Wakefield MDC

Hazel Garth

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 24 February 2016.

We last inspected Hazel Garth in October 2013. At that inspection we found the service was meeting all the legal requirements in force at the time.

Hazel Garth provides accommodation and personal care for up to 24 people. Care is provided to older people, including people who live with dementia or a dementia related condition. At the time of inspection there were 21 people living there and this included one person who was staying for a short term break.

A registered manager was in post. They were unavailable at the time of inspection and their position was covered by the registered manager of another 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.

People said they were safe and staff were kind and approachable. People's comments included, "Excellent care home, nothing is too much trouble for the management and staff," "I enjoy living here," and, "Happy to go back anytime for respite care." People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Systems were in place for people to receive their medicines in a safe way. People had access to health care professionals to make sure they received appropriate care and treatment. Appropriate training was provided and staff were supervised and supported.

There was a good standard of record keeping and records reflected the care provided by staff. Staff knew the people they were supporting well. People we spoke with and relatives told us staff were kind and caring and peoples' privacy and dignity were respected. Their comments included, "The staff are great," "We couldn't ask for better care," "Staff are really on the ball," and, "Staff are all very welcoming." There were activities and entertainment available for people

Hazel Garth was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment. Food looked appetising and people received a varied menu including people who required a special diet.

A complaints procedure was available. People told us they had no need to complain but they would feel confident to speak to staff about any concerns if it was necessary.

The home had a quality assurance programme to check the quality of care provided. People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. The provider survey results included several comments of appreciation and these included, "Fantastic home, tons of care, a lovely place," "I am pleased that (Name) is fortunate enough to live at Hazel Garth. They are content and all staff treat (Name) with kindness and consideration and do their utmost to ensure (Name)'s well-being. I thank you for this."

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

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.

Checks were carried out regularly to ensure the building was safe and fit for purpose.

People told us they felt safe.

Staff were appropriately recruited. Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Policies and procedures were in place to ensure people received their medicines in a safe manner.

Records were in place for supporting people who displayed distressed behaviour.

Is the service effective?

Good

The service was effective.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a balanced diet to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

There was a system for people to use if they wanted the support of an advocate. Advocates were made available to represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. Records reflected the care and support provided by staff.

Activities and entertainment were available to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff told us the registered manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

Hazel Garth

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.'

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales.

This inspection took place on 24 February 2016 and was an unannounced inspection. It was carried out by an adult social care inspector.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We undertook general observations in communal areas and during a mealtime.

As part of the inspection we spoke with five people who were supported by Hazel Garth staff, two assistant managers, the operational manager, the acting registered manager, a personnel member of staff at the local authority headquarters, five support workers, two members of catering staff, five relatives and two visiting health care professionals. We observed care and support in communal areas and checked the kitchen, bathroom and bedrooms after obtaining people's permission. We reviewed a range of records about people's care and checked to see how the home was managed. We looked at care records for four people, two peoples' medicine records, the recruitment, training and induction records for three staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits the registered manager and operational manager completed.

Good

Is the service safe?

Our findings

People told us they felt safe and they could speak to staff. Peoples' comments included, "There are plenty of benefits living here," "I do feel safe," and, "Staff are around when I need them." Relatives' comments included, "There are more staff now," and, "There are plenty of staff around." A visiting health professional commented, "The staff seem attentive and they're always available."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. They had completed local authority safeguarding training so they were aware of how to raise an alert and the multi-agency procedures which showed the areas of responsibility for different agencies. Staff members' comments included, "I'd report any concerns to the person in charge."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities where necessary. A safeguarding log was in place. Nine safeguarding incidents had been raised since the last inspection. These were mostly peer incidents and the provider had taken the appropriate action to deal with each incident. One unrelated safeguarding concern had been raised by the service with the local authority and this was still under investigation.

