their employment at the home. Staff had attended mandatory training set by the provider and there were opportunities for vocational qualifications. One to one supervisions meetings

were regular and where staff discussed with their line manager concerns, training and personal development.

People told us the meals were good and choices were available at each mealtime.

There were safe systems of medicine management. People were supported with their ongoing health and there was access to community NHS facilities such as dentists and opticians. Healthcare professionals said there was a visible "management" presence and referrals were timely and appropriate. People knew the registered manager and the procedures for making complaints, which were taken seriously.

Quality assurance systems were effective. Audits were specific to each unit and action plans were monitored by the registered manager and operations manager. The views of people, relatives and staff were gained using surveys. The registered manager had developed an action plan on developing the service from the feedback received.

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

Rating at last inspection

The last rating for this service was requires improvement (published 26 November 2018). Since this rating was awarded the provider has altered its legal entity. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected

This was a planned inspection based on the previous rating.

Follow up

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Details are in our safe findings below

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good ●

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good ●

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good ●

The service was well-led.

Details are in our well-Led findings below.

Blenheim House Care Home

Detailed findings

Background to this inspection

The inspection

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

Inspection team

This inspection was carried out by three inspectors 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.

Service and service type

Blenheim Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection

This inspection was unannounced on the first day. We told the registered manager the date of the second visit.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We used all of this information to plan our inspection.

During the inspection-

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. We spoke with 11 people and four relatives. We spoke with eight staff, the chef and housekeeping staff. The head of care, registered manager and head of dementia and supporting manager for Blenheim

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at five 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 also reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Is the service safe?

Our findings

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

Since the last inspection there was change in legal entity. This is the first inspection for this newly registered service. This key question has been rated as Good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people's safety had been identified and risk reducing measures were documented in their care plans for staff to follow. We saw people at risk of falling had assessments in place with measures such as staff ensuring the person was wearing appropriate footwear.
- There were other risk assessments associated with personal care and with maintaining a safe environment. Moving and handling risk assessments were developed for people with needs around their mobility.
- The assessments and care plans on safe environment, mobility and tissue viability detailed that due to a fall one person was cared for in bed. The staff were advised to use slide sheets to reposition four hourly and not to reposition onto the left side. Where it was documented we noted that staff had assisted the person to their left side and at other times they were not repositioned. The registered manager took immediate action and added additional information to the hand-held devices used by staff. The registered manager was to carry out supervisions with staff who had repositioned the person to their left side when they were given guidance not to. The registered manager investigated the source of the advice and the medical staff said the "advice was overcautious."
- During the inspection we saw two people being assisted by staff to move around the premises in wheelchairs. We saw the foot plates were not used when staff were supporting the person in their wheelchair which meant people were placed at potential risk of harm. A supervision note was sent to all staff who read and signed the directive to show their understanding. The guidance around footplates was detailed in the supervision notes.
- People at risk of falling had been assessed to see if any equipment was needed to support them. We saw people had sensor systems and crash mats in place. These alerted staff if the person was mobile and may need assistance, or if they fell from bed, their fall was cushioned.
- There were people, who at times, show signs of distress and frustration.

Emotional support plans were developed to give staff guidance on how to manage these situations. Where there were behaviours that challenged the staff and others, there was a debrief. During the debrief the actions from staff were reviewed and where guidance followed was not effective, the care plans was updated. A member of staff said "We try and take people to a quiet area or a walk around the garden. The key distractions are highlighted in the care plans."

Systems and processes to safeguard people from the risk of abuse

- People were kept safe from the risk of harm because systems and processes that safeguard people from abuse were in place. The staff had attended safeguarding of adults training and were knowledgeable about

their responsibilities to report abuse.

- People said they felt safe living at the home and relatives we spoke with were confident their family members were safe with the staff that worked at the home.

