Hamilton Care Limited

St Helens

Inspection report

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Scarborough
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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 5 July 2016 and was unannounced. We previously visited the service on 30 May 2014 where we found that the provider was meeting regulations relating to all areas of care that we inspected.

The service is registered to provide nursing care for up to 28 older people who were living with dementia or had a mental health condition. On the day of the inspection there were 24 people living at the service. The service is situated on the south side of Scarborough, close to bus routes and shops. There is a small garden area where people can sit and the service is very close to public gardens. There is a passenger lift so people can access the upper floors of the premises.

There was a manager who was registered with the Care Quality Commission (CQC) employed at 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at St Helens

People and their families told us that they were safe living at the service. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager, nursing and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. The staff worked within the principles of the Mental Capacity Act (MCA) and we saw that where it was necessary applications had been made for deprivation of liberty safeguards to be put in place.

Risk assessments identified any areas of concern in respect of people's care and support needs, and there were management plans in place to reduce these risks and inform staff.

Staff received thorough induction training when they were new in post and told us that they were happy with the induction and on-going training provided for them. Training included fire safety, moving and handling people, dementia awareness, nutrition and health and safety.

We checked medication systems and saw that medicines were recorded, stored, administered and disposed of safely. Staff who had responsibility for the administration of medication had received appropriate training and people received their medicines safely.

People who lived at the service and their relatives told us that staff were caring and that they respected

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

Care plans recorded people's individual needs and how these should be met by staff. Staff had a good understanding of people's specific needs and how they wished to be supported.

We saw that people's nutritional needs had been assessed and we observed that people's individual food and drink requirements were met and that they were offered a choice.

The complaints procedure was available to people. No complaints had been received by the service. There were systems in place to seek feedback from people who lived at the home, relatives and staff.

There was an effective quality assurance system in place at the service. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote people's safety and well-being.

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 who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff had received training on safeguarding adults and understood their responsibility to report any incidents of abuse to the relevant people.

The premises and equipment used by people who lived at the home had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles.

The service worked within the principles of the Mental Capacity Act (MCA)

People's nutritional needs were met and they received an appropriate diet which met their needs. People had access to health care professionals when required and advice received from health care professionals was incorporated into care plans.

Improvements had been made to the premises to make them more suitable for people who were living with dementia.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at

the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

People who lived at the home told us that their privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests, their preferences and the people who were important to them.

People were encouraged to take part in meaningful activities and to keep in touch with family and friends.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

Is the service well-led?

Good

The service is well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed.

There were opportunities for staff and visitors to express their views about the quality of the service provided.

There was an effective quality assurance system in place which identified required improvements and demonstrated where those improvements had been made.

St Helens

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 registered 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.

The inspection took place on 5 July 2016 and was unannounced. The inspection team consisted of an adult social care inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We received the PIR within the required timescale.

On the day of the inspection we spoke with three people who used the service, two relatives, two care staff, one member of the kitchen staff, a registered nurse, 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 looked around communal areas of the home, looked in bedrooms with people's permission and visited the laundry and kitchen. We spent time looking at the care records for four people who lived at the home, the recruitment records for six members of staff and other records relating to the management of the home. These included maintenance and servicing records, minutes of staff meetings and the results from a staff survey.

Following the inspection we spoke with a clinical nurse specialist from the hospice care homes team who gave us positive feedback.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. One person said, "I'm OK. I'm perfectly safe" and another said, "Oh yes I'm safe." Relatives we spoke with confirmed this and one told us, "[Relative] is safe. I'm sure of that. They pop in to see [Relative] every twenty minutes at least."

The registered manager told us in the PIR, "We have had no safeguarding issues this last year. The staff are all clear on how to report any safeguarding concerns. "We saw that staff at the service completed training on safeguarding adults from abuse. We also saw that policies and procedures about safeguarding adults from abuse and whistle blowing were available. This showed us that this information was available to staff in order to provide guidance.

The staff that we spoke with told us they had completed training on safeguarding vulnerable adults from abuse and this was demonstrated in the training records we saw. The training records evidenced that staff, including ancillary staff had completed this training. They were able to describe the action they would take if they became aware of an incident of abuse or a potential incident. Staff told us that they would report any concerns to the registered manager and that they were confident they would be listened to and that appropriate action would be taken. We saw that no safeguarding concerns had been identified.