We considered staffing levels were sufficient to meet the needs of the people who were using the service at the time of inspection. A staff member commented, "Staffing levels are getting better." The person in charge told us staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. At the time of our inspection there were 21 people who lived in the home. The home was staffed by four to five support workers who worked different shift patterns to cover day time and evening hours and three night staff members were on duty overnight. These numbers did not include the registered manager or assistant manager who were also on duty during the day. A member of the management team was available 'on call' overnight to provide any support and guidance when required.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. For example, "Only one tablet left, your Codeine. Put your hand out and I'll put the tablet in your hand and take a drink." Medicines records were accurate and supported the safe administration of medicines. There were no gaps in entries and all medicines were signed for after administration.

Staff members who administered medicines told us they would be given outside of the normal medicines

round time if the medicine was required. We saw written guidance was in place for the use of some "when required" medicines. The guidance included when and how these medicines should be administered to ensure a consistent approach to the use of such medicines, such as for pain relief or for agitation and distress. Care plans contained details to inform staff if a person was able to verbally communicate if they were in pain. For example, "(Name) is able to say if they are in plain," and, "(Name) is unable to say if they are in pain so carers to check for signs of discomfort and possible pain in (Name)'s stomach area."

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example, to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for pressure area care, moving and assisting and falls. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. They both included clear instructions for staff to follow to reduce the chance of harm occurring.

A personal emergency evacuation plan (PEEP) was available for each person, taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We were unable to access a copy of staff personnel files in the home or on the computer. We therefore spoke with the human resource person by telephone who accessed three staff files for us to look at via computer as they navigated the files centrally. This was to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if applicants have any criminal convictions, had been obtained before they were offered their job. We discussed with the operational manager that an accessible copy of staff personnel files were not available on the computer or a copy in the home. We were told that this would be addressed as the registered manager had previously had access to staff personnel files in the home.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff told us and their training records showed they had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "We get plenty of training," "I've done loads of training some on-line," "There are opportunities for training," and, "I've done lots of mental health training."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff members' comments included, "I love it here, when I first started I was not on shift by myself until I knew what I was doing," and, "I had an induction when I started, I'm doing the Care certificate at the moment."

The staff training matrix showed staff received training with regard to safe working practices. We saw some of this training was due to be updated, this had also been identified by the registered manager in the Provider Information Return (PIR). The PIR showed that staff were to receive updated training about safe working practices training and more training about dysphagia (swallowing.) There was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included dementia care, pressure area care, nutrition specifically to support people who lived with dementia, stroke awareness, pressure area care, dignity awareness, and confidentiality.

Staff were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months. Staff comments included, "I have supervision every two months," "I have supervision with the manager or assistant manager," and, "We talk about how I'm doing at work." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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 are called the Deprivation of Liberty Safeguards (DoLS). Hazel Garth records showed 17 people were legally authorised by the local authority and two applications were waiting for assessment by the local authority.

Records showed assessments had been carried out, where necessary, of people's capacity to make particular decisions. For example, with regard to their care. Staff said if a person refused support for example, with regard to their personal care or taking their medicine, they would offer alternatives or leave

the person and try again later. Staff members' comments included, "I'd go away for ten minutes and then try again," and, "I'd get someone else a different face helps sometimes."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, the community nurse, dietician, speech and language teams, psychiatrist and GPs. Records were kept of visits and any changes and advice was reflected in people's care plans. Comments from health care professionals from a recent provider survey included, "Excellent standard of care with a person-centred approach," "No problem keeping appointments," and, "Staff know residents very well." A health professional visiting at the time of inspection commented, "Staff refer people in good time and they follow any instructions to make sure people's health care is met," and, They will chase us up if they haven't received people's scripts (prescriptions)."

Relatives were kept informed by the staff about their family member's health and the care they received. Relatives' comments include, "They let me know if there have been any changes," "Staff let me know if (Name) isn't well and they need to get a doctor in," and, "I visit regularly and I'm always kept up-to-date with (Name)'s care."

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. Staff members' comments included, "The handover is good," and, "The handover sheet tells us about any issues and how people are." Other staff commented, "Communication is very good," "Communication is effective and we're kept informed about how people are," "Communication is good. I can pick up the communication book and leave messages," and, "We find out if there have been any changes whilst we've been off."