Staffing and recruitment

- People were supported by staff who had been recruited following safe recruitment processes. New staff were appointed following satisfactory reference and background checks. These included Disclosure and Barring Service (DBS) clearance. The DBS helps employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people.
- The staffing levels at the home were supported by agency staff, particularly at night. The service had profiles for each agency staff member from the staffing agency. These profiles gave the home management team an overview of the staff member, to ensure they had the skills needed.
- The number of staff needed was decided by a dependency calculation, based on assessments of people's needs.
- The staff said the numbers of staff on duty were mainly adequate to meet people's needs.

Using medicines safely

- Medicine systems were safely managed. People's medicines were administered as prescribed. Protocols were in place for medicines to be administered "when required". Appropriate mental capacity assessments were in place for administering medicines covertly (disguised) where people lacked capacity to make this decision. There were clear procedures where medicines were administered covertly (disguised).
- External and internal audits of medicines had taken place and where shortfalls were identified action was taken to ensure the safe management of medicines.
- The home used an electronic medicines system, which prompted safe medicines management and administration. We observed medicines administration and saw the system alerted the staff member of the time the person had received their previous medicines. This ensured people were not at risk of receiving too high a dose.
- The electronic system contained guidance for staff to follow and included a photograph of the person. This helped the staff member to ensure they were giving the right medicines to the right person and they were following the prescriber's guidance.

Preventing and controlling infection

- The home was clean, tidy and free from unpleasant smells.

Learning lessons when things go wrong

- The staff documented incidents and accidents which the registered manager reviewed. Counselling opportunities were offered to staff as part of the debrief conversations. There was an analysis of each event and a record of the incidents and the actions taken. The staff received feedback from the registered manager on the analysis from the monthly audits and guidance was given on how to prevent reoccurrence of the same events.

Is the service effective?

Our findings

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

Since the last inspection there was change in legal entity. This is the first inspection for this newly registered service. This key question has been rated as Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- There were people with complex needs in relation to their eating and drinking. Where food and fluid intake was to be monitored the care plans lacked guidance although the meals served met people's dietary requirements. For example, fluid intake targets. Records were inconsistent for people who had been assessed as needing their fluid intake monitored.
- Meals and fluid charts were not completed for one person on "nutrition watch". For example, there were no entries for breakfast, lunch and supper on the 28 October. On the 30 October there was an entry for breakfast and for lunch the staff had documented lunch was offered but refused. On the 1 November there was no entry for lunch and on the 3 November, there was no entry for tea time. This meant the staff could not be certain if the person had eaten.
- Records for six people showed they often drank as much as they were offered. On multiple dates between 1 October and 3 November 2019, records showed these people were offered less than 1000ml. While no target intake was detailed for these people, they all had potential to drink more when offered as they often did so on other days. It was unclear if this was a record keeping issue or if staff were not offering drinks as often as they should.

We recommend the provider seek from a reputable source guidance on the monitoring of food and fluid intake and on record keeping

- People were offered choices at meal times. On the ground floor of the home we saw the chef engaging with people and asking them what they would like to eat.
- Menus were reviewed by an NHS dietician prior to being published in the home. The registered manager advised us this was to ensure the meals offered would meet people's health needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- There were inconsistencies in the records of monitoring checks. It was not always possible to tell if this was due to staff record keeping shortfalls, or if this related to poor practice. For example, the repositioning chart for one person from the 28 October to 3 November 2019 was incomplete. The registered manager told us an investigation of the electronic system and recording was to be discussed with staff.
- People were supported with their ongoing healthcare needs. Records detailed people's medical condition and where there were healthcare visits the staff documented the nature and outcomes of the visits. There

were routine GP visits and the staff said the support from the GP's was good and there were partnership working with healthcare professionals.

