Methodist Homes

The Fairways

Inspection report

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18 December 2015

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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?	**Good**

Summary of findings

Overall summary

The Fairways is a residential care home providing personal care for up to 60 people. The inspection took place on 17 and 18 December 2015 and was unannounced. The home was last inspected in May 2014 and was found to be meeting all of the standards assessed. The service had a registered manager who was responsible for the day to day operation of the home. '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.'

At the time of our inspection there were 60 people living at the Fairways. People and relatives were positive about the home. People liked the staff who supported them and positive relationships had formed. Throughout the day we observed staff treated people with respect and afforded people their privacy when carrying out personal care.

Staff were knowledgeable about people's background, cultural and faith beliefs. Staff were able to tell us about people's preferences on how they wished their care to be delivered, along with people's likes and dislikes.

Medicines were managed safely and people received their medicines on time. Some people were supported to self-administer their own medicines.

The home was clean and well maintained; however, not all staff followed safe practices in relation to hand washing when serving food. The protective equipment staff wore when delivering personal care was not disposed of in a timely and appropriate manner.

A range of activities was available which people could take part in if they wished. People told us they made their own decisions about how they spent their day and what activities they wanted to take part in. Some people told us they did not wish to participate in activities and other people told us they sometimes felt lonely. The activities co-ordinator visited people in their room and offered one to one time to socialise.

People told us the food was good and there was sufficient to eat and drink. The chef catered for different types of diets such as vegetarian and fortified diets and the staff were knowledgeable about people's likes and dislikes. During meal times in the dementia wing, there was a lack of interaction between staff in ensuring people were able to make a choice and given appropriate support. The deployment of staff during the meal times meant that there was a delay in people receiving their meal together.

People told us they felt safe living in the home and with the staff who supported them. Staff had received training in how to recognise and report abuse. There was an open and transparent culture in the home and all staff were clear about how to report any concerns they had. Staff were confident that the registered manager would respond appropriately. People we spoke with knew how to make a complaint if they were

not satisfied with the service they received.

The registered manager carried out audits on the safety and quality of the service provided. People and relatives told us they were asked for their views on how the service was run.

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

Not all staff followed safe infection control practices.

People told us they felt safe living at the Fairways.

Staff had received training in how to recognise abuse and staff understood their responsibility in ensuring people were safe.

Medicines were managed in a safe and competent manner.

Is the service effective?

Requires Improvement

Staff did not always engage in a meaningful and inclusive way when supporting people to eat and drink.

People liked the food and told us there was plenty to eat and drink. People told us there were times when food was cold when it was delivered to their room.

People and their relatives spoke positively about the staff and told us they were skilled to meet their needs.

Is the service caring?

Good

Staff treated people with respect.

We saw that people were comfortable in the presence of staff and had developed caring relationships.

There were many compliments from relatives and families about the care and support people received.

Is the service responsive?

Good

Care records identified how people wished their care and support to be given and people told us they were happy with their involvement in their care and support.

There were opportunities for people to take part in activities although not everyone participated and some people told us they felt isolated at times.

People told us they knew how to make a complaint and would do so if needed.

Is the service well-led?

Good

The service was well led. The provider carried out an annual survey which enabled people and their families to give their view about the quality of the service.

Monthly and quarterly audits of the service provision were carried out to enable the registered manager to identify any shortfalls and to address these as required.

The service had clear values about the way care should be provided.

The Fairways

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 17 and 18 December 2015 and was unannounced. The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, for example older people and people with dementia.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before the inspection, we asked the provider to complete 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. This enabled us to ensure we were addressing potential areas of concern. We received feedback from a health care professional who has contact with the service.

During our inspection we spoke with 14 people who live at the Fairways, we also spoke with four visitors. Some people did not wish to speak with us, we therefore observed their care and interaction with staff. We spent time observing people in the dining and communal areas. During our inspection we spoke with the registered manager and the deputy manager, the chef, housekeeper, care workers including seniors, the activities co-ordinator and a volunteer.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with people, looking at documents that related to people's care and support and the management of the service. We used 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 talk with us. We looked around the premises and observed care practices throughout the day.

