M. J. M. (Furnishings) Limited

Eagle Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Eagle Care Home on 24 September and 4 October 2018. Eagle Care Home is a care home which provides care and support for up to 33 older people. At the time of this inspection there were 27 people living at the service. 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. This was the first inspection of the service since a change of registered provider.

The service is on two floors with access to floors via stairs or a passenger lift. Shared living areas include three lounges on the ground floor, and a dining room. The service stands in its own grounds with garden areas.

There was a registered manager in post who was responsible for the day-to-day running of the service. 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 was a friendly welcoming environment and people said they felt Eagle Care Home was a homely place to live.People told us that they felt safe living at Eagle Care Home. Staff had received safeguarding training and understood how to recognise and report abuse. We observed warm and friendly interactions between staff and people throughout the inspection and it was evident staff knew people well. Staff were compassionate about caring for people at the end of their lives.

Risks to people's health and welfare were not always clearly documented for staff to be able to support people safely or effectively. Care plans were well organised, with information easy to find. However, these were not always detailed enough to ensure people's needs were met fully.

Medicines were not always managed safely, with areas requiring improvement, particularly around recording and 'as required' medicines.

Staff felt supported to carry out their work and they understood their roles and responsibilities. There were enough staff to support people; they worked well as a team and communicated continuously to meet people's needs.

Staff understood how to keep people safe from the spread of infection and infection control practice was mostly appropriate. There were some routine maintenance checks and staff knew how to report maintenance issues, although safety checks for premises and equipment were not always robust.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible; the policies and systems in the service support this practice. People's consent to care was appropriately sought within the legal requirements of the Mental Capacity Act.

People enjoyed the quality food and there were always drinks available. There were some activities provided and most people felt there was plenty to do.

There was a complaints process in place and people and relatives knew how to make a complaint. There had been no complaints since the service was registered under the new provider name. Visitors told us that they felt welcome within the home and able to visit whenever they wanted.

People and relatives felt the registered manager was visible and accessible to people and they were confident in the care that was being provided. Systems and processes for assessing and monitoring the quality of the provision were not fully robust or consistent. The registered manager was very responsive to feedback about the service and welcomed people's views.

You can see the action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were aware of individual risks to people, although risks to people and guidance for staff to support people safely was not always recorded in people's care plans.

People had their medicines on time, although recording was not clear for some aspects, such as creams and 'as required' medicines.

Equipment and premises checks were not sufficiently thorough.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to access healthcare services but care plans did not always reflect advice given by healthcare professionals.

Staff were supported through training and supervision to enable them to meet people's needs.

Staff had a basic understanding of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS).

People had a choice of food that met their individual needs and preferences.

Is the service caring?

Good

The service was caring.

People had positive relationships with staff and were supported to make decisions affecting their care and support.

Visitors were welcomed at any time.

People's independence, privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care planning was not always managed in line with their needs.

Activities were carried out and most people said they enjoyed these.

People were informed of how to raise a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance audits were not robust enough to thoroughly demonstrate how the quality of the provision was assessed and monitored.

The registered manager was very involved in the service and knew each person well. There were close working relationships with other professionals to support people's care.

Staff were supported and felt valued. There was a positive culture where staff were committed to meeting people's needs in a homely environment.

Eagle 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 September 2018 and 4 October 2018 and was unannounced. The inspection was undertaken on the first day by two adult social care 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. On the second day there was one adult social care inspector.

Before the inspection 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 reviewed the PIR and other information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with a range of people about the service; this included 10 people who lived at Eagle Care Home. During the inspection we spoke with four staff members, the cook, a domestic, the registered manager and the registered provider. We also spoke with six people's visitors, two visiting social workers, a visiting district nurse, a community matron and a physiotherapist.

We looked at care records of four people who lived at the service and recruitment records of three staff members. We also looked at records relating to the management of the service. In addition, we checked the building to ensure it was clean, hygienic and a safe place for people to live.

