Eagle View Care Home Limited

Eagle View Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 30 November and 1 December 2016 and was unannounced. We last inspected this service on 4 September 2015 when the service was meeting the regulations. We had made recommendations about the environment and support for people when eating and drinking. At this inspection we found that these areas had improved.

Eagle View Care Home offers accommodation and personal care for up to 40 older people or people living with dementia. No nursing care is offered at this service. There were 39 people resident at the service on the day we inspected.

There was 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.

There were sufficient numbers of staff employed to meet people's individual needs. Staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with people who may be vulnerable because they were living with dementia worked at the service.

People and their relatives told us that they felt safe living at the home. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Risk assessments identified any areas of concern around people's care and support needs, and there were management plans in place to reduce these risks whilst promoting people's independence.

Staff received induction training when they were newly employed and had on-going training provided for them. This included training on safeguarding adults and the Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS).

We checked medication systems and saw that medicines were recorded, stored, administered and disposed of safely on the day of this inspection. We did identify that medicine room temperatures had been recorded as too high in the summer months which the provider would need to address so that medicines were stored safely. Staff who had responsibility for the administration of medication had received appropriate training.

People told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive interactions between people who lived at the home, visitors and staff. People told us they were made welcome at the home and were kept informed about their relative's well-being.

Activities were organised by an activities co-ordinator. Staff also assisted with activities in order that people received some stimulation. They spent time talking to people which helped to avoid them feeling isolated.

Care plans recorded people's individual needs and how these should be met by staff. It was clear that staff knew people well and had a good understanding of their specific needs and how they wished to be supported.

The service had links with the local hospice and people had access to a specialist advice line at the local hospice. People who were at the end of their life were supported by clinical nurse specialists from the local hospice who gave us positive feedback about the care people received at this service.

We saw that people's nutritional needs had been assessed and people told us that they were very happy with the food provided. We observed that people's individual food and drink requirements were met and that they were offered a choice at each meal time.

The complaints procedure was accessible to people and the complaints we saw recorded had been managed following the services policy and procedure.

People told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement that would promote people's safety and well-being. Relatives told us that the registered manager was knowledgeable and approachable. Staff told us they felt well supported by the registered manager.

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 safeguarded because staff recognised and knew how to report abuse. Medicines were managed safely by staff who had received appropriate training.

Staff were recruited safely with background checks and references carried out by the registered manager before a person started work.

There was an emergency plan in place at the service in case of any unforeseen events.

Is the service effective?

Good

The service was effective.

Staff had received an induction and further training which gave them the knowledge they needed to carry out their role.

Staff were working within the principles of the Mental Capacity Act making sure that where people were unable to do so decisions were made in their best interests.

People received food and drinks according to their assessed needs. Where necessary referrals were made to healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with dignity and respect.

Staff involved people throughout the inspection asking what people needed help with and respecting their choices.

Where people needed palliative support staff involved the care homes team at the local hospice working proactively to support people

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and individual to each person. They had been reviewed and updated each month.

Activities were planned but the activities co-ordinator was absent and so members of staff worked together to provide some stimulation for people.

People knew how to complain. The complaints we saw recorded had been dealt with according to the service policy.

Is the service well-led?

Good

The service was well led.

There was a registered manager employed at the service was experienced. People told us that the registered manager was supportive.

The registered manager had made all statutory notifications to CQC in a timely manner.

There was an effective quality assurance system in place which identified areas for improvement.

Eagle View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 November and 1 December 2016 and was unannounced.

The inspection team was made up of one adult social care inspector, one specialist advisor whose specialism was mental health and dementia 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. They had experience of caring for people who used social care services.

Prior to the inspection we looked at all the information we held about the service including notifications sent to the Care Quality Commission (CQC). Statutory notifications contain information that the registered provider must submit to the CQC to inform us of important events that happen in the service. In addition, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority commissioners for information about the service. This information helped us to plan the inspection.

During the inspection we spoke with nine people who used the service, two relatives, two senior care workers and three care workers, the cook, a member of the domestic staff team, the administrator, the deputy manager and the registered manager. 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 observed staff practice throughout the day especially around meal times.

We reviewed care plans for four people, looking at risk assessments and medicine administration records for those people. We looked at six staff recruitment and training records and examined maintenance and servicing records for the service. In addition we looked at policies and procedures and audits that had been completed.