Requires Improvement

Is the service safe?

Our findings

The home was clean, well maintained and safe throughout, although there were some lingering odours within the dementia wing. The housekeeper told us that they were in the process of replacing some carpets and they constantly strove to eliminate odours by cleaning carpets and furnishings regularly. Within the communal bathrooms and toilets there were ample supplies of hand washing gel and paper towels available. Staff had access to supplies of protective equipment such as gloves and aprons. However, not all staff followed safe infection control practices. During lunch time in one of the dementia wing dining rooms, we observed that not all staff washed their hands before helping to serve the meals. This could pose a risk to people from infection or cause cross-contamination with food. The training matrix showed that only 52 percent of staff had completed the hand washing training.

We observed other practices which compromised people's dignity and hygiene. One person was having their breakfast in their room next to a table where their urine bottle had not been removed. Supplies of used gloves which staff used to deliver personal care were not disposed of appropriately or bins had not been emptied. On the first day of our visit we saw a used glove had been left on a musical instrument and we advised a member of staff. However, we found similar concerns over the course of the inspection. In one bathroom on the ground floor, the bin was overflowing with used gloves and some gloves were on the floor. On another floor, a bathroom bin was overflowing with used gloves. One person told us "the cleaner puts the hoover over most days. Look over there, all the rubbish needs collecting, it piles up. This table is not clean, is it?" We were able to confirm that this was the case as there was dried food on the table. Other people told us, "most of the time my room is clean and I try and keep it clean and tidy" and "our room is cleaned often".

This was a breach of Regulation 12 Safe care and treatment, of the Health and Social Act 2008 (Regulated Activities) Regulations 2015.

All of the people we spoke with told us they felt safe living at the home. Comments included "we feel safe here, the entry is controlled and it is very difficult to open the doors with all the different codes", "A lot of staff say hello to me so I suppose they know me. I feel safe here, the home is all on the same level so it's easier and they have nice wide corridors; there is someone here 24 hours a day" and "We feel safe living here, someone checks on us at night". A relative told us "the deputy manager is always walking around and I see her most visits, my mother is very safe here. People appeared comfortable in the presence of staff. People smiled at staff and attracted their attention to request support. Staff were observant in ensuring people were safe, for example holding a person's hand when they became unsteady and guiding them to a chair and putting people's equipment such as their walking frame within easy reach.

People had access to their call bells within their own rooms and within communal areas and we observed that staff responded in a timely manner. Staff told us there were enough staff although there were times when they were busy. There was a mixed response from people living at the Fairways in relation to staffing. One person said "you might have to wait a while but they get to you in the end" and "the general feeling we have is that the home is under staffed first thing in the morning we all need help, we are constantly told [by

staff] 'there are three of us and 30 of you to look after". This statement was echoed by other people with further comments such as "there are not enough staff, yes they are approachable, they just forget to come back to us". Another person told us "there are not enough staff and I wait. When they are busy I think the staff get fed up and leave, so many have left since I have been here, about a year I think".

The deployment of staff did not always meet the needs of people. During our two day inspection we observed that staff were focused on tasks and at times, such as in the dining rooms, one member of staff would be available with further staff coming in when they had completed what they had been doing. This meant that people had to wait until staff were available to serve them their meal. During lunch time in the dementia wing, several staff were dishing out meals and taking them to people in their rooms, this further impacted upon the time it took for people in the dining room to receive attention and for people to eat together as a table.

We spoke with the manager about the staffing levels and asked for evidence of how they calculated the staffing ratio. The registered manager told us they had a set number of staff and at this time staffing was not based upon dependency levels. Within people's care records we saw a dependency rating form, however, these had not been kept up to date and had not been used to inform staff ratio's. The registered manager informed us that the provider would be introducing a dependency scoring tool for this purpose. In the meantime, they had made changes such as in, the chef serving breakfast and lunch and volunteers assisting with the tea trolleys.