Requires Improvement

Is the service safe?

Our findings

There were some weaknesses in medicines management. The service's role in relation to medicines was clearly defined and described in relevant policies and procedures. There was a system in place for ordering medicines in time for them to be available when people needed them. Staff told us emergency, new or changed medication was supplied promptly by the dispensing pharmacy and we saw new medication delivered when necessary. The registered manager told us they had changed pharmacy and now had a good relationship with the pharmacist and an improved service.

Medication was delivered and checked in by the registered manager or senior member of staff and stored securely in a locked trolley in a locked medication room. The policy of the service referenced NICE guidance for managing medicines in care homes and guidance was summarised in a document in the medication administration records (MAR).

The senior carer who administered medicines on the day of our visit said they were new to the role. We spoke with the registered manager who told us they had assessed the member of staff and was confident in their abilities and we saw evidence of this on the member of staff's file. They said this member of staff would have been more closely supported in their new role if the inspection had not have been taking place.

We observed people supported appropriately with medicines and the senior carer worked in a methodical way. We saw they asked people if they wanted 'as required' (PRN) medicines before preparing them. Protocols were available for all PRN medication stating what the medicine was for and if the person had mental capacity to decide they needed it. However, these lacked detail; some did not state the safe interval between doses or the maximum dose which could be safely be administered in 24 hours. The service's medicines guidelines gave staff prompts about how to decide how much PRN medication to give when variable doses had been prescribed but these had not been followed. When a person used non-verbal communication to express pain, information for the signs staff should look for were not specific to the person.

One person who had recently been admitted to hospital had been prescribed PRN laxatives. The protocol did not state signs and symptoms or refer to records which would help staff encourage the person to take the medication when they needed it. The person's continence care plan had not been updated to include this information. Relevant records had been maintained routinely but neither the person's care plans nor the PRN protocol provided guidance to staff how to review the relevant chart or act to support the person to minimise the risk of further health issues related to this.

When PRN medication was given, the time it was administered had been recorded but the reverse of the MAR was not always used to record the reason for administration. People were supported to have their medicines when they needed it, such as time critical medication. However, recording of when medicines were taken was not always clear. For example, one person left the home during the day and their medication had been given to them so they could take it at the time they needed it. Staff spoke with the person when they returned and checked they had taken the medication. They had not written details of this

on the reverse of the MAR but only signed the MAR for 11.00am and 11.30am. The person's medication was prescribed for 11.00am and 3.00pm. This meant staff relied on memory or verbal information to ensure the medicines were administered at the right time, rather than documenting it at the time.

Some people had been prescribed topical creams or lotions which were stored in their bedrooms and a separate topical MAR (T-MAR) was used to record administration. Protocols with body maps were in place for these, but they did not always contain enough information to enable staff to apply topical medication when people needed it. Records of when creams were applied were not completed in line with the prescribed instructions.

During the morning medicines round, a tablet fell on the floor as the carer was preparing this for administration. The carer recovered it, sealed it in its original container and told us they put it in the domestic waste bin. The registered manager showed us a returns book for when medicines no longer needed had been recorded. Two large boxes contained medicines to be returned to the pharmacy but neither had a lid although they were stored in the locked medicines room. We spoke with a senior carer who told us if a person dropped a tablet, they would document it and telephone the person's GP. When we asked about the dropped tablet incident about three hours after the event, they were unable to recall what the medication was and had not documented the incident or told the registered manager. When we left the home at around 5.00pm no incident form had been completed and the person had not received replacement medication. This showed us staff did not understand their responsibilities to raise concerns and record safety incidents or concerns and the person had not received their medicine as prescribed.

We found risk assessments did not always result in detailed care plans to support people's health and welfare. Risk assessments had been carried out using current evidence based scoring tools such as for tissue viability, falls risk and malnutrition risk. Risk assessments in areas such as falls, pressure ulcers, mobility, malnutrition and pain had been carried out when people first went to the home and every month thereafter. However these did not always lead to detailed care plans which meant there was a risk people's health was not supported safely.