Following the inspection we contacted four social workers, one community psychiatric nurse and the hospice care homes team to ask for their feedback

Good

Is the service safe?

Our findings

People who used the service were able to convey to us that they felt safe and well cared for. One person said, "Oh yes I'm definitely safe here" and another said, "Yes I do [Feel safe]. If I want a cigarette I go outside and someone always sits with me even if they don't smoke." A relative said, "They are as safe as any of them can be. [Relative name] recently fractured [Their] hip and staff went with [Them] to the hospital until I could get there." They went on to tell us that if staff had any concerns they telephoned them. Our observations confirmed that people were safe.

Staff understood what it meant to keep people safe and we saw that they had been trained in safeguarding adults. The care workers we spoke to on the day of inspection demonstrated a good awareness of safeguarding and were able to describe key issues to consider in relation to potential abuse. They had received training in safeguarding adults. They told us they would be confident raising issues with the manager under the whistleblowing process. A whistle blower is a person who raises a concern about any wrongdoing in their workplace.

There had been four safeguarding concerns raised with CQC since the last inspection, three of which were referred to the local authority as safeguarding alerts by the registered manager. A safeguarding alert is the raising of a concern, suspicion or allegation of potential abuse or harm. These had been investigated and two had been taken out of the safeguarding process and dealt with through the service's disciplinary procedures. The third allegation had been substantiated by the local authority as a form of abuse. The allegation referred to an action by an agency worker which a permanent employee had witnessed but not reported. The agency was aware of the allegation and had taken their own actions. The permanent employee was dealt with through internal disciplinary procedures. The fourth concern was an event which had been thoroughly investigated and found to have no substance. People could be confident that the registered manager was clear about their responsibilities in relation to safeguarding people when there had been incidents of abuse and had demonstrated that they would respond to incidents appropriately.

Staff were recruited safely. We looked at six staff recruitment files and saw Disclosure and Barring Service (DBS) checks and two references for each person. DBS carries out background checks of prospective staff which are used by employers to make sure that the people they employ are suitable to work with people who used the service. The files contained information about the interview decision making process demonstrating how managers reached their decisions when employing people.

On the day of the inspection there were two senior care workers, six care workers, one cook, two cleaners, a laundry assistant, an administrator and the registered manager on duty caring for 39 people. The deputy manager came into work later in the morning to complete some paperwork. We were told that there were five care workers and a senior care worker on duty at night. The rotas confirmed that these numbers were consistent and staff told us that staffing was "OK."

The activities coordinator was temporarily absent from work which meant that care workers had to organise activities for people. Care workers were fitting activities in to their schedule as a temporary measure. The

registered manager had recognised that this could not be sustained long term and had secured funding to advertise the post temporarily and to advertise for an additional permanent post of 17 hours which would mean that activities were provided more consistently for people.

During the inspection we saw that staff responded quickly to people's needs. One person used their call bell and staff answered it within seconds. We saw that the lounges and sitting areas were supervised throughout the day and at mealtimes staff were in sufficient numbers to assist people with eating and drinking. There was sufficient staff deployed appropriately to meet people's needs.

People received their medicines safely. We observed a medicine round being carried out safely and competently. Sample signatures of care workers who administered medicines were in place and up to date. We were informed by the senior carer that they had undertaken an annual competency review and saw evidence of this within their training records. This meant that medicines were administered by people who were properly trained ensuring that people received their medicines safely.

Medicines for people were stored in the nurse's room on the first floor. Refrigerators for storing medicines were checked daily and were within the prescribed range but the room temperatures had been recorded as too warm between July and September 2016. July temperatures were noted to have ranged between 26C and 30C and between 4 -14 September 2016 temperatures of 28°C 29°C and 30°C were recorded. Royal Pharmaceutical Society guidance, "The Handling of Medicines in Social Care 2010" states, "If the temperature is more than 25C it is too hot."

The discrepancy section of the temperature recording document had not been completed to reflect the high temperatures but we did see that the issue had been identified by the registered manager and it had been added to their action plan. This had been raised as an issue during the previous inspection. Although temperatures were within normal limits at the inspection the provider would need to ensure that an appropriate cooling system was in place to ensure temperatures were consistently below 25°C in the summer months to prevent further re-occurrence.

