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Beech Haven Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on the 9 December 2014 and was unannounced.

Prior to this inspection we inspected this service three times between March and August 2014.

On 20 March 2014 we inspected the service and found the provider was not keeping accurate and up to date records. We issued a warning notice telling the provider that they must make the necessary improvements by 15 May 2014.

We carried out an inspection over two days on 28 July 2014 and 4 August 2014 we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These breaches were in respecting and involving people who use the service, care and treatment of people who use the service, cleanliness and infection control, safety and suitability of the premises and assessing and monitoring the quality of the service.

Summary of findings

On 20 August 2014 a pharmacy inspector undertook an inspection and we found one breach of the Health and Social Care Act 2008 (regulated Activities) Regulations in the management of medicines.

The provider sent us an action plan which stated they would make the necessary improvements by 30 November 2014.

At the inspection of 9 December 2014 we reviewed whether the provider had made improvements to the service. We found that they had made improvements in all areas. However, we identified eight areas where the provider had breached the Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2010. Safeguarding people, supporting workers, consent to care and treatment, meeting nutritional needs, respecting and involving people who use the service, care and welfare of people who use the service and assessing and monitoring the quality of the service.

At this inspection we found the provider had taken action to address the Breaches we identified at the last inspections. Some of these Breaches had not been fully met.

Beech Haven Residential Care Home can accommodate up to 30 older people. There were 28 people living at the service at the time of our inspection. The majority of people were privately funded. The service is owned and managed by a partnership and is a family run business. The providers oversaw the day to day management of the home, and one of the partners was the registered manager.

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 and associated Regulations about how the service is run.

People living at the home were not always protected against the risks of abuse because the staff were not trained and were not able to identify abuse or tell us what action they would take if someone was being abused.

People could not be confident the staff had the knowledge and skills to carry out their roles and responsibilities because training was not up to date. There was no plan for on going training and staff development and there were no systems for appraising and formally supervising staff.

The Mental Capacity Act 2005 requires providers to ensure safeguards are in place when someone does not have the capacity to make an informed decision about their care and treatment. People's capacity to consent had not been assessed. The provider had not taken appropriate action in line with legislation and guidance to ensure people's rights were protected.

People's nutritional needs were not being met and they did not always have a varied and balanced diet.

People were not always given information about the service so they could make informed choices, for example about social activities or menus. Although some needs had been assessed, other areas of need had not been identified or assessed and people did not always receive personalised care which met their individual needs and preferences.

The provider had started to improve systems for monitoring the quality of the service; however, these did not always identify areas of concern, take account of the views of people living at the home and their representatives or include planning for the future based on an analysis of significant events and incidents.

People liked living at the home. They felt well cared for and their relatives also liked the care at the home. Some of the things people told us were, ''This home is better than we expected, we have no grumbles'', ''[the providers] are brilliant and the quality of all the staff is good'', ''the staff are quick to inform us if something is wrong with [our relative's] health'' and ''they treat [our relative] like we would.'' Although we received positive feedback during this inspection we discovered some significant concerns.

People had access to healthcare services and their health needs were monitored and met. The staff were kind and caring and people's privacy and dignity were respected.

The provider had made improvements to the service since the last inspection. There had been improvements to the environment including ensuring health and safety hazards were identified and removed. The way in which

Summary of findings

people's medicines were managed had improved and we were assured that they would receive the medicines they needed. There had been improvements to record keeping.

Staff were employed in sufficient numbers and the providers were involved in the day to day running of the home. They were available for staff and people living at the home to speak with and people felt able to raise concerns. The staff felt supported and told us they could speak with their managers if they had any concerns.

We identified eight areas where the provider had breached the Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2010. Safeguarding people, supporting workers, consent to care and treatment, meeting nutritional needs, respecting and involving people who use the service, care and welfare of people who use the service and assessing and monitoring the quality of the service. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe. People who use the service could not be confident that staff would recognise or respond appropriately to abuse because they did not have the skills and knowledge to do this.

Improvements had been made to the safety of the environment and risks for individuals and in the environment had been assessed and managed. There were enough staff employed to meet people's needs.

People's medicines were managed in a safe way.

Is the service effective?

Inadequate

The service was not effective. People were being cared for by staff who had not received the training and information they needed to make sure they had the necessary skills and knowledge to meet people's needs. There was no formal system for monitoring and assessing staff performance or for supporting professional development.

The provider was not meeting the requirements under the Mental Capacity Act 2005. People's capacity to consent had not been assessed and the provider had failed to follow appropriate legislation and guidance to ensure that decisions were made in people's best interests.