People were safeguarded from abuse by the processes and procedures in place. Staff attended safeguarding adults training to ensure they were able to identify abuse and received guidance on the procedure for reporting suspected abuse. Members of staff knew the signs of abuse and the expectations placed on them to report suspected abuse. The registered manager was vigilant in ensuring they made appropriate referrals to the safeguarding team when required and notifications to the Care Quality Commission of incidents and accidents occurring within the home.

Safe systems of medicine management were in place. Medicines were administered from a monitored dosage system and staff signed the medicine administration records (MAR) charts to show they had administered the medicine. We observed staff administering medicines to people where they explained what the medicine was for and people told us they understood the reason and purpose of the medicines they were given. Protocols for medicines to be administered when required gave staff guidance on the circumstances when the medicine was to be administered.

The re-ordering of the stocks of medicine was carried out in a timely way to ensure people had a constant supply of their medicine. All medicines were securely locked away in a dedicated medicine room. Some people were able to self-administer their medicines and their medicines were kept within a lockable cupboard in their room. There were risk assessments in place for people who self-administered their medicines. One person told us "I self-medicate for me and my husband, I have always done this. My tablets are best taken with food and I can control".

Systems were in place to identify risk and action was taken to manage the risk appropriately. Where risks were identified a plan to lower the risk was developed. Risk assessments were devised for people at risk of falls and for people at risk of developing pressure ulcers and malnutrition and for people with mobility needs. Where people were identified as having care and support needs relating to safe moving, equipment such as hoists were available. Staff told us they had received training in moving and handling, including the effective and safe use of equipment used to assist people to mobilise or transfer from, for example a bed to a chair. Accidents and incidents were monitored for trends and to ensure further preventative measures

could be taken.

The service followed safe recruitment practices. We looked at five staff files which included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

The communal areas of the home were clutter free and spacious with grab rails throughout the hallways. Bathrooms and toilets had support rails in place. Some of the communal rooms had a balcony and toughened perspex glass had been fitted at a safe height to ensure people were safe from the risk of falls and could still enjoy the views.

The provider had risk assessments and guidance in place with regards to the environment, legionella, fire systems, and equipment and how to respond in the event of an evacuation. Emergency plans were in place with a neighbouring care home should the need arise for people to be evacuated.

Requires Improvement

Is the service effective?

Our findings

People told us they had enough to eat and drink. A range of soft drinks, water, tea and coffee was available to people throughout the day to keep them hydrated. People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. Needs and preferences were also clearly recorded in their care plans. At meal times people were offered a choice of meal including vegetarian. In addition people were catered for through pureed and fortified diets.

We used 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 talk with us.

People commented that the food was good; however for people who preferred to eat in their room we were told "the food is cold when it arrives and I have to put it in the microwave. The care worker plonks the food on the table and shouts it is on the table, no-one helps me get my wife to the table to eat it, they are gone".

At meal times in some areas, we observed people being supported to go to the dining room. Carers brought people carefully into the room asking where they would like to sit, explaining, 'hold onto the table and feel the chair behind you'. However, during breakfast and lunch-time in the dementia wing we observed that not all staff interacted with people in a meaningful and positive way. One member of staff was assisting a person to eat saying "alright, here we go, is that nice?" However, they did not tell them what food was on the fork or offer them a drink in between mouthfuls. We did not hear staff describe the food they were assisting people to eat. Staff put plates of food and drinks in front of people without saying what they were being given. One care worker called the person's name, when the person turned around they offered the fork of food, again without saying anything about the food being offered. We were sat at a table where a care worker removed a plate from one person without asking if the person had finished their meal. One person went to pick up a pea from their plate to eat; the carer worker strongly remarked 'no, do it with a spoon'.

Two people were given a bowl of porridge. The porridge was hot yet the care worker did not leave it to cool before serving. One person sat looking at their porridge without any interaction from staff and the other person fell asleep. After 20 minutes the care worker returned to one person and realised their porridge must be cold and replaced it. Another care worker said to a person "oh you are awake now" and then proceeded to support them to eat their meal. The person had not been asleep.