Pharmacy services were currently being provided by a pharmacy that was new to the service. They used a monitored dose system (MDS) with medicines provided in blister packs. This was on a four week cycle. We were informed that this had recently changed when a new management company had taken over. Staff reported some initial problems in obtaining medicines in a timely manner from this pharmacy, particularly on Saturdays. We were informed that the service had experienced difficulties in obtaining standard medicines with a delay of days being reported. On reviewing the medicine administration records (MAR's) we identified one person who had waited four days before they had received one of their medicines in November 2016 as the pharmacy reported it as out of stock. We were told that this did not lead to unnecessary distress and had no impact on the person. The registered manager told us that they had already discussed the issue with the provider and identified it as a risk. They had discussed whether or not to return to the original pharmacy for consistency and better access which would ensure people received their prescriptions in a timely manner and decided that this would be the most appropriate option.

We checked the storage and recording of controlled drugs and carried out a random check of the stock. These were correct and up to date. Controlled drugs are subject to the Misuse of Drugs Act 1971 and require stricter legal controls to be applied to prevent them being misused, being obtained illegally or from causing harm.

Two people were receiving medicines covertly. Both had a diagnosis of dementia and were subject to deprivation of liberty authorisations. Within the MAR for both people there was a copy of a GP letter

indicating that they agreed to the administration of medicine covertly. Further exploration of care records indicated that professionals had been involved in discussions about what was in the best interest of the person. There was no obvious pharmacy involvement. National Institute for Health and Care Excellence (NICE) guidelines state that a "Best interest meeting involving a range of professionals including a pharmacist should take place." In this case it appeared that the process had not been followed in its entirety, although there was clear evidence of multi professional discussion. We discussed with the registered manager how they would make sure the process was followed in future and assurances were given that this would now be the procedure.

Weekly and monthly audits of medicines were carried out. The audits focused on checking stock and documentation as well as storage. Areas for improvement had been identified and acted upon.

During the inspection we checked people's personal monies kept in the safe by the service. This was managed by the administrator and registered manager. People could access their money, which was kept in a zipped wallet, at any time. The accounts for money were computerised and every transaction had a receipt recorded by the administrator. Head office could access these records for audit purposes. We checked one person's money which was correct. Because these processes were followed, creating an audit trail, there was less chance of financial abuse at this service.

Regular servicing and maintenance of equipment had taken place. On the day of the inspection there was a fire alarm check. The maintenance person told us they carried out regular checks of fire equipment, water temperatures and visual checks of other equipment. There were servicing agreements in place for the lift, fire safety equipment, gas and electric checks. The registered manager had taken advice from the fire safety and prevention officer for North Yorkshire fire brigade about celebratory decorations and we saw a letter containing their comments. This meant that the registered manager was doing all they could to maintain peoples safety by making sure that the equipment and the environment was safe and fit for purpose.

Any accidents or incidents were recorded and monitored by the registered manager. In the last month people had fallen seven times for a variety of reasons but there had not been any trends identified.

People were protected from the risks of infection because staff followed the infection control policies and procedures. When we had arrived on the first day of the inspection the entrance was malodorous and the alcohol gel dispenser was empty. When we returned to check the area later in the day there was no odour and the gel dispenser had been refilled. All other dispensers in the service were full. We spoke to two domestic staff who showed us their cleaning schedules. These covered every part of the service over a week ensuring each area was cleaned. Some areas had been missed in the previous week but it was explained that two staff had been absent and they had had to work alone. Overall we could see each area was cleaned thoroughly at least once every two weeks and everywhere was clean and tidy. We observed that staff washed their hands before and after providing care (including giving medication). Gloves and other personal protective equipment (PPE) was used by both care workers and ancillary staff at appropriate times.

The service had an emergency plan in place in case of unforeseen events such as flood or fire. The plan had identified the local school as the place of safety if people needed to be moved out of the service.

Good

Is the service effective?

Our findings

People told us that they were well looked after. One relative told us, "I can't speak highly enough of them. Everyone knows [Them] well[Relative]." We observed staff practice throughout the day and saw that staff were skilful in managing the diverse needs of people.

Staff had an induction when they started work at the service. One care worker told us, "I had an induction which helped me when I started work here." This covered practical areas and some training such as fire safety and safeguarding adults that the service considered to be mandatory. Within the first day staff were expected to complete fire safety awareness training and courses in dementia awareness and safeguarding adults within the first week. This meant that staff were properly prepared and supported with training to carry out their role.