People's nutritional needs were not being met and they did not have a choice or a varied and balanced diet. People told us they were not given a choice of food, the quality of food was poor and was often cold

Is the service caring?

Requires Improvement

The service was not always caring. People were not always given the information they needed to make choices about their care and treatment.

People said they felt well cared for. The staff were kind, polite and respectful and people's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. Not all individual needs had been assessed or met. People's emotional and social needs had not been identified and their preferences and individual interests were not considered when planning care and treatment.

People were able to raise concerns and felt these were listened to and the provider investigated these appropriately.

Summary of findings

Is the service well-led?

Inadequate 

The service was not always well-led. The provider had developed systems for monitoring the quality of the service. However, these did not always identify concerns, did not take account the views of people living at the home and other stakeholders and did not always lead to improvements.

There was no analysis of accidents, incidents, concerns and other significant events so the provider could not evidence they had learnt from these.

Some improvements to the service had been made since the last inspection.

Beech Haven Residential Home

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 checked 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 9 December 2014 and was unannounced.

The inspection team consisted of two inspectors, an additional pharmacy inspector and a specialist advisor who was a registered dietitian. Before the inspection visit we looked at all the information we held about the service including notifications of significant events. We looked at the last inspection report and other action we had taken.

We last inspected the service on 20 August 2014. We also inspected the service on 28 July 2014 and 4 August 2014. We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These breaches were in respecting and involving people who use the service, care and treatment of people who use the service, cleanliness and infection control, safety and suitability of the premises, assessing and monitoring the quality of the service, management of medicines and records. The provider told us they would make the necessary improvements. At the inspection of 9 December 2014 we reviewed whether the provider had made improvements to the service. We found that they had made improvements in all areas however there were still breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations and we had significant concerns.

We spoke with nine people who lived at the home, three visiting relatives, a district nurse who was visiting the home, the provider, the manager, four members of care staff and two staff who had managerial responsibilities. We observed how people were being cared for and how staff attended to their needs. We joined some people whilst they were having their lunch to observe their experiences.

We looked at the environment and records relating to this. We also looked at six care records, tracking the care for these people by looking at how their care was planned and delivered. We also looked at three records of staff recruitment and training, minutes of staff meetings, records of accidents and incidents and records of audits and checks. We looked at how medicines were being managed and the records relating to this.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from abuse and avoidable harm. The organisation had a policy and a procedure on abuse, however three of the four care staff we asked were not able to tell us how they would identify abuse and what they would do if they suspected someone was being abused. The staff could not remember whether they had received training in this area and the provider's own training records showed that some staff had not received safeguarding training since 2008. There was no evidence that protecting human rights, safeguarding, abuse or avoidable harm had been discussed during individual or team meetings. Therefore the staff did not have the up to date knowledge and skills they needed to recognise and respond appropriately to the risk of abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People living at the home and their relatives told us they felt safe at the home. However, as stated above, we found staff did not have adequate knowledge to safeguard people from abuse or avoidable harm.

Improvements had been made to the way in which individual risks were assessed. People told us they felt safe at the home and said the staff made sure their safety was maintained. Each care record we looked at contained assessments about people's mobility and how they could be supported to move from one place to another in a safe way. Where people required equipment this had been provided. We saw the staff supporting people to move around the home safely.

At the inspection of 4 August 2014 we found the environment had not been safely maintained and people were at risk. For example, hazardous substances were not stored securely and carpets were loose and presented a trip hazard. The provider had made improvements to the environment and these were on going. Some areas of the building were in the process of being refurbished. However, at the time of this inspection the risks in the environment had been minimised and all loose carpets had been secured or removed. Dangerous substances, such as cleaning products, had been stored securely.

At the inspection of 4 August 2014 we found that not all checks on the environment and equipment, such as water safety and electrical equipment, had been carried out regularly. The provider had failed to notice and act on risks throughout the environment which we identified. At this inspection the provider told us they were making regular checks on the safety and maintenance of the environment and we saw records of some of these checks. Therefore they had been able to identify and minimise hazards in the environment and people living there could move around the premises safely.

There were enough staff employed to keep people safe. People told us that the providers, and their family members who were employed as senior staff, worked at the home most days and were available in emergencies. We saw staff were available throughout the day and people told us they were able to ask for assistance when they needed. People who chose to spend time in their bedrooms told us call bells were within reach and were answered promptly. They also said the staff regularly checked on their wellbeing.

The majority of staff had worked at the home for many years. The provider had not employed any new staff since our last inspection. The staff recruitment files we viewed contained pre-employment check on the suitability of staff to work with vulnerable people, including criminal record and reference checks.

