Life Style Care (2011) plc

Ashmead Care Centre

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 20 and 21 November 2014 and was unannounced. At our last visit in March 2014 the service was meeting the regulations inspected.

Ashmead Care Centre provides accommodation for people requiring nursing and personal care. The service can accommodate up to 110 people. At the time of our inspection 93 people were using the service.

The home was divided into six units. Three units were allocated to people living with dementia and two units were for people requiring general nursing. One unit which was to become a private 20 bedded unit was closed and undergoing refurbishment at the time of our visit. There did not appear to be any distinguishing features to any of the units and we saw that people with very different needs were placed across all six units. These arrangements may have made it difficult to provide specialist care to people identified as having very high support needs.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. A newly appointed home manager was responsible for the day to day management

Summary of findings

of the service and was being supported in her role by a peripatetic manager, a deputy manager and a clinical nurse lead. The home manager told us she would be applying to become the registered manager in the near future.

People's needs were assessed and care plans were developed to identify what care and support people required. We saw that reviews of people's health and safety had been completed and updated in line with the provider's policies and procedures.

Staffing levels were based on the dependency levels of people using the service. People using the service, relatives and friends and members of staff expressed concern that staffing levels were not always adequate to consistently meet people's needs.

The home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. We found that staff had received training and understood when a DoLS application should be made and how to submit one. However, this had not happened when applications were needed in relation to people being able to independently access different parts of the building and/or leave the premises if and when they wished to.

Staff had qualifications in health and social care, previous experience of working in care settings and received regular training. Most of the staff had completed training in dementia awareness.

We saw evidence that the home worked collaboratively with other health and social care professionals to ensure people received specialist care and treatment. Palliative care nurses visited the home on a regular basis and the home had gained accreditation in the Gold Standards Framework (GSF) in September 2014. GSF is an evidence based approach to optimising care for people approaching the end of their lives.

Staff demonstrated that they understood how to recognise the signs of abuse. Staff told us they would report any concerns to senior members of staff who would then assess the situation and report to the local authority's safeguarding team and the Care Quality Commission (CQC) as required.

Activities were limited as the service did not have an activities co-ordinator. People using the service told us they had little opportunity to access the local community and take part in everyday activities such as going to the local shops, going out for a coffee or going to church.

We observed staff supporting people to make choices about the food they wanted. However, we noted that staff did not always ensure people were able to reach their food when it was served to them in their rooms. Some people who required prompting and/or support to eat their meal did not always receive this assistance. People's opinions as to the quantity, quality and choice of food on offer, were mostly negative.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Some people using the service told us there were not enough staff on duty. Relatives also expressed concerns that staffing levels were inadequate and resulted in people's needs not being met.

Assessments had been undertaken to identify any possible risks to people's health and safety. Assessments were detailed and covered areas such as falls, moving and handling, pressure area care, weight, diet and nutrition.

Staff were familiar with the policies and procedures relating to the safeguarding of vulnerable adults and knew how and when to report concerns and to whom.

The provider followed appropriate recruitment procedures and staff files we looked at contained copies of application forms, references, professional registration details and criminal record checks.

Is the service effective?

Inadequate

Aspects of the service were not effective. The home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People living in the home were unable to independently access other parts of the building and/or leave the premises if and when they wished to.

People were supported to make choices about the food they wished to eat but people's opinions as to the quality and quantity of food on offer, was mostly negative.

People's care plans were detailed and covered their health and personal care needs. Staff had received training in dementia awareness and had completed mandatory training covering areas such as fire safety, food hygiene and customer care.

Staff told us they received adequate supervision but one staff member told us they were not well supported by senior staff members.

Is the service caring?

Requires improvement

The service was not always caring. People told us staff were kind and caring but often too busy to talk to them.

Feedback received from relatives and friends since the last inspection in March 2014 indicated that there were concerns around the care and treatment of people living at the home.

We saw evidence that specialist health care professionals were involved with people with palliative care needs and that the home had gained accreditation in the Gold Standards Framework (GSF) in September 2014.

Summary of findings

Is the service responsive?

Inadequate 

Aspects of the service were not responsive. There were no activities co-ordinators employed by the service at the time of our visit and therefore people were not being provided with meaningful activity.

Care plans were detailed and contained many different sections covering areas such as health and safety, contact details, medical histories, information regarding advance care planning, medicines and consent forms.