We checked the recruitment records for six members of staff. These records evidenced that an application form had been completed, references had been obtained, the person's identity had been confirmed and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent people who may be unsuitable from working with vulnerable adults. This meant that only people who were considered safe to work with people living at St Helens were employed.

We saw that there were sufficient numbers of staff on duty to support people and the rotas confirmed those numbers were sustained over time. There was the deputy manager, who was a registered nurse, a second registered nurse and five care workers on duty during the inspection. In addition to this there were two kitchen staff, a cleaner and a housekeeper on duty. This meant that care workers were able to concentrate on providing personal care and support to people who lived at the home.

Risk assessments had been completed for areas of the service that were considered to be of concern. We saw that people who lived at the home had risk assessments. These included moving and handling, the use of bed safety rails, falls and skin integrity. Some people had risk assessments in place for their more specific needs, such as nutritional needs or mental health. We saw that risk assessments had been reviewed on a regular basis to ensure they remained relevant and up to date, and that the level of risk was identified. We noted that mobility assessments recorded any equipment and the number of staff needed to help people to mobilise safely, and that care plans recorded the equipment people had in place to promote good pressure area care such a specialist mattresses.

We saw that any accidents or incidents involving people who lived at the home were recorded. A body map was completed where any injuries could be recorded. This helped staff to monitor the person's recovery. The action taken by staff at the home was recorded, such as seeking medical attention and notifying the person's relatives. Accidents and incidents were reviewed to identify any areas that required improvement.

We saw the service had clear advice for staff on the action to take in the event of emergency situations such as fire. There was a fire risk assessment in place and we saw service certificates in respect of the fire safety system and fire extinguishers. In addition to this, weekly checks were carried out by the home's maintenance person on the fire alarm system and fire doors, and checks were carried out on emergency lighting.

The service was well maintained and servicing of equipment was carried out within appropriate timescales. We saw records of checks having been carried out on electrical wiring, portable appliance testing and gas. There were current certificates which showed these tests were up to date. The lift had been serviced and hoists, slings and other equipment had also been tested and serviced. There was a contract in place for clinical waste collection and disposal. This meant that the service was meeting their health and safety responsibilities by keeping the premises safe for peoples use.

Registered nurses had responsibility for the administration of medication and training records evidenced that these members of staff had completed appropriate training. Their recent medication training showed us that this had included checks on their competency.

We observed that there were systems in place to manage medicines and to ensure medication was administered safely. We observed that medicines were stored safely and securely; the medication trolley was locked when not in use in a designated locked room. On the day of the inspection we saw that the person administering medication did this safely.

We saw that controlled drugs (CDs) were stored securely. There are legal requirements for the storage, administration, records and disposal of CDs. These are set out in the Misuse of Drugs Act Regulations 2001 (as amended). There was a suitable cabinet in place for the storage of CDs and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cabinet balanced.

The medicine room and the medication fridge had the temperatures checked and recorded each day. This ensured medication that needed to be kept cool was stored at the correct temperature. The packaging of medication that was stored in boxes or bottles was dated which identified when the medication was opened to ensure it was not used for longer than the recommended period of time.

We looked at medication administration record (MAR) charts. We saw that MAR charts were clear, with no gaps in recording. There were protocols in place to advise staff on how 'as and when required' (PRN) medication should be administered and recorded. Staff used the 'Abbey 'pain scale to determine whether or not people needed pain relief. This is an instrument designed to assist in the assessment of pain in people living with dementia who are unable to clearly articulate their needs. There were associated care plans relating to pain management. Medicine audits were completed monthly. This protected people who used the service from unsafe practices.

Good

Is the service effective?

Our findings

People at this service were living with dementia. Relatives we spoke with told us that staff had the skills needed to carry out their role and provide a good standard of care. One relative told us, "I think they are perfect and do a good job." A second relative told us, "The staff seem to know what they are doing. Nothing is any trouble."

