Green Pastures

Green Pastures Christian Nursing 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 30 March 2016. This was an unannounced inspection. Green Pastures Christian nursing home is registered to provide accommodation for up to 30 older people some of whom may have a form of dementia who require nursing or personal care. At the time of the inspection there were 29 people living at the service. The home was set on two floors which comprised of 3 separate units namely Galilee dementia unit downstairs as well as Jordan and Bethany units upstairs.

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. The registered manager worked closely with the business manager and a senior nurse.

People who were supported by the service felt safe. The staff had a clear understanding on how to safeguard the people and protect their health and well-being. There were systems in place to manage safe administration and storage of medicines administered through monitored dosage systems. However, there was no system to monitor the stock of people's prescribed medicines which were stored in boxes. Medication administration records (MAR) were not always completed to show when medication had been given or, if not taken the reason why. Thickening agents were not always stored safely.

There were enough suitably qualified and experienced staff to meet people's needs. People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care.

The registered manager had a good understanding of the Mental Capacity Act 2005. 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. However, staff had a mixed understanding of their responsibilities relating to the MCA.

Staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. However, the registered manager did not have a clear understanding of their responsibilities in relation to the application of DoLS.

The registered manager informed us of all notifiable incidents. The provider had quality assurances in place. However, these quality assurance systems were not always effective. The provider's policies needed updating. There was no whistleblowing policy in place.

There were sufficient staff to meet people's needs. The home had robust recruitment procedures and conducted background checks to ensure staff were suitable for their roles.

The provider had an infection control policy in place. Staff knew how to protect people from the potential risk of infection.

People received care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively.

People were supported to have their nutritional needs met. However, we saw the dining experience for people varied. In the downstairs dining room, staff looked rushed to complete lunch tasks in time for the church service.

People felt supported by competent staff. Staff benefitted from supervisions (one to one meetings with their line manager) and team meetings to help them meet the needs of the people they cared for.

There was a calm, warm and friendly atmosphere at the service. Staff we spoke with were motivated and inspired to give kind and compassionate care. Staff knew the people they cared for and what was important to them. Staff appreciated people's life histories and understood how these could influence the way people wanted to be cared for. People's choices and wishes were respected and recorded in their care records.

People had access to activities and stimulation from staff in the home. Activities were structured to people's interests. We observed people engaged in reminiscing and one to one activities.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

The registered manager had a clear plan to develop and improve the home. Staff spoke positively about the management and direction they had from the manager. The service had systems to enable people to provide feedback on the support they received.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we have required the provider to take at the end of this 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.

People received their medicines as prescribed. However. Medicines were not always stored safely and records were not always accurate.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager had a good understanding of the Mental Capacity Act 2005. However, not all staff understood their responsibilities relating to the MCA.

The registered manager did not have a clear understanding of their responsibilities in relation to the application of DoLS.

Staff had the knowledge and skills to meet people's needs.

People were supported to have their nutritional needs met.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were involved in their care.

People were supported by caring staff who treated them with dignity and respect.

Visitors to the service spoke highly of the staff and the care

delivered.

Is the service responsive?

Good

The service was responsive.

People received activities or stimulation which met their needs or preferences.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's care plans were current and reflected their needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to monitor the quality and safety of the service and drive improvement. However, these were not always effective.

Some of the provider's policies needed to be updated.

The leadership throughout the service created a culture of openness that made people feel included and well supported.

Green Pastures Christian Nursing 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 March 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience in care of people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service and the service provider. The registered manager 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 looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from four healthcare professionals who regularly visited people living in the home. These professionals included a GP, a falls specialist, a specialist in adult psychiatry and social worker. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

We spoke with 16 people and four relatives. We looked at six people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the business manager and nine staff which included nursing, caring, housekeeping and catering staff. We reviewed a range of records relating to the management of the home. These included seven staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We reviewed feedback from people

who had used the service and their relatives.

Requires Improvement

Is the service safe?

Our findings

Medicines were administered safely. However, staff did not always keep a record of the stock of people's prescribed medicines which were stored in boxes. We reviewed five medication administration records (MAR) charts and could not confirm stock balances on any of these. Stock balances were not maintained or carried over on MAR charts despite medicines being replenished on a monthly basis. The home did not keep balances of stock and we were not assured people had their medicines as prescribed.