Staff went on to be trained in areas that related to the people they cared for. They worked alongside more senior staff until they were able to work with confidence. The company used an online training system which staff could access to complete their training as well as face to face trainers for practical skills such as moving and handling. They completed training in subjects such as safeguarding adults, dementia, mental capacity act and deprivation of liberty safeguards, manual handling and food safety. This meant that people were supported by staff who knew what they were doing which reduced the risk of poor care.

The care workers we spoke with had worked in the home for between five and 13 years. They had all undertaken NVQ training up to Level 3 in care. A national vocational qualification is work based and is part of the Regulated Qualification Framework (RQF). They had undertaken updates of their training to maintain their skills and knowledge which was recorded in their training records. The company had invested in their workforce by giving them the knowledge and skills required to carry out their role.

Staff had received training around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS) and were aware of their responsibilities in respect of this legislation. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There were twenty five people being legally deprived of their liberty with authorisations in place and a further eight applications had been made. 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 and we found that they were.

People were complimentary about the food that was provided. We joined people who were having their lunch in the top floor and first floor dining rooms and we observed some people being supported with

eating and drinking. There were two choices of hot food but if people did not want either choice they could have an alternative. One person asked for a jacket potato with a filling instead of the food on offer and staff provided that immediately demonstrating that they had planned ahead by preparing alternatives to the menu. People had access to a variety of hot and cold drinks. There were tablecloths and napkins with cutlery laid out. Condiments were available. There were pictures of foods on the walls which highlighted to people that this was a dining room. Food was served from a heated trolley individually so that people received their food fresh and hot.

In the top floor dining room two people needed some assistance to eat and drink. At the last inspection in 2015 staff had not always focussed on the person when assisting them but at this inspection this had improved. Staff sat with people until they had finished eating and gave assistance at the table to cut up their food if necessary.

Staff used the malnutrition universal screening tool (MUST) to identify if people were at risk of malnutrition. Use of this tool enabled staff to identify the most appropriate action to take such as weighing more frequently or referring to the GP. Where people had difficulty swallowing we saw that they had been referred to a speech and language therapist and that advice had been given about food and drink texture. For instance we saw that one person had a pureed diet and another had a fork mashable diet. The cook had received training about how to prepare foods of different consistencies from the speech and language therapy team so knew what each texture should look like in practice. Where one person had weight loss they had been referred to the dietician in line with guidance from the MUST.

People had access to health professionals when they needed medical support. One person told us, "I have aches and pains but if it gets worse the doctor would visit and he is kind" and another said, "I asked to see the doctor and he arrived the day after." People's care records identified that district nurses, opticians, speech and language therapists and the hospice care home team were involved in their care. Staff were proactive in identifying when people required medical support. A clinical nurse specialist with the hospice team told us, "If any residents on the existing caseload have a change in their condition or care needs the team at Eagle View do not hesitate to contact either the care home support team or if out of hour's Pallcall for advice." Pallcall is a telephone advice line run by the local hospice.

The service had made improvements to the environment. At the inspection in 2015 we had seen that the furniture and carpets in some areas were very worn. Some furniture in the dining room was mismatched and the chairs were stained. The registered manager had told us at that inspection that there were plans in place to upgrade the environment and furniture. When we carried out this inspection we saw that the flooring and carpets on each corridor, in the lounges and some bedrooms had been replaced making it feel fresh and clean. In addition, seating had been replaced in the lounges.

In addition we had found at the last inspection that the service's environment was not as dementia friendly as it could have been but at this inspection there had been improvements. There were tactile wall hangings and pictures on the corridors and in communal areas. The additional signage and contrasting colour handrails assisted people with way finding, although signage could be improved further. Some bedroom doors had people's names and pictures on them although this had not been completed for everyone. The registered manager told us that the newly appointed management company had plans to further improve the environment.

Good

Is the service caring?

Our findings

We spent time in the communal areas of the home and saw that there was always a member of staff available to provide support to people. Staff approached people in a sensitive way and encouraged conversations. For example, we saw one member of staff speaking with a person about Christmas and another walking with a person talking to them quietly. We could see the person responding as they smiled and joined in with the conversation.