At the inspection on 20 August 2014 we found that people's medicines were not managed in a safe way and they were at risk. At this inspection we looked at the medicines management for the service and found that the necessary improvements had been made.

Supplies of medicines were stored securely. We noted that when the medicine required cold storage in a fridge to maintain its potency, that the minimum and maximum daily temperature of the fridge was recorded accurately. The provider had new policies and procedures in place to manage medicines safely. The provider also carried out monthly medicines audits and MAR charts were checked weekly, so medicines were closely monitored to ensure they were being accurately administered and managed. We saw copies of these audits.

People's current medicines were recorded on the Medicines Administration Records (MAR) and we saw that there were records of medicines received into the home. All people had their allergy status recorded to prevent inappropriate prescribing. We audited 18 of the MAR and checked records of administration and supplies of medicines.

Requires Improvement

Is the service safe?

There was not detailed information about how staff would identify where individual people needed additional medicines, such as pain relief or medicines to relieve agitation. In particular there was no information where people could not verbally communicate their needs. Care workers recorded on the back of the MAR the reason why they gave as required (PRN) medicines for pain and mood and we saw a brief protocol for managing pain relief. This was fed back to the manager who said it would be addressed.

We observed medicines given to two people at lunch time. We saw that the staff member was patient and reassuring and gave the medicines professionally and signed the MAR when the medicine had been taken. One person was prescribed medicine for pain relief when needed. We saw how the person was asked if they were in pain and they said that they were, and were given the appropriate pain relief. One person was able to manage their own injections. The care plan recorded that the person was independent and we saw the risk assessment in the person's care plan. We saw evidence of regular review of medicines in the four care plans we looked at and changes in medicines correlated with the MAR. Copies of hospital discharge letters were kept in people's care plans for ready access, should there be any queries about changes to people's medicines on return from hospital.

At the last inspection the provider had not made adequate arrangements to protect people from the risk of acquired infections because the environment was not clean. The provider had made improvements to cleanliness and to monitoring this to make sure good standards of cleanliness were maintained. We found that one toilet at the home had a malodour but most of the environment and equipment was clean.

Inadequate

Is the service effective?

Our findings

People were supported by staff who did not always have the knowledge and skills needed to carry out their roles and responsibilities. There was no system for the formal appraisal of staff. The staff did not have individual meetings with their manager to review or appraise their work. There were four recorded team meetings in 2014. There was no formal system to assess and monitor staff performance or to provide opportunities for professional development.

We looked at training records for three members of staff. Two members of staff had not received training in infection control since 2007, despite this being an area where we identified risks for people living at the home when we inspected the service on 4 August 2014. One member of staff had no record of moving and handling training and there was no record of training in medicines management for two members of staff. There was no record of training for any staff in 2014 and no plan for on going training and development for staff.

The above issues were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff all told us they felt supported by the provider and senior staff. They said that they were able to discuss their work and felt listened to. They knew who they would talk to if they had any concerns about their work and said the provider was always available if they needed them. One member of staff said, ''I have all the support I need, they (the providers) are always here and I can talk to them if I need anything.'' Another member of staff told us, ''I do not have meetings as such but I can speak to them (the providers) if I need. If I have a problem they help.''

The Mental Capacity Act 2005 requires providers to ensure safeguards are in place when someone does not have the capacity to make an informed decision about their care and treatment.

The provider had not always sought the consent of people to their care and treatment in line with legislation and guidance. None of the staff we spoke with, including senior staff, could demonstrate an understanding of the relevant requirements of the Mental Capacity Act 2005. There was no evidence that people's capacity to consent to care and treatment had been assessed. The provider told us that everyone living at the home had the capacity to consent and make decisions about their care however this had not been recorded and some care records indicated that people lacked the capacity to make certain decisions.

In two of the care files we looked at the person had signed their consent and agreement to the assessment of their needs and their care plan. There was no evidence in the other care plans we looked at that people's consent had been sought or that the provider monitored the way in which staff sought people's consent to make decisions about how they were cared for. There was no evidence that decisions had been made in people's best interests or in line with legislation and guidance.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The provider had not made any referrals in respect of these. We did not see any restrictions in place on the day of our inspection. However, the provider was unable to tell us about the legal requirements and their responsibilities under this legislation.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not always support people to have sufficient amounts to eat and drink and to maintain a balanced diet. People told us they were not normally given a choice about what they were given to eat. They said they were not told in advance what food they would be offered. Three people we spoke with told us they had never seen a menu at the home. When served the lunch time meal some people were shown two different plated meals and were able to choose which one they wanted. However, they told us this was not normally the case. One person said, "I don't want to be unkind but that's the first time I've ever been offered a choice at lunch time. It's just put in front of you. I think everyone likes a choice." Another person told us, "You are offered a choice of food in the evening but only if you make yourself vocal. The food is very basic – we get a lot of tinned frankfurters and repetition e.g. ham salad."