MAR charts were not always completed to show when medication had been given or if not taken the reason why. For example, there were gaps on both MAR charts and topical cream charts for four people for both regular and when required medicines, so we were not assured people received their medicines as prescribed.

We also found concerns in relation to the storage of thickening agents. A thickening agent is prescribed for a person where they have swallowing difficulties or are at risk of choking. These were stored in people's rooms instead of locked cupboards as per guidelines. Although the senior nurse took immediate action and locked the thickening agents away, the home had not followed safe storage guidance.

This was a breach of Regulation 12 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff administering medicines to people who needed support; staff supported people to take their medicines in line with their prescription. Medicines in monitored dosage systems were stored securely in locked cabinets in medicine store rooms which were kept locked at all times when not in use. Controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) stocks were checked by two staff to ensure medicines had been administered as prescribed. There was also a medicine fridge which was kept at the appropriate temperature. Staff who administered medicines were trained and their competency was observed by senior staff.

People told us they felt safe and supported by staff. Comments included; "It's safe here", "I love it here", "I am quite happy here" and "I feel safe and looked after". Relatives told us they felt the service was safe. Comments included; "I feel my mum is safe here" and "Oh yes, very safe. No problem. I have not seen anything to worry me at all".

Staff were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us if they witnessed any abuse in the home, they would inform outside agencies such as the Care Quality Commission (CQC) and the local authority safeguarding team.

Risks to people's safety had been assessed and people had plans in place to minimise the risks. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one

person's mobility had deteriorated. This person's risk assessments and care plans were reviewed timely and the person now used a hoist for transfers.

Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. Risk assessments included areas such as falls, weight loss, challenging behaviour and moving and handling. Some people had restricted mobility and information was provided to staff about how to support them when they moved around the home.

People were supported by sufficient staff with the skills and knowledge to meet their individual needs. Staffing levels were determined by the people's assessed needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The registered manager considered staff sickness levels and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels. One member of staff said, "We always have enough staff on duty. The manager makes sure of it".

Safe recruitment procedures were followed before staff were allowed to work at Green Pastures nursing home. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

The environment was clean and tidy whilst maintaining a homely feel. Equipment used to support people's care was clean and had been serviced in line with national recommendations. Where people had bedrails to reduce the risk of falling out of bed, checks were conducted by staff to ensure their safety for use. Records showed risk assessments and consent documents had been completed for the use of bedrails. We observed staff used equipment correctly to keep people safe. Staff were aware of and adhered to the provider's infection control policies.

Requires Improvement

Is the service effective?

Our findings

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. Where people were thought to lack capacity, assessments in relation to their capacity had been completed in line with the principles of MCA.

Although the registered manager had a good understanding of the Mental Capacity Act 2005, not all staff could demonstrate an understanding of their responsibilities relating to the MCA. Staff comments included, "We talked about MCA during induction. It's about letting people have rights", "I need more training in MCA and DoLS, I don't really understand it" and "I would like more training in different types of dementia and MCA". Therefore we could not be sure people were being supported in line with the principles of the MCA.

Staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. However, the registered manager did not have a clear understanding of their responsibilities in relation to the application of DoLS. Six people on the Galilee unit had been identified as not being able to make specific decisions in relation to their care. One application had been made to the supervisory body. The registered manager told us they were seeking further advice regarding the remaining five people as to whether their liberty was being restricted from the local authority as they were unsure if they met the criteria for DoLS.

We recommended the registered manager refers to the MCA to refresh their understanding of the principles of MCA and their responsibilities under DoLS and to check staff understanding of the principles.

People's consent was always sought before any care or treatment was given. We observed staff knocked on people's doors and asked for verbal consent when they offered care support. Records showed people or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance. For example, all files and electronic records reviewed showed consent for taking and using photographs.

