Simply CareHome Limited

Becket House Nursing Home

Inspection Report

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Summary of findings

Overall summary

Becket House Nursing Home provides nursing and residential care to people, some of whom are living with dementia. The service can accommodate 23 people. At the time of our inspection there were 19 people living at the service, although one person was in hospital when we visited. The home had 13 people who required nursing care and five people who received personal care.

There was no registered manager at the service at the time of our inspection due to a change in management. The current manager had applied for registration with CQC. 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.

We found that people's care needs were being met by staff who were adequately trained to do so. Staff told us that they felt supported, however, some staff said that they were rushed in their work and that they would benefit from more staff. We observed staff to be task focussed during our inspection and saw that they lacked time to spend with people using the service. Staff did not have time to engage with people who used the service and spend meaningful time with them. People were happy living at the home. They told us staff treated them with kindness and that they responded to their needs. Some people told us that there was a lack of activities at the home and we observed this during our visit. We found that people sat for long periods with little to do and we found no evidence that people were encouraged to remain independent and access the local community. We found there a breach of Regulation 17 of the Health and Social Care Act 2008 which we have detailed in this report.

We looked at nutrition and hydration as part of our inspection and found there to be a lack of choice for people and little fresh fruit and vegetables at the home. We found there to be a breach of Regulation 14 of the Health and Social Care Act 2008 which we have detailed in this report.

The Mental Capacity Act 2005 had been adhered to at the home and there were robust procedures in place that ensured people's best interests were being considered. Deprivation of Liberty Safeguards had been appropriately applied for.

When we inspected this service in June 2013 we found that staff did not have the required knowledge in relation to protecting people from the risk of abuse. We also found that improvements needed to be made in relation to staff supervisions and appraisals as these had not been taking place at the service. During this inspection we found that the required improvements had been made by the current manager and that the service was now meeting the regulations in these areas.

We found that the manager in post had started to implement some of the changes which needed to take place at the home. The manager showed us an improvement plan they had implemented and were working towards. One safeguarding incident had not been reported to CQC and this was a breach of Regulation 18 of the Health and Social Care Act 2008.

Due to the number of concerns raised during our inspection and the fact that there were insufficient systems in place to monitor the service and identify these concerns we found there to be breach of Regulation 10 of the Health and Social Care Act 2008. There was a lack of management checks to ensure that people were receiving safe, effective, and responsive care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

The service had made most of the required improvements following our last inspection in June 2013 in relation to safeguarding people from the risk of abuse. However, we found that they had not notified the CQC of a safeguarding incident. Staff had received training since our last visit and knew the types of abuse to look for and were able to explain how to report these. There were up-to-date policies and procedures in place.

There were robust measures in place to assess people's mental capacity and procedures in place that ensured people's best interest were represented when they lacked the capacity to make decisions about their care and treatment. Deprivation of Liberty Safeguards had been appropriately applied for.

Risk assessments were in place and contained detailed information that ensured people received safe care. Medicines were being safely stored, managed, recorded and administered at the service.

People told us that staff listened to them when they were able to but reported that staff were often rushed due to the number of staff on duty.

Are services effective?

We found there to be a lack of choice in what people were being offered at meal-times. The same meals were being prepared each week and there was only one option available to people at lunch-times, unless they requested an alternative. There was little fresh fruit and vegetables at the service at the time of our inspection. This meant there was a breach of regulation 14 of the Health and Social Care Act 2008.

We found that the service consulted relatives in relation to people's needs assessments but there was little evidence that people using the service were involved in this process. Improvements were needed in terms of involving people in their care and treatment.

People's health was being monitored and the relevant health professionals consulted with.

The necessary improvements that had been required following our last inspection had been made in relation to staff supervisions and appraisals and there was now a programme in place which ensured that staff were supported on an on-going basis. Staff told us that they felt supported in their roles. There was a training programme in place for staff and this was being monitored by the manager.

Summary of findings

Are services caring?

There was little evidence that people were involved in the delivery of their care and treatment. This meant there was a breach of regulation 17 of the Health and Social Care Act 2008 as people were not being encouraged to express their views about how the service was being run. We saw little evidence that people were involved in decisions about how their care and treatment was delivered to them.

Staff treated people with kindness and respect, however, they did not have the time to spend with people. One person was observed being hoisted without staff speaking to them or engaging with them. The manager told us that this would be addressed with staff during our inspection.

We found care plans to be task focussed and they lacked detail about people's personal histories and their likes and dislikes. Staff were also task focussed as they lacked time to spend with people due to staffing levels at the home.

Are services responsive to people's needs?

We found there to be a lack of activities at the service and people were not being encouraged or assisted to access the local community. People sat for long periods of time with little in terms of stimulation. There was little evidence of how people were being encouraged to remain independent. This meant that there was a breach of regulation 17 of the Health and Social Care Act 2008.