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes. We spoke with the cook who was very aware of people's different nutritional needs and special diets were catered for. The cook was enthusiastic and keen to ensure people who required a special diet were able to enjoy food they previously liked. For example, we saw recipes that accommodated nutritional needs such as if people had difficulties swallowing and we saw 'dysphagia' biscuits that were made for people who had such difficulties swallowing. The cook told us they received information from the registered manager when people required a specialised diet. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce.

We saw food was well presented and looked appetising. People were offered a choice and a menu advertised what was available each day. People were positive about the food saying they had enough to eat and received good food. Their comments included, "There's plenty to eat and drink," "I really enjoy the food," "It's a very good lunch today," and, "It's smashing here, there's plenty to eat." Hot and cold drinks were available throughout the day. A letter of compliment from a relative stated, "The kitchen girls are marvellous with (Name) letting them choose what to eat and trying to coax them to try new things." A relative's comment in the provider survey also complimented the food stating, "With regard to food I consider the standards to be excellent, this applies to the quality of food, menus and serving."

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised

Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day. We spoke with a person from the Rapid Access team, (a health resource that provided additional support to people if there was an assessed additional need). They came each meal time and provided one to one support to a person who required encouragement to eat.

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were all very positive about the care provided by staff. Comments included, "The girls are great," "Staff are very kind," "It's an excellent home," "Staff listen to me," "It's lovely here," and, "We get very good care." Responses from relatives in a provider's survey included, "On behalf of (Name) and myself may I compliment each and every member of staff as to the high quality care delivered in such a patient, loving and dignified manner," "Hazel Garth has been a lifesaver for (Name.) I have a 100% faith in all the staff…..," "Pleasant and welcoming home. Staff approachable and helpful," "and, "(Name)'s respite stay was enjoyable and friendly. The home was also friendly for relatives."

People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Good relationships were apparent and people were very relaxed. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff asked the person's permission before they carried out any intervention. For example, as they offered people drinks or assisted them to move from their chairs to the dining tables. Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say, for example, if they were in pain. Staff member comments included, "Some people can verbalise to tell us," and, "You get to know by facial expression." Staff also gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. A person's care plan stated, "(Name) is independent in choosing their clothing and when they want to get up and go to bed," and, "(Name) is able to select their own clothing and is able to realise that their clothing is soiled."

We observed the lunch time meal. The meal time was relaxed and unhurried. Staff interacted with people as they served them. Some visitors enjoyed lunch with their relatives. People sat at tables set with napkins and condiments. Tables were set for three or four and staff remained in the dining area to provide encouragement and support to people. Staff provided prompts if required to people to encourage them to eat, and they did this in a quiet, gentle way. For example, "Are you ready for your pudding yet?" We observed people were given a choice of meal and staff verbally described to people what was available. However, we noted people were not shown two plates of food to help them make a choice. The person in charge told us this did happen but it depended upon a person's level of dementia and the amount of choice that was available. For example, a selection of puddings was available and the pudding trolley would be taken around to tables to assist people to make a choice.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. A comment from a relative in a recent provider survey stated, "(Name) has only been at Hazel Garth just over a month. They

have settled in beautifully….Their demeanour is calmer and they seem much happier. It's like they have a new family." Comments from professionals from the same provider survey included, ""Staff were approachable and knowledgeable about the client concerned. They demonstrated warmth to the people and knew their personal, likes, dislikes and preferences," "The staff level of care was exceptional," "Staff have a good knowledge of the person's history, personality and medical condition," and, "Lovely to see staff knowing 'residents' so well." The PIR stated that staff were 'dementia friends' so they were keen to champion the human rights of people who lived with dementia. Staff told us as a dementia friend they would challenge poor practice. A visiting professional had commented in the provider survey, "I was very impressed with the staff knowledge of dementia care, attitude and approach to people who live with dementia."

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told an advocate was to become involved with one person to provide an independent 'voice' due to the person's circumstances.