- People had access to NHS facilities such as the dentists and opticians. The staff told us people were referred to community specialists such as speech and language therapists.
- Oral Health assessment were linked to care plans and for some people it was part of their personal care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Procedures were followed for people seeking admission to the home. Assessments of needs which included a review of staffing levels were completed prior to people receiving care at the service. The assessment process included consultation with the person about how they managed their care and about their preferences. Information was also gathered on people's life story, relationships, hobbies and interests. Care assessments were provided where the placement was funded by continuing health care or the local authority.
- Good practice guidance such as NICE and Skills for Care were used to achieve effective outcomes for people. For example, oral health

Staff support: induction, training, skills and experience

- People's care was delivered by staff that were skilled and supported to carry out the roles they were employed to perform. Mandatory training was set by the provider and the matrix showed staff were up to date with this training. The training staff had attended included safeguarding of adults, dementia awareness, first aid and infection control.
- The registered manager said there were opportunity for vocational qualifications and 30 staff were registered on the Skills for Care level 2 training. The registered manager said two staff were on the care practitioner course.
- There was a 12 week induction for new staff. However, some staff said there were some issues with accessing procedures linked to the eLearning induction. The registered manager had developed a work around to ensure staff were aware of the policies and procedures.
- One to one supervision meetings were quarterly with the line manager. The matrix of supervisions showed some meetings were overdue and was included in the improvement plan. This meant supervision was an area identified for improvement.

Adapting service, design, decoration to meet people's needs

- Blenheim Care Home was set in secure grounds with accessible garden spaces, safe walkways and shaded areas. During the inspection we saw people and their visitors access the outdoor space. This area was well used, with people having refreshment on the terrace and taking part in a reminiscence activity.
- The design of the service supported people using mobility equipment to maintain their independence. We saw people using motorised wheelchairs, which had plenty of space for turning and accessing different parts of the home.
- Since the last inspection the provider had made improvements to the environment. People, relatives and staff had all been consulted about what they thought would improve the environment for people living with dementia. One relative told us they had been involved in creating the music area and visited charity shops looking for items.
- The provider had opened the doors on the first floor where people with dementia lived. Small areas had been created where people could stop and engage. Rooms had been developed to provide more opportunity for people to reminisce or carry out activities. A small room had been decorated to represent a train carriage, another was a sweet shop. This meant people could move around freely without being confined in a small area.
- People's private space was personalised with items of personal furniture, family photographs, art work and

memorabilia. The comments from people we spoke with included "Homely, own furniture. We both had a room each, but it was our choice to have a bedroom and a sitting room. We love going out on the balcony." "Lovely garden at the back, overlooking green fields. A nice setting". "Like the outdoor space, bit of a wonder, like being in the country." "Lovely view, it's just like the view that we used to have at home when we first came down [to live in this part of the world]."

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

- The assessments for people's capacity around some specific decisions was not in place. For two people this included the decision to not use foot plates when self-propelling in their wheelchairs. We discussed this with the registered manager, who informed us they would implement the assessments and follow the appropriate process.
- Where people lacked the mental capacity to consent to decisions about their daily care and treatment, this had been assessed. There were best interest decisions made and DoLS applications were submitted to the local authority. When applications were waiting approval, these were reviewed to ensure they remained relevant.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Since the last rated inspection there were changes in legal entity. This is the first inspection for this newly registered service. This key question has been rated Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence

- We observed mostly positive interactions, where people were supported with their dignity and independence. However, some interactions which could have better promoted people's dignity. These included observing a staff member who was distracted when supporting a person and walked away from them after offering to help.
- The head of care advised us some people may still need additional assistance after seeing to their own needs. They told us the staff would offer the person help with their personal care a little later in the day. This was to not stop the person completing their routine to the best of their ability.
- We observed staff knocking on bedroom doors and asking people if they could enter. We observed staff speaking to people in a kind and respectful manner.
- People said the staff were caring. We saw many examples of good interaction with staff. People's rights were respected. One person we spoke with said "definitely dignity and respect, [Privacy] knock on my door, call out," and a relative said, "generally treated with respect, know she has spoken out [re dignity]."
- Staff promoted people moving around the home independently. We observed staff promptly getting people's mobility aids if the person had forgotten them, so they could continue with their journey.