The above examples illustrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was visibly clean and we saw cleaning staff were busy throughout the inspection and they understood how to clean effectively. Staff had access to disposable gloves and aprons when managing particular tasks, such as people's personal care needs, to minimise the spread of infection. However, we noted a staff member who administered medicines, including eyedrops, wore a pair of gloves but did not change them or wash their hands between administering medicines to people. People and relatives said the home was clean. One person said, "They have a housekeeper and a cleaner it's all clean." There were posters and reminders around the home regarding good hygiene practice and regular handwashing.

Staff we spoke with knew how to identify safeguarding concerns and the procedures to follow if they were worried about any person. Staff told us they would report concerns without delay. Where one person sometimes showed behaviour that challenged we saw behaviour charts had been completed detailing antecedents, actual behaviour and actions taken by staff. Care staff understood the triggers for the person's behaviour and there was a care plan in place to guide staff as to how to minimise any risks to the person or others.

We saw staff regularly reminded people how to stay safe throughout the day. For example, people were reminded to take their time when walking, and to use any walking aids they may have. Staff were observant

of people when supporting them to stand or move and they were very patient, giving reassurance about safety.
Staff were recruited safely and staffing levels were appropriate to meet people's needs. The registered manager told us how they calculated staffing levels according to people's dependency needs and this was flexible to be adjusted as needs changed.

Throughout the inspection we saw care staff were always available to support people to stay safe and meet their needs in communal areas. People told us they felt safe. One person said, "I lock my door at night, I have my own key. They bring my tablets on time. It's clean here. Sometimes I think they could do with a few more staff when they are really busy, like if someone falls or is poorly. I have a buzzer on my wrist which is good as I sometimes wobble a bit." Another person said, "Whatever you need they are here for you. I feel safe".

One relative told us, "[My family member] feels better here. [They have] someone here all the time for [them]. They check [them] at night." Another relative said "They have been fantastic, they communicate and they couldn't be better. We feel comfortable now [our family member] is safe here."

Requires Improvement

Is the service effective?

Our findings

People had access to healthcare services. However, care plans did not provide guidance for staff to support people living with diabetes. One person received regular insulin injections and another received medication each day. Blood glucose monitoring was carried out by district or clinic nurses but results were not communicated to care staff. Advice given by a specialist nurse in a letter, to encourage one person to reduce sugar consumption due to high blood sugars had not led to a diabetes care plan and staff we spoke with were unaware of this advice. However, their nutrition care plan had been updated to state they had recent raised blood sugars and should be discouraged from eating cake and sweet foods. A list of people who required particular diets stated the person had 'no restrictions' and had not been updated. Both of these people were at risk of blood sugar instability but no care plans were in place about how staff would recognise the signs and symptoms or what action they should take. We found there was no risk assessment for one person who self-administered insulin. A medication care plan merely stated they were prescribed insulin but there was nothing to guide staff how to ensure the person was cared for safely.

One person had been assessed as having a high risk of developing pressure ulcers when they arrived to live at the home. Guidelines were in place from a local NHS Trust advised determining 'repositioning frequency according to clinical need'. A body map had been used to record checks made in January and April 2018. The care plan stated a profiling bed, an airflow cushion and mattress was in place. However, repositioning frequency was not recorded and the care plan did not direct staff to encourage and assist the person to change position. The personal care plan stated staff should 'monitor pressure areas daily when delivering personal care.' Staff said the person had a pressure area on their heel when they arrived at the home but the grade was not recorded. When we visited the service the person had a pressure ulcer on both heels but this was not recorded or updated in care plans. Staff said community nurses redressed the area. Staff told us the person wore protective boots when in bed. This was not documented in care plans. Daily care records did not refer to skin checks or pressure areas.