Between the two dining rooms in the dementia wing there was a lack of consistency in how staff supported people to eat and drink. In one dining room, staff showed people the plates of food to enable them to make a visual choice. In the other dining room this was not always the case. People were served with a meal without being asked what they wanted. Staff told us "we know what they like". We asked one person what they were having for breakfast; they replied "I like breakfast". There were no picture menus to enable people to take their time to make a decision and visually choose their meal.

We found that some staff continued with tasks such as clearing the kitchen when people required either

prompting or encouragement to eat. Towards the end of the lunch-time meal, a care worker sat down at a table with people and ate a meal in a pudding bowl. They did not have a meaningful conversation with anyone at the table. Another care worker told us "we have adopted eating with people here and it works well". Without interaction with people, this practice would not be beneficial in encouraging people to eat. There were times throughout the serving of meals that staff came into the room and did not acknowledge people, staff chatted to each other to the exclusion of people and a test fire alarm went off during a meal time with one person remarking "the noise is putting me off my food".

This was a breach of Regulation 14 Meeting nutritional and hydration needs, of the Health and Social Act 2008 (Regulated Activities) Regulations 2015.

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 legally authorised under the MCA. 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). The Deprivation of Liberty Safeguards (DoLS) provides a process by which a provider must seek authorisation to restrict a person's freedoms for the purposes of care and treatment. The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body.

At the time of our inspection the provider was introducing new paperwork to record mental capacity assessments and the best interest decision making process. We were provided with a copy of the documents which explained a clear pathway of seeking and recording consent. The registered manager had followed their current processes; however, not all recording was complete such as in how best interests decisions were arrived at or how staff had supported the person to understand the decision being made. Staff had varying levels in their understanding of the MCA and DoLS.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Where decisions were made by someone other than the person, the provider kept a copy of the appropriate documents to validate the decision making process was lawful.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "from what I can see staff are well trained" and "I am upstairs all the time and I see well trained and skilled staff". Staff told us they had the training and skills they needed to meet people's needs. Comments included: "the training is really good" and "we are reminded when we need to take refresher courses". Staff completed training which included safeguarding and the Mental Capacity Act 2005, fire safety, moving and handling and infection control. Staff participated in other training relevant to their role such as, hydration and nutrition, food safety and managing challenging actions with dementia awareness.

Many of the staff had qualifications in health and social care such as, national vocational qualifications and the new diploma. New staff were following the care certificate and completed an induction period with specific training and mentoring before working on their own.

People were supported by staff that had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "we talk about how we are personally doing, if we have the training

we need and if anything else needs to be addressed". Staff confirmed they had an opportunity each year to review their progress and review their personal development plan. Regular team meetings were held to enable staff to come together and share their views, look at practice across the team and areas for development.

Staff told us they felt supported by the registered manager, and other staff. Comments included: "they are definitely approachable, so supportive and we have a brilliant team, we work well together" and "we have two staff teams where we work alternate weekends, it gives us a better work life balance. Communication between the teams is good especially during handovers".

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. District nurses, GP's and other professionals visited the home to offer health care as required. Referrals were made by the registered manager to ensure people received appropriate care such as a dietician, the memory clinic, mental health services and occupational therapy. A visiting health care professional told us "I have found them to be a helpful and caring team and they are clearly highly regarded by their residents". Visiting professionals documented the care they had given people which ensured care staff had appropriate information about follow up care including monitoring of their condition.

The dementia wing had wide hallways where people could move around freely. Communal rooms such as the bathroom and toilets had some signage, however, these were a small size and may not clearly depict to a person with dementia, the purpose of the room. The hallways were painted the same colour and lacked interest such as pictures, differentiation in colour and sensory materials to support people with dementia to orientate and maintain their independence.

Good

Is the service caring?

