Findings of CQC visit on 9th February 2016

What have CQC told us ?	What have we said we will do ?
Is the service safe? Medicines were not always managed in a safe way " We found insufficient details were recorded for people who required there medicines crushed"	This referred to the pharmacist agreement that medication could be crushed. GP agreement had been given and the relevant documentation with regards to crushed medication was in place in line with our policies and procedures, however there was no evidence of pharmacy involvement, this is now in place.
Is the service effective? Speech and Language Therapist team recommendations that had been made were not always communicated to all staff. This meant people were at risk of choking as they did not always receive the appropriate textured drink.	The relevant care plan has been reviewed and updated, however the specific resident was not at risk as they was receiving the correct textured drink. Further training for all staff on thickening of fluids and swallowing will commence week commencing 7th March 2016.