Another person who was at risk of developing pressure ulcers had a care plan that stated 'all equipment in place. Airflow mattress and profile bed' however it did not provide detailed advice for staff to support the person. Staff said they did not set up airflow mattresses and did not know what settings they were on. The information was not recorded in the care plan. Records showed both people had been checked hourly by night staff but did not record if they had been assisted or encouraged to change position in bed.

The above examples illustrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were able to do their jobs well. One person told us, "I know they are well trained because I can tell. It's not just about the training either, it's about having the right staff for the job. They've got a good bunch working here, they know what they're doing."

We saw staff had opportunities to complete training. We looked at training records on the first day of the inspection. The way in which these were recorded meant it was not easy to determine the skill level of the

staff team at any given time. We discussed this with the registered manager and by the time we returned for day two of the inspection, they had produced the information in a training matrix to show which staff had undergone different aspects of training. Where there were gaps in training, we saw this was scheduled. The registered manager carried out competency checks of staff practice as well as spot checks at different times of day. We saw records of staff supervision in line with the organisation's policy. Staff we spoke with said they had good levels of support through training and supervision.

People were supported to eat and drink enough to maintain a balanced diet. We observed breakfast served in the dining room. People arrived at different times throughout the morning and sat where they chose. The chef offered choices of fruit juice, cereals, tea or coffee and toast with marmalade or jam. A hot breakfast of sausage and beans was also offered. Different care staff came and went as they supervised and supported people into the dining room but a member of staff was always present while people were eating. Staff assisted people, for example, by buttering toast and cutting up food and everyone we saw was able to eat and drink independently.

The chef had a list of people's names and recorded what people had been given for breakfast, and what they had actually eaten. They also had access to a list showing people's particular dietary needs which included the support people needed, for example cutting up of food. Comments made on the meal were, "Very hot", "Oh yes, it was lovely", "It was lovely, just the way I like it" and "very nice." One person told us, "I'll have put weight on when they weigh me. The cook asks what we want." And another person said, "I like all the food they make here. Sometimes it is so nice I can't make a choice, so the cook always lets me have a bit of each."

At lunchtime, two people remained in their bedrooms; we spoke with them and they confirmed they chose to remain there. Both were eating independently. One person who chose to eat in a communal lounge said they chose to eat there because it was quieter. People all said the food was very good, there was always a good choice and they never felt hungry.

During the inspection we spoke with a physiotherapist and an NHS community Matron. They both spoke positively about the home and the care people received. The physiotherapist said they could always easily find staff to help them and thought staff referred appropriately and acted on advice. They said, "They are all very good, especially the registered manager." The matron said they visited frequently and referral forms usually had enough details. They said staff asked for advice and they believed they acted on it. They felt the registered manager was well informed and could always answer questions about people. They said they had not looked at care plans and were unsure if staff followed plans to reduce the risk of pressure ulcers.

Care files included a record of professional visits from GPs, district nurses, chiropodists and therapists. We saw advice recorded there was not used to create or update to care plans to inform and support care staff to follow professional advice. For example, a person had been seen by a community nurse then a GP who advised staff should check and monitor for pain, but this was not in the person's care plan. We discussed this with the registered manager who told us they did this and spoke with the person but did not record it as the person did not want medical intervention.

The premises were in the process of being refurbished and we saw there was a schedule in place for this to be completed. There was signage around the home to help people find their way round. Some people had their names on their own doors, although these were sometimes just written on a piece of paper and not personalised.
People had signed consent to photography, information sharing, medication administration, using a lap belt in a wheelchair and having their bedroom door locked but we saw limited evidence people had been

involved with or consented to their care plans. We saw during the home's daily routine, staff asked people their choices and preferences and gained consent before attempting to support them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards.

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. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. We noted a number of people had been referred to the local authority for a Deprivation of Liberty Safeguards assessment. The registered manager had ensured they made appropriate and timely applications and appropriate records were kept showing the correct process was followed. There was evidence of best interest meetings being held where this was required.

Good

Is the service caring?