We saw copies of the complaints policy displayed within the home. The policy explained how to make a complaint and to whom. We saw that where appropriate, issues and/or concerns had been resolved following review meetings, changes to care plans and/or the implementation of action plans.

Is the service well-led?

Inadequate 

Aspects of the service were not well-led. The service did not have a registered manager. A newly appointed home manager was responsible for the day to day management of the service.

The service had a whistleblowing policy which provided staff with guidance on how to voice their concerns with the provider. The policy did not make it clear that concerns could be reported in confidence to organisations including the local authority and/or the Care Quality Commission.

There were processes in place for reporting accidents and incidents. We saw that accident analysis records had been completed and were told that these records fed into the monthly service report completed by the manager.

The provider conducted regular audits to monitor the quality of service provision in areas such as dignity issues, hospital admissions and health outcomes. However, audits had not identified aspects of care and treatment that were inadequate, unsafe or inappropriate.

Ashmead Care Centre

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.

We carried out an unannounced inspection on 20 and 21 November 2014. The inspection team included an inspector and a specialist advisor with experience in social work and the care of older people. We were also assisted by two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses services, in this case services for older people and people with dementia.

Before our visit we reviewed information we held about the home including the last inspection report from March 2014 when we judged that the provider was meeting the regulations we inspected. We reviewed notifications we had received from the provider and other agencies since our last inspection and spoke with a lead safeguarding officer from the local authority and other health care professionals involved in people's care. We also reviewed complaints and concerns reported to us by the relatives and friends of people who use the service.

We spent time talking with 20 people living at the home and 10 visiting relatives/friends. We spoke with the home manager, a peripatetic manager and a regional manager. We also spoke with five nurses, three care staff members and the home's housekeeper. We discussed people's care with a visiting GP and a palliative care nurse.

After the inspection we were contacted by two health and social care professionals who voiced concerns around the home environment and the care and treatment received by people living at the home.

We looked at all the communal parts of the home and with people's agreement, looked at their rooms and bathrooms.

We reviewed six care records, five staff files and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People using the service told us there were not enough staff on duty to meet their needs. One person told us "There aren't enough staff and they don't always answer the call bell." Another person said "All the things I'm supposed to be doing I can't because staff are too busy." Some of the relatives we spoke with also expressed concerns that there were not enough staff on duty to enable people to do the things they wanted to do when they wanted to do them. For example, one relative told us their family member had been left in bed until midday, without having their personal care needs attended to. Another relative told us that there were too few staff to operate hoists, to support people who required assistance at meal times and to settle people in the evenings. One member of staff we spoke with during our visit told us they had serious concerns about people's safety.

The manager told us that normal staffing levels during the day were three care staff and one nurse for the 20 bed nursing units and four care staff plus one nurse for the 20 bed dementia units. The deputy manager or clinical lead nurse covered all floors. We were also told that staffing numbers were based on people's dependency levels. It was unclear from this information whether these staffing numbers were static or adjusted when people's needs increased. A nurse told us that the worst thing about her job was that at times there weren't enough staff on duty.

The manager told us that several staff had left in the past six months due to the opening of a new care home nearby. The service was therefore using a significant number of agency staff particularly at weekends when almost half the numbers of staff on duty were agency workers. The clinical lead told us that wherever possible they used the same agency staff to offer continuity of care. The manager told us that the service was in the process of actively recruiting new staff.

Staff told us they received regular supervision and staff records confirmed this. One staff member told us, "Supervision is useful; you can speak about things you might not be happy with or about training you might want to do." However, another member of staff told us she did not feel adequately supported by senior members of staff and was finding that her responsibilities were often beyond her capabilities.

People's concerns as described above and the lack of evidence to demonstrate how the service measured people's needs and adjusted staffing levels accordingly, indicates that there were insufficient numbers of suitably qualified, skilled and experienced staff on duty to safeguard people's health, safety and welfare. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We had received no safeguarding notifications from the provider since the last inspection took place in March 2014 despite receiving information from the local authority indicating that a number of serious incidents had occurred within this period. The manager told us that they had notified CQC of safeguarding incidents but that notifications had been sent to an incorrect email address. We were shown email correspondence that verified this error. We have requested that in future all notifications are sent to the correct email address so that where needed, action can be taken.