We saw that both the company director and registered manager had attended a year long course provided by Dementia Care Matters, an organisation which teaches a model of care that focuses on emotional intelligence. The PIR stated, "Staff had always known how important emotional care was but this has been re-emphasised and can be seen in practice." We observed the staff were skilled at communicating and engaging with people. We saw one care worker talking to a person about the activity they were undertaking in a positive and encouraging way which resulted in the person smiling and chatting to the care worker. From the conversations we heard throughout the day it was clear that staff knew people well and used this knowledge to have positive interactions with people.

We checked the training records for six members of staff and these showed that care workers completed a thorough induction programme prior to commencing work unsupervised. Topics covered in induction training included safeguarding adults and moving and handling.

The training records showed that the organisation considered mandatory training to be fire safety, food hygiene, moving and handling, health and safety and safeguarding vulnerable adults from abuse. Other training was also available to staff, such as dementia awareness, end of life care, managing challenging behaviour and mental capacity and deprivation of liberty. Records showed that staff had completed this training. The staff we spoke with told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively.

We saw that staff received supervision to support them in their role. Supervision is a one to one or group meeting where staff can discuss and reflect upon their work, training and development with a senior person. This showed that staff had two or three supervision meetings with a manager during the year. Staff told us that they felt well supported; they said that they attended supervision meetings with a manager and that they got the opportunity to raise any concerns and discuss their practice. One member of care staff said in their staff survey response, "I feel valued and appreciated by others at work. Have a clear understanding of my job role."

We saw that staff had a handover when each shift changed. A member of staff told us, "We get a handover. The nurse in charge gives us information and any details about any new admissions to the home." This meant that staff communicated important information internally so that all relevant information was shared in order that people's needs were known.

We observed lunch in the main dining room and a smaller dining room. There was a pleasant atmosphere with staff encouraging people to enjoy their meal and to chat to each other. Tables were set with cutlery and

napkins and condiments were available for people to use. We saw that people were able to eat at their own pace and when they had finished their meal, staff asked them if they had enjoyed their meal and if they had had sufficient to eat. If they did not want the meal on offer they were provided with an alternative of their choice. Staff were sensitive to people's needs and encouraged those people who were reluctant to eat in a kindly way. We saw that people were offered plate guards and other adapted cutlery to assist them to maintain their independence when eating.

Kitchen staff told us that there was a list in the kitchen of people's likes and dislikes and any special dietary requirements. There were also information leaflets for use by the cook provided by the speech and language therapy team (SALT). Nutritional assessments were included in care plans and we saw that details of any special dietary requirements were included, such as thickeners for liquids to reduce the risk of choking. We saw that people were offered drinks throughout the day.

Relatives told us they felt involved in decisions about the health and welfare of their family members. We saw from peoples care records that they had access to their own GP when necessary and also had input from other professionals such as the district nurse and chiropodist. Any contact with health care professionals was recorded in people's care plans, including the reason for the visit and the outcome. We saw that any advice received from health care professionals had been incorporated into people's care plans. Any communication from hospital appointments or outside healthcare organisations was retained with people's care records so that it was available for staff to refer to ensuring they had current and up to date information about people's healthcare.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw in the care plans we reviewed that some people had a DoLS in place. We noted that when a person had an authorisation in place this was clearly recorded in their care plan. There was also a record of when the authorisation expired. We saw that decisions about peoples care had been taken in their best interests. One person had a decision about how their medicine was administered recorded. The registered manager told us in the PIR, "We take care to listen to the resident and do as they ask or get them what they want. We credit the resident with being having a degree of capacity even when it is very limited. For instance if a person does not want personal care, we will go back to them later and try again, if they don't want to sit in the lounge they don't have to." This demonstrated that the staff worked within the principles of the Act because every adult has the right to make their own decisions if they have some capacity to do so.

The training record evidenced that most staff had completed training on MCA and DoLS. However there were still some staff that would benefit from this training. When we spoke with the registered manager they told us that training was currently being organised to ensure that all staff had been provided with information to help them to understand the principles of the MCA and DoLS. One registered nurse who had received training in these subjects told us that they were confident working within the principles of the MCA

and understood when an authorisation for DoLS should be made. This meant that senior staff were clear about their responsibilities which ensured that people's rights were protected when decisions about their care were needed.