Staff were supported to improve the quality of care they delivered to people through yearly appraisals. One member of staff told us, "I am due for my appraisal in April". Another member of staff told us, "We get support from the manager and senior staff all the time". However, records did not evidence staff received periodic supervisions (one to one meeting with their line manager) to ensure they had the opportunity to raise concerns and discuss their training needs. Out of the seven staff files we reviewed, only one had a recorded supervision in the last six months. The supervision policy did not specify any frequency for supervisions. We discussed these concerns with the registered manager and they told us they were addressing this. They said they would add the frequency to the policy and showed us a training and supervision planning record which showed staff were in the process of going through supervisions.

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. Staff comments included; "My induction was very good "and "Training is available to me".

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. For example, nurses had attended syringe driver (A small, battery-powered pump that delivers medication through a soft plastic tube, placed just under the skin for management of pain) training and dementia training. Staff told us they had the training to meet people's needs. We observed staff were aware of people's individual needs.

People's specific dietary needs were met. Kitchen and care staff had the information they needed to support people. Some people had special dietary needs, and preferences. For example, people having softened foods or thickened fluids where choking was a risk. The home contacted GP's, dieticians and speech and language therapists (SALT) if they had concerns over people's nutritional needs. One person had been referred to SALT for guidance and this guidance had been followed. Records showed people's weight was maintained. We observed snacks were available for people throughout the day, such as fruit, cakes and biscuits. Staff were aware of how much fluid people needed on a daily basis. However, people's daily intake was not always recorded correctly. We discussed these concerns with the senior nurse and this was rectified immediately.

People told us they enjoyed the food. Comments included; "It's perfect home cooked food", "The food is great" and "Food is good". Catering was provided by an outside company. The home had four weekly menu cycles which had been chosen by the people. The chef told us he "Took pride in the presentation of the food and especially tries to make soft food more attractive". The registered manager performed monthly dining experience audits which had resulted in some changes being implemented. For example, people suggested changes to the menu and these had been adopted.

During lunch time we observed people having meals in both the dining rooms, upstairs and downstairs. In the upstairs dining room, the atmosphere was pleasant. There was conversation and chattering throughout the dining room. People chose where they wanted to sit and did not wait long for food to be served. People were given choices. One person said, "I get to choose what I like". People were supported to have a meal of their choice in a dignified way by attentive staff. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace. We saw people supported with meals in their rooms having the same pleasant dining experience as those in dining rooms. We saw staff asked people if they wanted more and this was provided as needed. However, in the downstairs dining room, food service appeared rushed. The downstairs dining room was mainly used by people living with dementia. Lunch was served at 12:30hrs and there was a church service at 14:30hrs. Staff looked rushed to complete lunch tasks in time for the church service. We discussed this with the registered manager and they told us they would look at increasing lunch time in the downstairs dining room.

People had regular access to other healthcare professionals such as, chiropodists, opticians and dentists and specialist nurses. People were referred for other specialist advice. For example, from the tissue viability nurses for wound issues or the falls team for issues with mobility. We saw evidence that specialist advice was followed. Professionals told us they were notified of people's changing needs.

People could move around freely in the communal areas of the building and gardens. There were two sitting

rooms, a conservatory and garden areas, which gave people a choice of where to spend their time. On the Galilee unit, which was a dementia unit, there were memory boxes outside people's rooms. People's bedrooms were personalised and contained photographs, pictures and the things each person wanted in their bedroom. However, the unit was not decorated in a way that followed good practice guidance for helping people with dementia to be stimulated and orientated. For example, the unit was painted in the same colour as people's bedroom doors. Some communal bathrooms did not have contrasting colour toilet seats to aid location. We discussed these concerns with the manager and they said they had sought guidance on dementia friendly environment and assured us this would be addressed.

Good

Is the service caring?

Our findings

People told us the staff were caring. Comments included; "Wonderful staff", "Very well looked after, thank you", "I wouldn't want to live anywhere else. I get treated like a queen" and "A very, very perfect place. I went out with my family on Sunday but was pleased to come back". One person's relative told us, "Staff are angels. They are very caring".

We observed many caring interactions between staff and the people they supported during our inspection. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and appropriate use of humour throughout the day.

Staff told us they were caring. One member of staff said, "We are a Christian home but open to everyone". Another member of staff told us, "It's a small home. Family knitted". People recognised staff and responded to them with smiles which showed they felt comfortable in their company. Staff took time with people. Tasks were not rushed and they worked at the person's own pace.