The provider followed appropriate recruitment procedures and staff files we looked at contained copies of application forms, references, professional registration details and criminal record checks. The manager told us she was a dementia specialist and we saw from the staff training matrix that most staff had completed training in dementia awareness. In addition to mandatory training covering areas such as fire safety, food hygiene and customer care, some staff had completed training linked to the Qualification and Credit Framework (QCF) in health and social care.

Senior staff completed assessments to identify any possible risks to people's health and safety. Assessments were detailed and covered areas such as falls, moving and handling, pressure area care, weight, diet and nutrition. We saw that these assessments were reviewed and updated on a monthly basis and there was clear evidence that action had been taken when concerns were flagged with senior staff and other healthcare professionals.

Medicines were stored correctly. We observed medicines being checked against medication identity records and medicines administration recording (MAR) sheets before being administered to people living in the home. People were offered water to take with their medicines, given the time to take them and observed before the relevant records were signed by the nurse. We saw that allergies noted in care plans were also clearly marked on the MAR sheets.

Inadequate

Is the service safe?

We asked staff what they would do if they felt someone living at the home was being abused. Staff demonstrated that they understood how to recognise the signs of abuse and told us they would report any concerns to senior members of staff who would then assess the situation and report to the local authority's safeguarding team and the Care Quality Commission (CQC) as required.

Inadequate

Is the service effective?

Our findings

People's rooms were situated along corridors accessed by a series of locked doors with coded key pad access. We were told that key codes were known only to staff members. People were unable to independently access other parts of the building and/or leave the premises if and when they wished to. We asked staff for and could find no information in people's individual care plans demonstrating that assessments had been undertaken or best interest discussions had been held in relation to this matter. This meant that the home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). We discussed this issue with the manager who told us they were in the process of submitting the relevant DoLS applications to the local authority. Staff understood the reasons for these decisions and their potential impact on people's freedom. The management team were aware of the need to inform CQC of any DoLS applications submitted to relevant agencies.

The home was set out over three floors and divided into six units, one of which was closed for refurbishment. People living at the home had a range of different care needs with a significant number of people having some form of dementia. We saw that the home also cared for people with communication difficulties and behaviours that challenged the service. Some people were staying at the home for relatively short periods of time before returning to their own homes. This was termed 'step down' care. Other people living at the home were nearing the end of their lives and receiving palliative care. The home did not appear to support particular needs by unit. These arrangements may have made it difficult to provide specialist and personalised care to any of the identified groups above. A senior nurse told us that people were missing out due to the high levels of need of some of the people living in the home. This nurse told us "We need more staff."

During our inspection we noted that some areas within the home smelt strongly of urine. We saw from staff meeting minutes that the issue of odours had been addressed. However, there was no indication that people's continence needs had been considered in these discussions. The advice given focused instead on how bad odours could be eliminated by thorough cleaning and the use of air freshener.

The above paragraphs demonstrate that proper steps had not been taken to ensure that people were protected against the risks of receiving care that was unsafe or inappropriate. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's opinions as to the quality and choice of food on offer, was mostly negative. One person told us, "I don't think the food's very good, it's repetitive and you don't get a choice". Another person told us the food wasn't great and there wasn't enough. Others told us they thought the food was "vile" and "too English." People were asked to select their meal choices from written menu cards. We were told that pictorial menus were not available. We observed staff supporting people to make choices about the food they wanted. Staff told us that kitchen staff provided alternatives if people did not like what was on the menu. However, we noted that staff did not always ensure people were able to reach their food once it had been served to them in their rooms. Some people who required prompting and/or support to eat their meal did not always receive this assistance. This meant that people were not being protected from the risks of inadequate nutrition and dehydration. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's names were not always displayed on the doors to their rooms and rooms often appeared to be void of personal touches or items which could have supported people's sense of identity and/or aided memory. In some areas, the provider had attempted to consider the design of the service in supporting the needs of people living in the home. For example, some bathrooms and toilets had cartoon pictures on the doors indicating their use and some door frames had been painted in contrasting colours to the walls. Some of the recesses along the corridors appeared to have themes, railways or woodland animals for example. However, the use of pictures, themes and colour codes was inconsistent and for some people may have led to even greater confusion as they attempted to navigate their way around the home.