There was a calm, positive atmosphere throughout our visit. We saw that staff noticed when people needed assistance. Some people who were living with dementia were unable to tell us about their experiences in the home, so we spent time observing the interactions between the staff and the people they cared for. Interactions were positive and benefited people's wellbeing. Discussions with staff showed they had an interest in and a very caring attitude towards the people they supported. Staff interacted with people who appeared or preferred to be quiet. This made sure people did not feel isolated.

Staff were respectful when talking with people and used their preferred names. They knocked on people's doors and waited before entering. This meant staff respected people's privacy and dignity. One person said that they wanted a bath. There was a male member of staff on duty. The person was asked if it would be acceptable for the member of staff to assist them to which they agreed. The member of staff knocked on the bathroom door when the person had finished. The whole experience was discreet which was appreciated by this person. This encounter demonstrated the care that we saw staff take throughout the day when engaging with people who used the service.

One member of staff said, "We treat people as we want our own relatives to be treated. I always think about my mum." One person told us about a recent visit their relative had to make to the hospital following an injury. They said, "A member of staff went with her until I could get there. They comforted her; put their arms around her. It meant such a lot to her just knowing someone was there because she did not fully understand what was happening."

People and their relatives were involved in any discussions about their care and wellbeing. One relative told us, "They always include the relatives. They telephone me if there are any problems." A second relative said, "They're [Staff] there to support us. If we are anxious or something doesn't make sense they will explain things."

We observed that two people were involved with the hospice care homes team. One clinical nurse specialist (CNS) from the hospice team told us, "I do not have any concerns regarding the care home's ability to provide a high standard of end of life care with support from the district nurse and hospice community teams. In my opinion previous residents who have died during my involvement have always been treated with kindness and compassion as have their families." Staff told us they worked closely with the hospice care homes team in order to make sure people received care that reflected current best practice. People's care records confirmed their involvement clearly identifying when they had visited and what actions had been taken.

Some people had an Independent Mental Capacity Advocate (IMCA). An IMCA is a specific type of advocate whose role is to provide representation and support for particularly vulnerable people (aged 16 or over) who lack capacity and who are facing important decisions about certain serious life-changing events without a supportive network of family or friends. The registered manager told us they promoted an open door policy for people and their relatives. During the day we saw visitors coming and going and they were offered a warm welcome by staff. We spoke with two visitors who said they were very happy with the care their relatives received. One person told us, "They [staff] keep in regular contact and discuss any issues or changes with [name]."

Good

Is the service responsive?

Our findings

Relatives told us, "Staff meet her needs. Everyone knows her" and "Staff are brilliant and always include relatives." Peoples care plans were personalised and reflected individual needs. We saw that the information from needs assessments and risk assessments had been incorporated into an individual plan of care. The care plans included physical and social aspects of care; nutrition, continence, skin integrity, cognition, dependency rating and hygiene and dressing.

When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk. The risk assessments were up to date and had been reviewed.

Each person's care records included information about their GP, their medical conditions and any known allergies. There was information about the person's hobbies and interests; this gave staff useful information that they could use to get to know the person better and therefore provide more person-centred care. In addition there was detailed information about how each person's communication style. At our last inspection records had not been accessible to staff but we saw that staff were able to access care plans and other documents when they needed to at this inspection.

People's relatives who we spoke with were aware that there was a care plan and told us that staff had involved them in planning their relatives care. They all said that staff understood their relative's care and support needs. One relative told us they had input into their family member's care plan and said, "Staff give me an update about how she is every time I visit."

We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information, and more formal reviews had been organised by care co-ordinators from the local authority to review the person's care package.

We asked staff how they got to know about people's individual needs. They told us that they would read care plans; speak to the person concerned, and to their relatives and friends. One member of staff said, "We can always ask the seniors if we are unsure of anything."

We saw that care plans included a 'relative's communication record' that listed any discussions, either face to face or by telephone, held with people's relatives, and the topic of the conversation. The relatives who we spoke with confirmed they felt there was good communication between themselves and staff at the home.

Relatives told us that they could visit the home at any time and were made to feel welcome. They added that they were encouraged to visit over mealtimes and could have a meal if they wished. This meant that people enjoyed the social interaction of a mealtime with their family which assisted people to focus on eating and enjoying their meals. We observed one person assisting their relative to eat their lunch. Staff were ready to offer support but left the couple to enjoy the time together.