Staff showed they cared for people by attending to them in a caring manner. We observed people being assisted to comfortably have breakfast in bed. One member of staff asked one person if they wanted them to stay with them whilst having their meal. The person responded, "No dear, you go and get your breakfast".

Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. For example, one person's record said, 'Unable to verbally express themselves and uses gestures for responses. Observe for facial expressions'. We observed staff communicated with this person and watched them closely for gesture responses. Another person's record prompted staff to maintain eye contact and to stand close within a line of vision when speaking to a person who could not communicate verbally. We observed staff followed the care plan.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. For example, staff told us how they treated people with dignity and respect. One member of staff said, "I close doors during personal care. It is respectful".

Staff understood and respected confidentiality. One member of staff told us, "We do not discuss personal information about our service users to other people". Another member of staff commented, "Our records are electronic. It's a safer way to keep records". We saw records were kept in locked cabinets of locked offices only accessible using a keypad. Most of the records were electronic and we observed staff logged off whenever they were leaving the computers.

People were involved in decisions about their end of life care and this was recorded in their care plans. For example, one person had a do not attempt cardio pulmonary resuscitation (DNACPR) order document in

place and an advanced care plan (a plan of their wishes at the end of life). We saw the person and their family were involved in this decision. People, their families and professionals contributed to the plan of care so that staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life.

Relatives told us end of life care was provided in a compassionate and supportive way. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. They talked about how they maintained people's dignity and comfort and involve specialist nurses in the person's care. Staff told us they stayed with people during end of life in their own time if a person did not have any family or friends. On the day of the inspection, staff congregated mid-morning to honour one of their residents who had passed away. They talked about the times they had spent with the person and raised 'a glass' to them. That same morning a member of staff attended the person's funeral.

Good

Is the service responsive?

Our findings

Before people came to live at the home their needs had been assessed to ensure they could be met. These assessments were used to create a person centred plan of care which included people's preferences, wishes and needs.

Care planning was focussed on a person's whole life, including their goals skills and abilities. The provider used a 'Knowing me' document which captured people's life histories including past work, social life, likes and dislikes which enabled staff to provide person centred care and respect people's preferences and interests. The knowing me document was also used when a person went into hospital to allow continuity of care. People's care records contained detailed information about their health, social care and spiritual needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to get up. One person had a percutaneous endoscopic gastrostomy (PEG) (feeding tube placed through the abdominal wall and into the stomach) tube for medicines and fluids. The care plan specified this person also ate soft food and had thickened fluids orally. We observed staff supported this person to eat food orally and gave medicines through the peg tube.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, one person who was at risk of developing infection around peg insertion site had been referred to a tissue viability nurse who had advised staff changed the person's treatment. We saw the care plan had been updated to reflect the changes in a timely manner.

The provider employed an activities coordinator. The activities coordinator had arranged different activities including day trips. The provider planned to use a 'Lifestyle kitchen' for people. This was a purpose built kitchen which people were going to be supported to use just like they would do in their homes. Staff understood the importance of involving people in appropriate activities which stimulated and helped people to feel involved. Staff told us activities were based on people's preferences. For example, one person used to be a school teacher and she wanted to attend a school assembly. This was arranged for them and they had a wonderful time. Another resident who did not often get out of bed but loved poetry had staff and volunteers reading poetry to them often.

Records showed there were one to one activities such as talking, reminiscence, arts and crafts as well as group activities. Records also showed people had been involved in several day trips. Other people preferred to remain in their rooms and staff respected that. On the day of our inspection we observed some meaningful engagements between people and staff. One person said, "I like making things and staff help me with that". Another person told us, "One thing I particularly like is that there is plenty going on and I really like playing shot balls".

Feedback was sought from people, their relatives and staff through the registered manager and senior staff going around the home and meeting them as well as quality assurance surveys. Records showed that the feedback was very positive and allowed the management to regularly talk to people about things that

mattered to them.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. People's relatives commented that the registered manager "Was easy to get hold of and responsive to concerns". Staff knew how to raise concerns. Staff comments included, "If I have to make a complaint, I will go to the manager and I know they will do something about it" and "I have no reason to complain but I know I can talk to any senior member".