People's care records included the contact details of people's family members, GPs, health care professionals and other relevant representatives. There were sections covering people's childhoods, working life, significant places and people, interests and preferences. We saw that

Inadequate

Is the service effective?

reviews of people's health and safety had been completed and updated in line with the provider's policies and procedures. People had given consent for the use of photographic identity records and in most cases these forms had been signed, witnessed and dated appropriately. Daily progress notes were completed and up to date.

One person told us they wanted to see a dentist and another person asked us if we could arrange an appointment with a chiropodist for them. We spoke to the manager about these requests and were informed that appropriate appointments had already been booked.

Requires improvement

Is the service caring?

Our findings

We noted from our observations and from talking to people that the interaction between people living in the home and care staff was minimal. A number of people told us that no one talked to them. One person told us they "would like someone to come and talk with them once a week or even once a month" and another person told us that the inspector was the first person they had spoken to at length since they had moved into the home over a month ago. Some people also told us that staff did not always speak English very well and that sometimes they had difficulty making themselves understood. However, all the staff we spoke with during our visit were able to converse in English of a good standard.

Feedback received from relatives and friends since the last inspection in March 2014 indicated that there were concerns around the care and treatment of people living at the home. For example, relatives told us their family members were left in bed for lengthy periods of time, assistance with personal care was not always delivered in a timely manner and that on occasion people's personal belongings had gone missing. Where we were able to contact these relatives, we were informed that most of these issues had been resolved.

People told us the staff were kind and caring. One person told us how the nurses had done a very good job of looking after them and that they were now a lot better and ready for home. Another person told us "I get on with all the staff, if I ask for help, they help me."

Care staff told us they always asked people for their consent before they carried out any personal care. We saw staff drawing people's curtains before using hoists and offering reassurance and encouragement to people during these and other tasks. One relative told us about an incident involving their family member where staff had had acted with kindness and had respected this person's dignity. Other relatives told us they appreciated the fact that staff went to the trouble of pinning people's hair and painting their nails.

A member of staff told us, "People always have choices about whether they want a male or female [member of staff] and what clothes they want to wear, we make sure people are well presented." Care plans contained sections to be completed about how people wished to express their sexuality and maintain their self-image and asked important questions about end of life issues, spirituality, cultural practice and preferred funeral arrangements.

We saw evidence that specialist healthcare professionals were involved with people with palliative care needs and that the home had gained accreditation in the Gold Standards Framework (GSF) in September 2014. GSF is a systematic, evidence based approach to optimising care for people approaching the end of their lives. GSF meetings were held on a regular basis and the home worked closely with Trinity Hospice nurses.

Relatives and friends told us they were able to visit their family members whenever they wished. One relative told us they visited every day and always had lunch and tea with their family member. Another relative told us they were always made to feel very welcome by staff and could make themselves a cup of tea or coffee in the reception area whenever they liked.

We saw evidence that people were asked for their views about the care they received and how the service was run. We were told meetings were held for residents and relatives on a regular basis. Relatives told us that they were contacted by the home if there were any concerns regarding the health and welfare of their family members.

Inadequate

Is the service responsive?

Our findings

People using the service told us they had little opportunity to access the local community and take part in everyday activities such as going to the local shops, going out for a coffee or visiting local amenities. One person said, "I haven't been to church since being here, [staff] should ask us if we want to go to church." Another person said, "I need to go out and about more often but I can't because [staff] are too busy."

The provider's service user guide stated that there was a wide range of activities available. An activities programme was displayed on the noticeboard which listed activities such as biscuit decoration, floor netball and listening to music. When we enquired as to where these activities were taking place the manager told us there were no activities co-ordinators employed by the service and therefore no activities currently organised for people living at the home. The manager told us that they were hoping to recruit two new co-ordinators in the near year but that in the meantime a volunteer was assisting once a week with activities such as singing and games.

On the day of our visit some people were watching television in the day room. However there appeared to be insufficient comfortable chairs for the number of people attending and many people remained seated in their wheelchairs for long periods of time. We spoke to one person who told us their partner was also living in the home but that they had been placed on different floors which made visiting difficult. Some people had relatives visiting but a significant number of people were alone in their rooms and not occupied in any form of meaningful activity. One member of staff told us "I would love to go in and read a book to those in their rooms but there aren't enough staff, those people get left out."