People told us the quality of food was not good. Some people told us they thought the food was poor quality. Others gave specific examples of food they did not like. One

person told us, “They are not unkind but with regard to cooking there is a tendency to cut corners.” People told us there was little variety of food and many of the meals were repeated each week.

People living at the home did not have an input into planning the menu. The manager told us that they decided what they would cook each day. Therefore the provider had not planned a varied and balanced menu and could not assure themselves that people were receiving an appropriate nutritional variety.

We observed people being served their midday meal. Some of the food, including mashed potato, vegetables and the dessert were cold. People commented on this. One person told us the food was often cold. All meals contained the same size portions and did not reflect individual preferences. People were not offered, although one person was given when they asked, gravy for their meal. The provider said that people were offered second helpings, but two people living at the home told us they had never been offered second helpings and no one was on the day of our visit. Some people chose to eat in their bedrooms. A tray containing three courses, soup, the main meal and dessert were taken to the person at the same time. There were no coverings to keep the food warm.

People were not being consistently or regularly weighed. For example, one person who had a low weight which had dropped significantly had not been weighed for three weeks since this weight loss.

Some people had been referred to a dietitian and evidence of these consultations and guidance from the dietitian was included in care records. The staff maintained food and fluid charts for some people. However we looked at these for two people. We saw that on two occasions no food or fluid had been recorded on these charts after midday. Therefore the records could not be used to accurately monitor people’s food intake.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they had access to healthcare professionals when needed. One person told us, ‘’They help me to stay healthy, I can see the doctor when they visit and the optician and dentist.’’ Their healthcare needs were recorded in care plans and there was evidence people saw a range of healthcare professionals as needed. We met a visiting health care professional. They told us they felt people’s healthcare needs were being met. They said that when they gave specific instructions for someone’s care, the staff followed these. They said the staff communicated clearly with them however, they said staff were sometimes slow to alert them to a new need – for example someone developing redness in a pressure area.

Requires Improvement

Is the service caring?

Our findings

People told us they felt listened to and the staff respected them. However, some of the routines at the home did not always consider the individual needs and wishes of people living there. For example some of the people we spoke with did not feel they could contribute their ideas and their individual preferences were not being met. One person said, "We tend to just put up with things." Another person told us, ''I don't want to make a fuss.'' People told us decisions about the home were made by the providers and they did not expect to have any say in what was happening there.

Some of the actions of staff indicated they followed set routines rather than looked at individual needs. For example, people were escorted to the lounge and dining room in the morning but were not supplied with things to do or offered alternatives, although people who expressed a wish were supported to go elsewhere. One person told us, ''I would like to spend more time in the garden or to go out once in a while.'' The majority of people were seated for their midday meal at 11.55am but were not served until 12.45pm. The staff did not explain the delay to people. There were no menus on display and no information about activities or Christmas events. Therefore people were not always given the information and explanations they needed and were not always able to contribute to decisions about their care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People living at the home and their relatives told us the staff were kind and caring. One person said, ''It's a home from home'' and another person said, "I feel at home here it's really very nice and the staff are very attentive'' and a third person told us, ''Staff are all very nice and patient – they always knock on the door before coming in." One relative commented, ''The staff are very good here, the providers are brilliant and [my relative] gets the best care possible.'' We observed the staff treating people in a kind and considerate way. They sat and spoke with them before offering them care or supporting them to move. People were able to spend time in their bedrooms or communal areas and we saw the staff responding to people's requests to move to another area of the home.

The staff were discreet and attentive when someone asked for assistance with intimate personal care. They knocked on people's bedroom doors before entering. People told us they were supported to do things for themselves if they wanted. They said the staff did not interfere and allowed them to be independent. The staff were quick to respond to a person who said they were in pain and uncomfortable. People told us they were able to make choices about what time they went to bed and rose in the morning and whether they wanted to spend time in their bedrooms. They felt their privacy and dignity were respected.

People were clean, dressed appropriately and looked well cared for. They said they were supported to have a bath or shower when they wanted.

Requires Improvement

Is the service responsive?

Our findings

People told us there was not much for them to do. One person said, ''There is never anything to do, I would like to go out or do something.'' There were a small number of organised group activities each week but no planned schedule of events and the staff did not engage in activities with people. A senior member of staff told us one person liked football. They told us they talked with the person about this interest but other staff did not. There was no information in the care plan about this interest or how the staff could support this person to pursue their interest, for example making sure the person had access to watching games of their choice or information about football scores.