We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. There were forms in care plans to confirm peoples consent to care. In some instances a relative had signed these consent forms that had the authority to consent on behalf of their family member because they acted as Power of Attorney (POA). This means that they have been granted the legal right to make decisions, within the scope of their on a person's behalf. These would normally relate to a person's health and welfare or finances. In other cases a best interest decision had been made by professionals with input from staff. We saw examples of how staff supported people to make day to day decisions on the day of our inspection.

Adaptations were being made to the environment. These supported people living with dementia. The building was an adapted property and so the provider had to work within the confines of that structure but we saw that people had profiling beds. These are specialist beds which can be adjusted and have integral bed rails. These aid staff when moving people who were nursed in bed. In addition there was a passenger lift for people who were unable to use stairs. Window restrictors had been fitted to ensure that windows could only be opened to a safe level in order to prevent any unnecessary accidents. There was some signage around the building to aid people in finding their way around. However more could be done to enhance people's independence through use of colour such as contrasting coloured hand rails and toilet seats to promote way finding and continence.

Photographs and pictures were placed at a height where people could look at them and carpets were not overly patterned. According to the Kings Fund report 'Enhancing the healing environment' people living with dementia can become restless and distracted in environments that are visually over stimulating or where there is competing visual information. This meant that the environment felt calm and peaceful which assisted in maintaining people's sense of wellbeing.

Good

Is the service caring?

Our findings

People told us they were happy living at the home. One person who used the service told us, "I like it here. They [Staff] are lovely." A relative told us, "They're wonderful here. I can't fault anyone. Some are beyond superb."

We saw many positive interactions between people who lived at the service and staff on the day of the inspection. We noted that people were comfortable in the presence of staff, and that staff were polite and sensitive to people's needs. One staff said in their survey response, "A positive experience happens here every day."

We saw that staff were courteous towards people who lived at the service, knocking on bedroom doors prior to entering and dealing with any personal care needs sensitively and in a way that respected the person's privacy and dignity.

Positive relationships were developed at the service. We observed an interaction between a member of staff and a person who used the service when they were looking at pictures and laughing about something together. We saw that that staff treated people politely and with respect. One relative told us, "It's very friendly here; lovely, right from cleaning staff, laundry, care staff and nurses." The quarterly newsletter produced by the service welcomed new residents making them feel at ease in their new home.

There were people who used the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We saw that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy and understanding in respect of people's needs.

There was information about advocacy services available if people had no support. However, people were supported by family members at this service. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

We saw that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve.
For instance we heard staff asking what level of support they needed with personal care.

St Helens held the end of life Gold Star award which was accredited by the local hospice. The training had been given by St Catherine's hospice community team and all of St Helens staff had been involved. There was a close working relationship with the hospice care homes team who supported staff with advice for those nearing the end of life and those who were very ill. St Helens had good links with the community teams at the hospice and people's GP's. The deputy manager was the lead nurse in the service for end of life care and she ensured that everyone had care plans in place which identified their wishes at end of life. This meant that people were supported by well trained and knowledgeable staff as they reached the end of their

life. The clinical specialist nurse from the care homes team at the local hospice told us, "The staff at this service provide good care and support for people at the end of their life."

Good

Is the service responsive?

Our findings

Care plans we looked at included pre admission assessments, risk assessments and management plans. Areas covered in care plans included nutrition, mobility, mental and physical health needs. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool which measures the level of risk of skin damage to pressure areas and the Malnutrition Universal Screening Tool (MUST) which identifies people at risk of malnutrition. 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.

We saw there were clear management plans to guide staff when caring for people. For example, we saw that one person was assessed using the Abbey pain scale. This measured the level of pain the person was feeling. There were detailed descriptions of how the person communicated their pain and this gave staff the information they needed to recognise when this person required some pain relief.

Each person's care records included information about their GP, their current diagnosis and health needs. Care records also included a document called 'This is me' which contained the headings 'The person who knows me best', 'I would like you to know', 'My home and family and things that are important to me' and 'My life so far'. 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.