The above paragraphs demonstrate that people's wellbeing was not being maintained or promoted through the implementation of meaningful activity programmes or opportunities for social interaction with others. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home completed assessments for all people newly referred to the service. Care plans were detailed and contained many different sections covering areas such as health and safety, contact details, medical histories, information regarding advance care planning, medicines and consent forms. The size and detail of care plans may have meant that new staff and staff from agencies did not have the time to read all of the information available before working with people living in the home. Not all sections of people's care plans had been fully completed and/or signed by the relevant parties.

The service had recently introduced a new system of handover which involved all levels of staff. However, staff told us that these meetings were not always taking place, particularly when there were high numbers of agency staff on duty. One member of staff told us the new handover arrangements were a positive thing whilst another member of staff said the meetings were too brief and that clearer communication was required between nursing and care staff.

We saw copies of the complaints policy displayed within the home. The policy explained how to make a complaint and to whom. We saw that the provider had received and logged eight written complaints since the last inspection in March 2014, all relating to standards of care. We saw that where appropriate, issues and/or concerns had been resolved following review meetings, changes to care plans and/or the implementation of action plans.

Inadequate

Is the service well-led?

Our findings

Not all staff members were aware of who was managing the service. One member of staff told us "I couldn't tell you the name of the manager." The service did not have a registered manager. A newly appointed home manager was responsible for the day to day management of the service and was being supported in her role by a peripatetic manager, a deputy manager and a clinical nurse lead. The home manager told us she had been in post for just two weeks at the time of our visit and was in the process of applying for the registered manager position.

Staff told us the manager was "supportive" and that they were happy in their jobs. A relative told us that the new manager had stopped to introduce herself and inform them about a cheese and wine party that was in the process of being organised so that relatives and visitors could get to know her.

We saw that quality monitoring was undertaken to assess compliance with internal standards. Monthly audits looked at areas such as dignity issues, hospital admissions and health outcomes. The monthly home audit conducted in November 2014 gave an amber score rating meaning that the majority of internal standards had been achieved but that minor improvements were required. Recommendations instructed staff to review all care plans against the audit findings.

During our visit observations and conversations with people who use the service and their family members, indicated a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These shortfalls had not been identified or addressed by quality assurance processes demonstrating that these processes were not always effective or robust enough to ensure people's health, safety and welfare was protected and promoted. This is a breach of Regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home had recently instigated a daily management meeting where managers and senior clinical staff discussed admissions and discharges and any other healthcare related issues. During the meeting staff discussed hospital admissions, in particular the high level of admissions related to urinary tract infections (UTIs). The manager told us that the service was now focusing on better infection control practice and other standard interventions such as increased fluid intake. However, we noted that drinks were not always placed in reach of people and that staff were not always recording people's fluid intake.

The home worked closely with people's GPs, palliative nurses and clinical staff from the Behaviour and Communication Support Service (BACSS), a specialist multi-disciplinary team commissioned by the local NHS mental health trust. Staff described an episode where they had worked collaboratively with the team in order to reduce incidents of behaviour that challenged the service. We saw evidence that demonstrated behaviour changes had occurred and that the person receiving this support was more settled than previously.

People using the service, their family members and representatives were asked about their views about the care and treatment provided. Meetings for people living in the home and their relatives were held every six weeks and we saw minutes had been recorded from these meetings. Relatives told us they felt able to raise any concerns they might have with staff and that matters were usually dealt with satisfactorily.

There were processes in place for reporting accidents and incidents. We saw that accident analysis records had been completed and were told that these records fed into the monthly service report completed by the manager. Incidents were discussed during staff meetings and within staff supervision sessions.

The service had a whistleblowing policy which provided staff with guidance on how to voice their concerns within the company they were employed by. The policy did not make it clear that concerns could be reported in confidence to the local authority, the Care Quality Commission and other relevant agencies.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of service users.** **The registered person must take proper steps to ensure each service user is protected against the risks of receiving care or treatment that is inappropriate. Regulation 9 (1) (a) (b) (i) (ii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** **The registered person must protect service users and others who may be at risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to regularly assess and monitor the quality of the service and identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 10 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. Staffing. The registered provider must ensure people who use the service are safe and their health and welfare needs are met by sufficient numbers of appropriate staff. Regulation 22.
	The registered provider must ensure people who use the service are protected from the risks of inadequate nutrition and hydration. Regulation 14.