Good

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in activities. Comments included, "I go out with my family," "I go to a club," and, "I'd like to attend a knit and natter group." "Activities and events took place in the home such as quizzes, baking, arts and crafts, chair exercises, sing-a-long, reminiscence, pamper sessions, hairdressing, church services, visiting entertainers and planned seasonal parties.

Records showed people's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Up-to-date written information was available for staff to respond to people's changing needs. Records showed that monthly assessments of people's needs took place with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, mobility and falls and personal hygiene. A care plan for communication stated, "(Name) has a communication book which helps them find words. They are able to read and will point to words in their book if they find they are unable to recall a word."

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, with regard to nutrition. Care plans reflected the advice and guidance provided by them and other external health and social care professionals such as the dietician and speech and language therapy team.

Staff completed a daily report for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when people were bathed or assisted with personal care. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

The care plans gave staff specific information about how the person's care needs were to be met. They gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They detailed what the person was able to do to take part in their care and to maintain some independence. For example, a care plan for personal hygiene for a person stated, "(Name) will cut their own finger nails but they need to be observed as they will not use a nail cutter and they may cause themselves harm," and, "(Name) prefers a shower and needs to be prompted and to change their clothing." A care plan for nutrition stated, "(Name) does not like their plate full of food as this puts them off eating." Care plans were up-to-date and they were reviewed monthly and on a more regular basis, if a person's needs changed. Staff told us they were responsible for updating designated people's care plans.

Information was available to help staff provide care and support for when a person was no longer able to tell staff themselves how they wanted to be cared for. People's care records contained information which had been collected from the person or from their families about their life history and likes and dislikes. This gave staff some insight into people's previous interests and hobbies when people could no longer communicate

this themselves. People's care plans also provided information about their social interests. For example, "A meaningful activity for (Name) would be music or drink based." Information was available with regard to people's wishes for care when they were physically ill and recorded their spiritual wishes or funeral requirements.

Regular meetings were held with people who used the service and their relatives. Relatives told us they took place and were also an opportunity for socialising. We were told meetings provided feedback from people about the running of the home.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw no complaints had been received since the last inspection. Relatives' comments included, "I'd speak to the staff if I needed to,"

Good

Is the service well-led?

Our findings

A registered manager was in post and they were registered with CQC in 2015. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The atmosphere in the home was bustling, vibrant and friendly. People moved around different areas and sat and watched the comings and goings around the home. People told us the atmosphere in the home was warm and friendly and relatives and visiting professionals said they were always made welcome. Staff, people and relatives said they felt well-supported. Comments included, "The registered manager is very approachable," "You can speak to the manager and staff at any time," "The staff are so welcoming," and, "The registered manager is extremely
helpful."

The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. Staff we spoke with were passionate and enthusiastic about ensuring people who lived with dementia were encouraged to lead a fulfilled life whatever their level of need.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on care documentation, complaints, safeguarding incidents, the environment, medicines management, training, accidents and incidents and nutrition. Three monthly audits were also carried out for care documentation, health and safety, catering, medicines and infection control. The person in charge told us monthly peer visits were carried out by a manager from another service to speak with people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans. The operational director of care also carried out a regular visit. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

Regular analysis of incidents and accidents took place. The person in charge said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. We were told if an incident occurred it was discussed at a staff meeting to look at 'lessons learned' to reduce the likelihood of the same incident being repeated. We saw in recent staff meeting minutes the action that was to be taken to warn relatives of the choking risk if people who were at risk of choking were kindly given a sweet that they were unable to swallow. This risk was to be discussed at a relatives' meeting to ask people to check with staff before they offered a person a sweet in case they had difficulties with swallowing and were at risk of choking.

Staff told us regular general staff meetings took place as well as individual health and safety meetings and departmental meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues. Meeting minutes from February 2016 showed health and safety, staffing, training and the running of the service were discussed at the meeting.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service and their relatives and visiting professionals. We saw the survey results for 2015 and the eight returned had been overwhelmingly positive. We saw that results were analysed so that action could be taken as a result of people's comments, to improve the quality of the service. Throughout the report people's comments have been used to illustrate some of the quality of care provided.