Despite the absence of the activities coordinator people were supported to take part in activities which provided some stimulation. The registered manager told us that the activities coordinator was absent and we saw that activities were reduced in their absence. This put additional pressure on the staff but they were interacting at all times with people. At the last inspection we saw that there were no dementia friendly activities but this time there were some activities in the home and in the local community. Members of staff had taken over the organisation of any activities during this period and until new activities personnel were appointed.

The activity programme included plans for non-denominational prayers and hymns, bingo, sing songs and quizzes. We saw an impromptu sing song taking place with a large group of people led by the administrator and one person was taken out to a singing for the brain activity run by the local Alzheimer's society. One person told us that their daughter brought in large print books from the local library as they liked to read. However, we did not see books or magazines for other people which they may have benefited from. Staff took time to stop and chat to people as did ancillary staff and interactions were unhurried. Staff helped people to do a crossword and there were a lot of one to one activities with members of staff doing word search or other word puzzles with people.

All members of staff acted as part of the team and we saw the maintenance person talking to a person and helped to give out drinks. The administrator's office was in the entrance and they interacted with people throughout the day.

We saw that the home's notice board displayed the activities programme so that people knew what was on offer that day. Relatives were invited to take part in activities. One relative said, "They celebrated Halloween, took people to the cenotaph for Remembrance Sunday, have newspapers for people to read and organised quizzes" when describing the activities they had observed. They said, "They've got it right."

We recommend that the provider refers to current guidance on activity for people in care homes.

People told us that they knew how to make a complaint and there was information made available for people telling them how to do so. We checked the complaints log and saw that there had been two complaints made to the home since September 2015. These were dealt with in line with the company policy and procedure. Relatives told us that they were confident the registered manager would deal with any complaints appropriately.

We saw that meetings were held for people who lived at the home and their relatives but these were infrequent and poorly attended. People told us that they were able to talk to the registered manager or any of the staff if they had concerns. Relatives told us that they were updated about their relative's condition and any events when they visited. This meant that people were able to discuss concerns and hear about what was happening at the service through some means.

Good

Is the service well-led?

Our findings

Eagle View is part of the Brand Careport. Careport has ten providers in their portfolio and Eagle View Limited is one of those. They have two locations registered with CQC one of which is Eagle View Care Home. The provider had recently appointed a management company to oversee the running of the service which required the registered manager to organise new paperwork and policies and procedures. The management company were being careful to release new policies in small batches to allow staff time to read and absorb them.

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

Relatives were positive in their feedback about the registered manager and told us they could approach them to talk about any problems they might have. We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that they all responded well. One relative said, "She's bright and breezy but knows her facts. She has such an insight. You have confidence in her" and a second person said, "She rings me if there are any problems."

Staff told us that they felt supported by the good management and leadership at the home. One member of staff said, "[Name of registered manager] is very good." Staff told us they would use the whistle blowing procedure if they needed to, and were confident the registered manager would protect their confidentiality.

We saw that there was an effective quality assurance system in place that included surveys, audits and meetings. Audits were carried out each month on health and safety, catering, infection control and medication. We saw that they highlighted any shortfalls in a corrective action plan which was shared with the provider. The registered manager told us that if any urgent shortfalls were identified, these were dealt with immediately. This was not always recorded as there was no written record of actions taken when temperature discrepancies were identified in medicine rooms in summer months although it was recorded as a need on their action plan. We saw that one person's medicine record did not have a photograph attached and the registered manager dealt with it straight away. The information gathered in the audits was fed into a quality key performance indicator (KPI) report that was submitted to the organisation's head office for analysis and monitoring purposes.

A satisfaction survey had been distributed to relatives in October 2015. The information in the surveys that had been returned to the home had been collated and analysed, and the outcome was displayed on the relative's notice board. This showed that the organisation was open about the feedback they had received.

Staff meetings were held on a regular basis. There were meetings for the full staff group and managers meetings were held monthly where they shared good practice and ideas. The minutes of these meetings showed that the dining experience, maintenance of the service and care matters had been discussed. Staff were required to sign the minutes of meetings to evidence they had read them. This ensured that all staff were aware of the topics discussed and the decisions made. Staff told us that these were 'two-way' meetings where they could express their views.

Staff described the culture of the home as "Friendly and caring" and one member of staff said, "I love working here." They told us that staff would learn from any accidents, complaints or incidents as they would talk about the issues at staff meetings and could make sure they did not occur again.