We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to sympathetically, followed up to ensure actions completed and any lessons learnt recorded. People spoke about an open culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Requires Improvement

Is the service well-led?

Our findings

The provider had quality systems in place. However, these quality systems had not identified the concerns we found at this inspection. For example, the provider had not identified medication stock levels were not recorded and that there were gaps in people's MAR charts.

Some of the provider's policies needed to be updated. For example, the supervision and appraisal policy was generalised with no specific timelines for supervisions. The medicines policy did not address medicines taken when required (PRN Medicines) or medicines given without the person knowing (Covert medicines). We discussed these concerns with the registered manager who told us they were in the process of updating and rewriting policies.

There was no whistleblowing policy in the home. However, staff knew how to whistle blow if need be. One member of staff said, "I can whistle blow to CQC. It's important to protect the residents and keep them safe". Another member of staff said, "I have no reason to whistle blow at the moment but I know how to".

We recommend that the service seek advice and guidance from a reputable source, about good, effective quality control systems and policies.

The service was managed by the provider and a registered manager who were supported by a business manager and a senior nurse. The registered manager had been in post for eight months. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. There were a range of quality monitoring systems in place to review the care and treatment provided at the service. These included regular audits of medicine administration records, care plans, and gathering peoples experience of the service through satisfaction surveys and other feedback. However, there were not always effective as the areas of concerns in this inspection had not been identified by the provider. Where issues had been identified, an action plan was put into place to address them and this was followed up to ensure actions had been completed.

The manager had an open door policy, was always visible around the home and regularly worked alongside staff to deliver care. One person's relative said, "There is an open door policy". People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. The registered manager was in the process of developing a 'comments and suggestions' leaflet which staff, people and their relatives could use to provide feedback. People and relatives could drop in anytime to speak with the registered manager.

The registered manager had a clear vision for the service. They told us, "There is a lot of work to be done and I know I cannot do it alone". The registered manager had just appointed a clinical nurse manager to support them in the day to day running of the home. The registered manager had also facilitated a 'Breakfast with the home manager' meeting to allow staff to meet with them regularly and discuss concerns or

improvements required to ensure staff support.

People knew the registered manager well and they told us the registered manager was always visible around the home and approachable. Staff were complimentary about the registered manager. Comments included; "I have faith in the management and senior staff", "The manager is wonderful" and "Our manager listens to us. They are really good". Staff told us they felt valued and respected by the provider and registered manager. Staff told us their views were listened to and good practice was promoted. One member of staff said, "Where I was, if you told managers of any issues related to residents, nothing was done and you never had feedback. But here, you are listened to, things are done and you know about it".

The provider facilitated a 'Home manager/Senior nurse Walk-around' every two months. This was aimed at identifying any issues within the home by walking around the home, asking staff, people and relatives for feedback as well as observing staff giving care to people. Action plans created were followed through. For example, staff fed back that 'small family working groups' were not working well on Galilee unit and this led to a review of dementia care philosophy within the home.

Staff told us there was good communication between all staff within the home. People and staff attended daily morning prayer meetings. Staff received handovers daily. The registered manager cascaded any incident and meeting outcomes throughout the team. The registered manager also facilitated a team leader meeting quarterly.

Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff discussed complaints raised, recent incidents and how to improve catering services. Staff had discussed how they could learn from the incidents and complaints to ensure people's safety. The registered manager facilitated 'Espresso' training. These were short but sharp training sessions which were done to highlight important parts of care. For example, these had covered topics including fluids records, bed rails as well as following incidents or accidents.

There was a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the chance of further incidents occurring. The registered manager discussed accidents and incidents with staff and made sure they learnt from them. All accidents and incidents were audited and analysed every month by the registered manager. The registered manager told us this was to look for patterns and trends with accidents to see if lessons could be learnt and changes made where necessary.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not always keep a record of the stock of people's prescribed medicines which were stored in boxes. MAR charts were not always completed to show when medication had been given or if not taken the reason why. Thickening agents were not always stored safely.