Our findings

We spoke with one person who was leaving the home after a period of respite. They said they had been, "Very happy here." They asked if they could leave their own home and come back to live at Eagle Care Home. The person's relative confirmed they had been well cared for and had enjoyed their stay. They said they had been invited to return for a Halloween party in a few weeks and were hoping to stay for a week in the future.

We observed many interactions between care staff and people living in the home and they were all pleasant, cheerful, kind and supportive. The way staff spoke with people showed us they knew them well. Staff in all roles spoke clearly, offered choices, listened actively and waited for people to respond. Staff repeated information slowly if necessary and they were patient, treating people with kindness, respect, and compassion.

We spoke with two care staff and asked them individually to tell us about different people living in the home. They both knew details of people's lives, knew about their families and preferences and their care needs. The care staff had greater knowledge of people than the details recorded in care plans, for example about continence or pressure relief care. All staff told us how much they enjoyed working with people in the home and it was evident they had very caring dispositions.

Care staff said everyone living in the home had a bath or shower when they wanted to, at least once a week. This was not always recorded in daily records of personal care but people we saw were clean and tidy and wore clean clothes. People we spoke with said their personal care needs were met. One person said, "I just ask [the staff] when I fancy a shower, it's no trouble to them." All staff, within all roles, ensured people's dignity and privacy was promoted well.

People spoke freely to staff, calling them by name and in a way that showed they were comfortable asking for drinks, or care and support. There was friendly banter between people and staff. One person said, "I don't know what I'd do without them [the staff] because they are so good." Another person said, "All staff are very kind. They get me up in the morning and look after me right."

We saw one person became distressed during the meal service. Care staff knelt down beside them and quietly and discreetly asked what was wrong. We saw this was done with empathy and compassion and the person was reassured. At other times we saw people spontaneously hug staff and staff responded warmly with affection.

Relatives told us, "I can come at any time and never come across any problems. The staff are kind", "They are always cuddling my [family member] and giving them a hug. We can come at any time" and "The way staff speak to people, they are really nice and understanding. I can come at any time but I tend not to come at mealtimes."

Requires Improvement

Is the service responsive?

Our findings

The registered manager said pre-admission assessments had been carried out for everyone before they came to live at Eagle Care Home. They used this and assessments made by a social worker to ensure they could meet the needs of people before they came to live at the home.

People's records were legible, securely stored and available to relevant staff. However, we reviewed care files for four people and found care plans were not up to date, despite a review list having been signed each month. They were not up to date because we saw other information, including letters from hospital appointments and directions from senior staff following conversations with health professionals which had not led to new or updated care plans.

We saw a letter in one person's care record following their discharge from hospital which showed the person must complete exercises for 20 minutes three times every day. This information did not lead to a care plan and staff we spoke with were unaware what exercises the person should be encouraged to do. There was no reference to exercises having been done in the person's care record. One member of staff said the person "Should be doing exercises but we don't know what they are."
Several people had 'do not attempt resuscitation' (DNAR) forms in their care files and these had been discussed with the individual and were current. We saw people were asked about their wishes concerning the end of life and this was recorded in a document titled, 'Celebration of Life'. When a person had chosen not to discuss their wishes, this had been recorded. A person who was approaching end of life care had been reviewed by their doctor and anticipatory medicines had been prescribed and delivered to the home. This meant if their condition deteriorated, there would be no delay obtaining medicines to alleviate symptoms and keep them comfortable and pain free.

Care files included information about people's social history and preferences. We spoke with staff who knew about people's lives, family and interests and we observed staff interact with people and talk with them about people or things important to them such as family. One person had had once had two dogs and staff said they really enjoyed when people visited the home with dogs.

We observed activities in the morning and the afternoon with the service's activities coordinator. The singing activity lacked preparation since the activities organiser did not know the words of the songs to support people. When one person needed to go to the toilet the activity stopped when the activities organiser left the room; some people then wandered off and the activity fizzled out. The activity schedule did not always happen in practice and we observed on occasions, there were a number of people sitting passively for long periods of time.