Ensuring people are well treated and supported; respecting equality and diversity

- We observed positive exchanges and interactions between staff and people. One staff member was greeted warmly by a person who told them they had missed seeing them. Another person blew a kiss to a staff member as they left their bedroom after supporting them. There was a genuine affection between people and some members of staff.
- Comments from people about the staff's caring manner towards them included "reasonable rapport, things followed up, respect between us, good relationship in a way". "Carers very good-yes I would say caring." "Cares fine, good care, respect you. Can still have an amusing time. Treated as a human being- enjoy being with people." "Staff seem much happier now."
- Comments from relatives included "good relationship with me, get on well. Have a good relationship with Mum, tell me if they are worried about Mum." "Regular core of staff, occasionally new ones but fine." "Fantastic personality- carers Mums best friends- very happy."
- We observed staff show compassion to family member of one person on end of life care. The staff went to great extent to contact families and ensured the person had regular checks. When staff discussed this person they showed empathy for the person's loved ones.
- Although delivered with positive intentions, the terminology used by some staff risked being inappropriate. We some staff frequently using terms of endearment which would not be appreciated by

each person. These included calling people, "sweetie", "darling", "my love". One person told us they disliked being called these names, this wasn't recorded in their care plan and they were visibly frustrated when staff continued to use this approach.

- There were some areas of kind and person-centred wording in people's care plans, to promote respecting the different ways people needed to be supported. For one person this included, 'Approach [person] with a warm and welcoming approach, use a soft tone, reduce communication and attempt to establish what might be causing her distress. [Person] needs to see a calmness in yourself to feel relaxed in herself.'
- People's care plans included their preferences and needs regarding their sexuality and identity. Staff received training in supporting and promoting equality and diversity.

Supporting people to express their views and be involved in making decisions about their care

- People could attend meetings at the home with their family member. We saw there had been some mixed feedback received at one meeting about the quality of the food. To address this, people's feedback was sought in the weeks which followed, and changes made accordingly.
- Relatives comments included "any issues, [I] e-mail them then I've got a trail. Get back to me straight away. When she first came Mum had a room overlooking the car park at the back, so waited until a room overlooking the garden became free and took it." "Talk [care plans] through with Mum. She didn't like one tablet, so they said your decision, GP review tablet removed."
- People were asked about their care and relatives said they were invited to reviews. Their opinions were valued.

Is the service responsive?

Our findings

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

Since the last rated inspection there was a change in legal entity. This is the first inspection for this newly registered service. This key question has been rated Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People had care plans in place which gave an overview of what was important to them, as well as their care needs and preferences. We found there were some areas where the care plans could be improved. Daily reports focused on the task and less on the individual.
- Care plans were reviewed monthly and updated if people's needs had changed.
- The head of care had designed a training tool to help staff develop the content of people's care plans. This was to ensure all important information was included and accessible to staff about how the person would like to be cared for.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- For people who required hearing and visual aids, their needs were documented in their care plans. Staff knew what they required and any support they needed to provide to help meet people's audio and visual communication 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

- People were supported by a team of coordinators to pursue their interests and hobbies as well as experiencing new activities. The programme of activities was led by a team of four coordinators and the scope and range of events was widened from people's feedback.
- There were inclusive trips organised for people to visit places of interest, local pubs and theatres. There were creative therapies for people to learn watercolour painting and for people to pursue interests including gardening and craft workshops. For people who preferred one to one activities or small group events there were quizzes, board games, puzzles, games and reminiscence sessions.
- People told us "always things to do. List goes around, choose to join in or not. I go along to the talks, very varied programme, very interesting. [I] enjoy the entertainment." "Since [name of lifestyle coordinator] came more going on, can't take up all the offers." "Watercolour painting has been an interest of mine it has started up here [Name of artist] comes in." "Taken out a couple of times [trips]. Had a good pub lunch."
- Relatives told us "when Mum doesn't join in, [I] know that something is not right." "Does join in- some things she can't do. [Name of lifestyle coordinator] amazing, takes things on board."

Improving care quality in response to complaints or concerns

- The complaints procedure was clearly displayed in the building and outlines how to make formal complaints and if necessary how to escalate them to the organisation.
- People told us they knew the registered manager and the procedures for making complaints. They said there were meetings with people and relatives and their concerns were taken seriously.