The people that we spoke with were unaware that they had a care plan, but a relative told us they had been consulted when their relatives care plan was being written. They said that staff understood their relatives care and support needs

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 local authority staff 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 were given details of any new admissions to the service and then given time to read care plans, speak to the person concerned, and to their relatives and friends. Staff had a key worker system and were allocated people for whom they would be a point of contact. This enables the person moving into the home to begin to trust and develop a rapport with the key worker.

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 join their relative for meals and were always offered drinks. This meant that people could maintain their relationships whilst enjoying their meals.

People told us they had access to a hairdresser who visited the service each week. All the staff were involved in activities because they were considered an essential part of people's lives. We saw staff in one to one

interactions throughout the day and sitting with groups of people doing activities. We spoke with one person who told us that they had a book of memories containing photographs which they showed us. This stayed with them so that they could look at it whenever they wished. There were rummage boxes in the lounges which people used at different times throughout the day. Everyone had something in front of them to look at, touch or read and were engaged in some form of activity at different times during the day.

We saw that the home's notice board displayed photographs of all the outings undertaken recently. This provided a topic of conversation for people who lived at the home, visitors and staff.

Trips out were a feature of the service which people enjoyed regularly and staff were planning a trip the week of this inspection. Two members of staff regularly gave performances at the service which people told us about with a smile on their face. This was clearly enjoyed by people who used the service and staff. The registered manager said in the PIR, "All our residents are encouraged to enjoy their lives with us and we emphasise that dementia does not mean that a person cannot feel happiness."

The complaints procedure was displayed in the service. We checked the complaints register and saw that there had been no complaints made to the service in the last twelve months and that there had been nine compliments. The registered manager was aware of how to deal with any complaints.

People who lived at the home and relatives told us that they felt able to express their opinions and if necessary, raise a complaint. One relative told us, "I would talk to the manager if I had an issue." Relatives and staff told us were confident people's complaints were listened to and dealt with.

We saw that meetings were held for people who lived at the home and their relatives. These were informal and were in the form of afternoon tea and cake on a Sunday. The registered manager attended. This gave people an opportunity to express their views, make suggestions and ask questions about their relatives care.

Good

Is the service well-led?

Our findings

There was a manager who was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration. 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, and the deputy manager was able to provide, a variety of records and documents during our inspection. We found that these were well kept, easily accessible and stored securely.

There were registered nurses working at this service who were clear about their professional accountability. They were supported to maintain their registration and keep up to date with developments through external training where necessary. The director and registered manager were aware of good practice in dementia care and made sure they kept their knowledge up to date. This demonstrated that the service was committed to best practice in their field.

People who lived at the home and relatives knew who the registered manager and deputy manager was and told us they could approach them to talk about any areas of concern. The registered manager was not at work on the day we inspected but their deputy was able to support the inspection in a very professional and knowledgeable way. One member of staff told us, "[Name of deputy manager] is really supportive and gives us help whenever we need it."

Staff told us that there was good management and leadership at the home. One member of staff said, "[Name of registered manager] is very good" and another said, "[Name of deputy manager] works with us and explains things to us." Staff told us they could talk to either manager if they had concerns and were confident they would respond appropriately.

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 areas of the service such as medication. We saw that any shortfalls were identified in an action plan and that the next month's audit checked the matters had been dealt with.

A satisfaction survey had been distributed to staff in June 2016. The information in the surveys was still being collected. We were told by the registered manager that it would be collated and analysed, and the outcome used to make improvements where needed. This showed that the organisation was open about the feedback they had received. We looked at the feedback received so far and saw that although there were suggestions for improvements the staff were overwhelmingly positive about working at the service.

Staff meetings were held on a regular basis. There had recently been a meeting for the team leaders in May 2016. The minutes of these meetings showed that a variety of topics had been discussed including the way people worked and other more practical matters relating to peoples care. Staff told us that these were meetings where they could express their views. One member of staff said, "We can ask questions and make

suggestions" demonstrating that staff were involved in the way the service was run.

A relative described the service as "Like happy families." A member of staff said, "It's a lovely home to work in and I love my job" and "We work as a team." This was evident in the way they constantly interacted with each other throughout the day showing them to be a cohesive team.