Our findings

Visitors to the home told us "I looked at other care homes for my relative and this was the best, the staff are caring but they are also very busy", "the carers are absolutely lovely and we are very happy" and "this home is second to none and they have been brilliant". One person said "I would recommend this home, I get what I want, they help me most of the time" and another person told us "it's a lovely place and I am happy here"

We observed carers knocking on people's doors before being invited in and personal care was carried out in the privacy of the person's room. All of the people we spoke with thought they were treated with dignity and respect by staff. Staff responded promptly to people who were requesting assistance and they did so in a patient and attentive manner. When time permitted, we saw staff engaging with people through general banter and sharing jokes. Staff encouraged people to do as much as they could for themselves with one person receiving praise when they had managed to successfully walk back to their room. On different occasions we saw when people became agitated or distressed, staff were able to comfort them and de-escalate the situation. When people shouted out, staff responded quickly, offering an arm or a hug to calm the person.

The registered manager and staff treated people equally and as individuals. Staff had received training in equality and diversity and there was a policy in place to support staff in this practice. Staff were knowledgeable about the people they cared for, such as their cultural background, faith beliefs and likes and dislikes.

There were a range of accommodation options for people, from individual bedrooms with en-suite facilities to two bedroom options with a lounge and kitchen. People had personalised their accommodation with their own furniture, preferred décor and personal items. People had access to their care plans and these were displayed behind a discreet box on the wall of their room which had a painting on the front.

In several places within the home, information was available about a range of subjects, such as using advocacy services and different health conditions such as diabetes, dementia awareness and keeping well.

People and their relatives were given support when making decisions about their preferences for end of life care. Staff had received training in end of life care from a local hospice and where necessary, people and staff were supported by palliative care specialists.

The provider carried out an annual satisfaction survey for people and families, however at the time of our inspection, the feedback had not yet been collated. We looked at the minutes of the residents meetings and found a core of people were involved in stating their views about the quality of the service and how it was run, however, we did receive some comments from people which was contrary to this such as "we are never asked our views, the service varies according to who is on duty, there is a residents meeting but we have never managed to get to one, I can't walk there", "we are asked to fill in a form about our views it says if you can't fill it in yourself ask your next of kin or ask a member of staff to help – honestly!. I don't go to the residents meetings I read the minutes; there is no point in going". A visitor told us "I think this home is

brilliant, the set up is really good. They are always asking for feedback to improve the home".

The home received many compliments from people and relatives such as 'Thank you for everything you do all year round', 'well done to you and all the volunteers you do an amazing job' and 'thank you for all your on-going care and support you give to my mum'.

Good

Is the service responsive?

Our findings

People received personalised care and support. We looked at the care records of eight people. They were person centred and had taken into account the person's wider individual needs, including: personal care, medical and cultural and spiritual needs. The records clearly identified how people wished their care and support to be given. Before people moved into the Fairways, a pre-admission assessment was carried out to ensure the home could meet the person's needs. Once the person moved into the home, the registered manager ensured they were monitored and fuller assessments were carried out to ascertain the person's day to day needs. People's care was reviewed on a regular basis and also if there were any changes to the person's care needs. People told us they were involved in their care planning and their families where they wished. Care records were signed to confirm this.

The deputy manager was in the process of updating the care records and we saw evidence of the audits. Where care plans lacked sufficient detail, signatures or cross-referencing to other records, the deputy manager had already identified this for action and care records were being amended. One aspect which had not been identified was the lack of information around emotional wellbeing within some of the daily records which could indicate a decline in the person's health. We were advised that this would be a priority to remind staff to record this. In line with the care plan and risk assessments, daily monitoring charts were kept in relation to food and fluid, continence management and re-positioning.

Staff told us they had access to the care records and felt the care plans were detailed and enabled them to give timely and appropriate care. Records were personalised with a photograph of the person and included their next of kin details and other important relationships. Staff was able to tell us about the people they cared for, such as their likes and dislikes, their personality, what made them laugh or annoyed. Staff described how some people could display behaviours which challenged and were able to demonstrate to us a good understanding of how to calm, distract or de-escalate certain situations.