Most people and relatives said there was enough to do. One person said, "We play bingo and have sing songs", another person said, "I'm not into activities, I can't stand. I enjoy some of the activities; we have a few entertainers doing older type music we all know, the singer is brilliant. If I wanted to go out staff would take me out." One relative said, "[My family member] loves singing, they had a party the other day and [they were] singing and dancing."

People and their relatives said they knew how to raise a complaint if they felt they needed to, but told us they did not need to do this. They said the staff and the registered manager were all approachable and they were confident any concerns raised would be addressed immediately. The complaints procedure was displayed prominently for people to see. The registered manager told us they were aware of the accessible information standard and would make information accessible in different formats if people needed this. The registered manager told us there had been no complaints received at the service. We saw many thank you cards and letters giving praise to staff for how they care for people who had been in the home.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place although they were not robust enough to demonstrate how thoroughly and consistently checks were made to ensure people received good care. For example, safety checks for some equipment were recorded, but not for all equipment. We saw a sling used with a hoist to lift a person, which had safety checks at six-monthly intervals carried out by an external company. However, there were no routine checks of the sling being carried out within the home, to ensure it remained safe for use. Hot water temperature checks were carried out and recorded, but we found water was too hot to touch in two of the taps we tested. We found a bath seat which was taped over a cracked area and posed a hazard to people's safety. The registered manager said they did daily walk rounds but these were not always documented.

The registered manager told us where equipment was on loan, such as beds, there were no internal safety checks carried out, although any faults were reported to the local authority loan stores. We saw records which showed wheelchair maintenance was done in January and August 2018 but no other records of checks were in place. Mattress checks were recorded monthly, but there was no indication of who had done these and the last audit was done in August 2018. Care plans showed information had been regularly reviewed, but our inspection found there were gaps in the information, particularly around health risks to people.

The above examples show there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where accidents and incidents had occurred, there was some analysis of these, and appropriate referrals were made to other professionals where necessary, such as the falls team. Where incidents needed to be referred to CQC we saw statutory notifications were sent.

The registered manager was enthusiastic and committed to providing high standards of care for people. They were very involved in people's care and support and knew each individual and their families, promoting good relationships. The registered manager told us they had an open door policy and we saw this was effective, with people, staff and relatives approaching them with ease.

The registered manager was supported by the registered provider and we saw evidence of regular visits made. We saw the registered provider was involved with the inspection process and in support of the registered manager.

Relatives we spoke with said they thought the home was well run and they all knew the registered manager. Comments included, "It's like one big family and everybody is friendly. Yes, I can talk to the manager. We have resident meetings we talk about what we would like to do, and it happens, it's always been good here. If you have anything that bothers you, you can go to the manager and they will help you with it,", "Everything here is good, all the residents and staff. You can ask for anything and they will do their best to get it. You can speak to the manager and staff like they are your family", "It doesn't matter what you need doing [the

registered manager] will do it" and [Registered manager's name] is straightforward and answers questions about [my family member]". Relatives told us they contributed to surveys and we saw results were positive.

Staff were given clear direction in their work and they told us there was good morale and respect for one another in the team. Staff meetings were held and we saw minutes of these, which gave information as well as praise to the staff team. Staff told us they felt valued and respected and said the registered manager gave good levels of individual support. The registered manager told us they valued the staff and knew if they supported them, then staff would be more effective at supporting the people. The registered manager told us they felt very proud of the home.

The registered manager told us they worked hard to foster relationships with other professionals and draw upon resources which would help them drive up standards and improve the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found risk assessments did not always result in detailed care plans for people's health, such as pressure care and diabetes. Equipment and premises checks were not sufficiently thorough. Topical medicines recording was not robust and PRN protocols lacked detail.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance audits were not robust enough to thoroughly demonstrate how the quality of the provision was assessed and monitored.