Throughout the morning we saw that 10 people were seated in the lounge and dining area with no organised activities and little to do. Some people were reading a newspaper or doing cross words, but other people were not engaged in any activity. A radio was playing pop music but no one was given a choice about the music, or whether they wished to watch television. There were no games, craft materials or other resources for people to help themselves to. The staff did not suggest or offer activities and their interactions, although polite and caring, were brief and generally task based rather than asking people about their wellbeing or just spending time talking to them.

The provider had made improvements to the way in which care needs were assessed, planned and recorded. However, there was no system for assessing people's nutritional needs. Information about their nutritional needs was brief and there was no evidence of screening and monitoring people with poor appetite for risk of malnutrition. There was also limited information about how to support people who were living with the experience of dementia, in particular how to meet their individual needs. There was no, or limited, information about people's social histories, interests and life events. Therefore the staff did not have the information they needed about individual people and could not plan care which was specific to their needs. The staff told us about how they would meet individual personal care needs but could not explain how they would support people with their social needs or interests.

Therefore people did not always receive personalised care which met their individual needs. These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had a complaints procedure. Everyone we spoke with told us they were able to speak with the provider if they had a complaint. People told us the provider was always available and they felt complaints would be investigated. Relatives of people living at the home said they were able to speak with the provider or staff about any concerns they had. They said these were generally remedied and they felt confident the provider would listen to their concerns. The provider told us there had been no recorded complaints in 2014.

People living at the home and their relatives told us that us that the providers were always available at the home for them to speak to. We saw the providers and senior staff spending time in communal areas. When people raised queries or had minor concerns they spent time listening to these.

Inadequate

Is the service well-led?

Our findings

The provider had started to develop systems to monitor the quality of the service and to take action where problems arose. For example, they had improved the auditing of medicines management and infection control. However, they had not developed a comprehensive system of recorded checks for all areas of the service. They carried out general service audits but these had not always identified areas of concern, for example how people's capacity to consent was being assessed and how people's nutritional needs were being met.

The provider had not developed a business plan which laid out a clear vision and values for the service. The staff were not aware of the organisational values or how the service planned to develop, other than environmental changes. People living at the home, their representatives and staff were not consulted about service developments. Some of the records of audits and quality monitoring were difficult to locate or unclear. There was no analysis of accidents and incidents, concerns or feedback from people living at the home. Therefore people living at the home could not be confident that the provider had taken the necessary steps to protect them from the risks of unsafe and unsuitable care and treatment because systems to monitor the quality of the service were inadequate.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a positive and caring culture at the home. The providers were available for people who lived at the home, staff and visitors to speak with. People confirmed this was always the case. The staff told us they felt there was a friendly atmosphere and supportive culture. The providers, a partnership, and senior staff they were training to take a more active role in the management of the home, worked there each day and were available for people to talk with. People felt they were listened to and able to raise concerns. The providers were aware of the day to day culture of the service and the values and behaviours of staff.

The provider had taken action to improve the service since our last inspection. They had improved the way in which medicines were managed, the safety of the environment, records and care planning. They had plans for further improvements.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risks of abuse because they had not taken reasonable steps to identify the possibility of abuse and prevent it before it occurred.** **Regulation 11(1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person had not made suitable arrangements for persons employed to receive appropriate training, professional development, supervision and appraisal.** **Regulation 23(1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person had not made suitable arrangements for obtaining and acting in accordance with the consent of service users in relation to the treatment provided for them.** **Regulation 18(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not ensured service users were protected from the risks of inadequate nutrition because they did not offer a choice of suitable and nutritious food in sufficient quantities to meet their needs.

Regulation 14(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not made suitable arrangements to enable service users to participate in decisions about their care or treatment, provided people with appropriate information about their treatment or involved people in decisions relating to the way in which the regulated activity was carried out. Regulation 17(1)(b), 17(2)(b) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving inappropriate care and treatment because they had not carried out an assessment of all the needs of people and did not always plan and deliver the service in a way to meet individual needs. Regulation 9(1)(a) and (b)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not taken steps to protect service users against the risks of inappropriate or unsafe care and treatment because they were not operating an

This section is primarily information for the provider

Action we have told the provider to take

effective system to assess and monitor the quality of the service. There was no analysis of the incidents that resulted in or had the potential to result in harm. The registered person did not seek the views of people using the service, persons acting on their behalf and staff.

Regulation 10