People could participate in a range of activities such as music therapy, singing in the choir, bingo, arts and crafts and flower arranging. At the time of our visit there was a visiting drama company which presented 'Jack and the Beanstalk'. People told us they had enjoyed this activity and they tended to join in with activities when they 'felt like it'. We also observed one of two activity co-ordinators and a volunteer making 'pom poms' with people in the dementia wing. We did not see people taking part apart from picking up the wool, as the volunteer and activity co-ordinator chatted to each other whilst people looked on.

Three people told us they had no interest in participating with activities as they spent time with their families and were able to get out and about. The visiting chaplain was appreciated by all of those he visited and faith services were held in the home. Other people were content to stay in their room watching television or reading. Further comments included "I get very lonely, I don't do anything all day, the days just drift away and I go back to sleep, it is not often I get anyone to talk to" and "I can't join in any activities as I am deaf and I haven't got a hearing aid anymore, too much trouble so I stay in my room". We asked the activities co-ordinator how they ensured that people were not socially isolated. They were able to tell us how they visited people in their room to offer social contact, sometimes reading to people, listening to music or just chatting.

She told us they were aware that some people may not like too much social interaction and worked hard to make sure people did not become isolated.

A copy of the complaints policy was available within the foyer of the home and within the information pack about the home. People told us they knew how to make a complaint, although two people told us they had complained about various things yet did not feel they were always listened to. We reviewed the complaints which had been received over the previous year and found that 'speaking up' was encouraged; people's concerns and complaints were investigated and responded to in a timely manner.

Good

Is the service well-led?

Our findings

The service had a registered manager in place and there were clear lines of accountability from provider to care worker. Staff were able to tell us about their roles and spoke positively about their relationship with the registered manager and deputy manager. Comments included, "we are valued for our work" and "we can go to the manager about anything, they always listen".

The provider had a system in place to monitor the quality of the service. This included submitting statutory notifications to the CQC as required. In addition, monthly and quarterly audits completed by the registered manager and regional managers. The audits covered areas such as staff training, supervision and appraisals, care plans, management of medicines, environmental risks, incidents and reporting on the levels of falls. Internal audits had identified some shortfalls and action had been taken, for example in the completeness of the care records. However, the infection control issues had not been identified and staff practice when supporting people to eat and drink.

There was an open and transparent culture and the registered manager and staff welcomed the views of people and their families. People who used the service were able to provide feedback about the way the service is led. The last satisfaction survey for people and their families was carried out in 2015, and at the time of our inspection was being collated. The information would be used centrally and locally to inform future planning and development of the service.

The registered manager told us that one of the challenges they faced was the recruitment of staff. The home was fully occupied and there were some staff vacancies still to be filled. They were seeking to recruit staff who shared the vision of the home to offer first class care. The registered manager told us "we want staff that are sunny and willing with a bend over backwards disposition".

Recent changes had been the introduction of a training lead and also assigning staff lead roles or champions to take forward areas such as for infection control and dementia care. Improvements were to be made to the keyworker system and the senior care staff would now lead a team. Key staff would participate in a dementia care facilitator course who would then roll out training sessions for staff, looking at dementia from the person's perspective. Other training was being arranged in understanding care planning, expressing sexuality, communication and in mental health.

The service worked in partnership with key organisations to support the provision of joined up care. Care planning documents evidenced that referrals were made by the service for the involvement of various health and social care agencies. The registered manager was proactive in working with local initiatives such as skills for care, community centres, schools, hospices and provider meetings. They had also signed up to NAPA National Activity Provider's Association which offers resources, training and best practice in meaningful activities for older people.

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risk of the spread of infection was increased because staff did not always follow safe infection control practices through hand washing. Supplies of used equipment for the use in personal care were not disposed of in a timely way. Regulation (12) (1)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Staff did not always engage with people in a meaningful and inclusive way at meal times. Staff did not always support people to eat and drink as required and in a timely manner. Some people received cold food. Regulation 14 (1) (2) (b) (f)