End of life care and support

- There were people receiving care and support from the staff and external hospices during their end of life. There was appropriate documentation on the person's wishes which included Do not attempt resuscitation (DNAR) and treatment escalation plans (TEP). While one person's wishes was for pain free care there was little detail on advanced decisions such as priorities of care or funeral arrangements. The care plan stated this was to be discussed with relatives at the review due in November 2019.

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.

Since the last rated inspection there was a change of legal entity. This is the first inspection for this newly registered service. This key question has been rated 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 head of care told us the values of the organisation and explained how they were put into daily practice. They said it was about the "involvement of people and relatives, supporting people on a one to one. Building trust with people. If I say I was going to do it, I do it. Listening it's not always about doing."
- Staff told us about the impact the values on the organisation had on their practice. A member of staff said, "I believe I can only follow the values because I am here for the residents and to support staff." Another member of staff said, "I am caring I am very creative, and I am compassionate." Some staff told us they felt valued and the registered manager was approachable and had introduced changes which had positive impact on the quality of care people received. However, some staff said the support from senior managers could improve. These staff said there was little recognition and felt disconnected from the other units. We gave the registered manager this feedback.

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 providers understood their regulatory requirements to report notifiable incidents to CQC and the local authority. They understood their responsibility to be open and honest when things went wrong.
- Senior staff were knowledgeable about their responsibility towards Duty of Candor. They said accidents and incidents were reported to the registered manager, then families and where appropriate CQC notification or the local authority as a referral.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A registered manager was in post. The registered manager explained the impact their leadership style had on how outcomes were achieved. The registered manager said that their role included "supporting the staff and responding to people's needs. I am managing somebody else's home. I listen to their comments. I have recorded all the requests and I respond to them."
- The registered manager was supported by senior managers and systems were in place for staff to receive feedback and support from their line manager. A general staff meeting occurred in October to share with staff the changes of legal entity and to discuss recruitment. While feedback about teams was good some staff said team cultures could be improved.
- There were a range of audits to assess the quality of service delivery. Audits were specific to each unit and action plans were based on the improvements needed. For example, the accident audit in the nursing unit

had identified the risk reducing measures necessary to prevent one person from further falls. In the dementia and residential units, it was identified that staff were not consistently attending daily meetings. The actions were for the head of care to be present at meetings until there was an improvement in attendance. Staff told us the registered manager and operation manager signed the audits to confirm they were completed.

- We spoke with the providers dementia lead who told us they had been working full time at the service since the last inspection. They had provided staff with dementia training and had mentored senior staff to improve dementia care and support. They carried out audits of dementia care and identified what needed to improve. They had worked with families and staff to make improvements

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Surveys were used to gain the views of people, relatives and staff about the service. There was maximum positive feedback from staff about training and concerns. However, there were some negative comments regarding involvement and management. People gave high scores in areas such as staff, well-being, meals and drink. Scores were lower for accommodation, laundry and social. The registered manager has responded by developing an improvement plan on how feedback will be addressed.

Continuous learning and improving care; Working in partnership with others

- We received positive feedback from health care professionals. They said there was a visible "management" presence whenever they visited. Another community healthcare professional said the staff made referrals were "appropriate" and were made in a timely manner. Another healthcare professional said, "I would recommend this home to anyone."

- There were external visits from the local authority commissioning and from the Clinical Commissioning Group (CCG). The commissioners visit report detailed the outcomes assessed and advice was provided on areas for improvement. The CCG visit dated had identified shortfalls with medicines and the registered manager responded to the recommendations made. For example, another supplying pharmacy was being used.

- The registered manager told us about "Continued being me" and "Star Catching" projects. The registered manager said people were involved in the selection of staff and about group recruitment where candidates were observed against the values of the organisation.

- People were supported to have a variety of virtual reality experiences. For example, one person experienced a long journey" in a vintage train carriage, to see the penguins in Antarctica.

- The registered manager told us there was partnership working as "to promote shared learning [we] invite agencies and relatives to attend training courses. The staff were supported with developing their skills to improve sustainability. The registered manager said progression was evident.