There were systems in place that ensured that people's mental capacity was assessed and that their best interests were represented where appropriate. This was being done in accordance with the Mental Capacity Act 2005. One person was under a Deprivation of Liberty Safeguard and this has been applied for to protect the person's human rights.

People's health was being monitored on an on-going basis and their care plans were regularly reviewed. People's changing health needs were responded to and the relevant health professionals consulted in relation to their care and treatment. However, care plans lacked detail about people's personal histories and their likes and dislikes.

Are services well-led?

Although there was currently no registered manager at the service, this was due to a change in management and the current manager in post did have an application in the system for their registration.

Staff felt supported by the manager and were positive about them. However, two of the three care workers expressed concern about

Summary of findings

staffing numbers and felt, at times, they lacked the time to spend with people who used the service. We looked at call bell response times and found these to be answered in a timely manner. However, we did observe staff to be rushed during our inspection.

The manager at the home was aware of some of the ways in which the service needed to improve and was working on implementing some changes at the home. For example, they were looking at introducing a dependency tool to assist them in deciding how many staff would work during each shift. This would be based on people's needs. However, this was not in place at the time of our inspection.

Incidents and accidents were logged and dealt with appropriately. However, we found that one safeguarding incident had not been notified to CQC, although Social Services had been informed. This was a breach of regulation 18 of the Health and Social Care Act 2008.

We found a number of concerns with how the service was being managed at the time of our inspection which we have highlighted in this report. These concerns with staffing numbers, nutrition, people's involvement in their care and the lack of activities for people using the service had not been identified by the current manager. Due to these concerns and the lack of effective monitoring at the service we found there was a breach of regulation 10 of the Health and Social Care Act 2008.

There were arrangements in place to deal with any foreseeable emergencies which may affect the running of the service.

Summary of findings

What people who use the service and those that matter to them say

We spoke with five people who used the service as part of our inspection. People expressed concern about staffing levels at the home and felt that staff did not always have the time to spend with them. One person told us, “Staff have the correct skills to care for me and they are very kind but they rush my care because there are not enough on duty.” Another person told us that their care needs were met, commenting, “The staff will help us with anything we ask for.” People told us that their care needs were met but some people felt that the care could be improved by more staff being on duty.

Three of the five people we spoke with told us that, at times, they felt bored and that there was little on offer in terms of activities and accessing the local community.

One person said, “I haven’t been to church for a while but staff have arranged for a priest to visit the home.” People told us that there was a lack of activities and that they had little opportunity to access the local community.

We asked people about the food offered at the home. People told us that it was adequate, however, two people commented that there was a lack of choice and variety in the meals being provided.

Although people felt that their care needs were being met by staff who were adequately trained they felt that some improvements could be made in relation to staffing numbers, activities and in relation to the choice of food on offer at the service.

Becket House Nursing 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 was planned to check whether the provider is meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Before our inspection we reviewed the information we held about the home, contacted the local authority and the Clinical Commissioning Group to find out their views of the service and reviewed the inspection history of the service. We needed to follow-up on some areas of care which did not meet the regulations at the last inspection we carried out in June 2013. We looked at how the service dealt with safeguarding issues and how staff were supported and supervised at the service in order to follow up on these areas.

We visited the service on 16 May 2014. The inspection team consisted of a Lead Inspector, an Expert by Experience who had experience of mental health services and end of life care and a Specialist Advisor who was a registered nurse.

We spoke with five people who used the service as part of our inspection. We also spoke with the manager of the service, the provider and four members of staff. We looked at a number of records including people's care records, staff records and reviewed the policies and procedures in place at the service.

Are services safe?

Our findings

Three people told us that, although staff would listen to them when they requested something, there were not enough of them to enable staff to spend meaningful time with people. One person told us, "Staff have the correct skills to care for me and they are very kind but they rush my care because there are not enough on duty." We observed staffing numbers to be low and staff to be rushed during our inspection. There was no dependency tool used at the service and staffing numbers for nursing residents were low at one nurse to 13 people requiring nursing care. We found staff to be task focussed and that they lacked time to spend with people in any meaningful way.

From speaking with the manager during our inspection, we found that an allegation of abuse had not been responded to appropriately by the management at the service. This incident had been recorded, however, it had not been referred to CQC. We highlighted this during our inspection and the manager of the service explained that this had been an oversight on their part. This safeguarding incident should have been reported to CQC. From looking at the record of incidents, accidents and safeguardings at the service we found that other incidents had been logged and reported as necessary. The service had not met CQC requirements to notify us of all the events they are required to by law. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

At our last inspection of the service in June 2013 we found that there were some failings in relation to how people were safeguarded against the risk of abuse at the service. In that inspection we found that staff did not fully understand their responsibilities in relation to safeguarding and were not clear on how they would report any allegations of abuse to external agencies.

During our inspection in May 2014 we looked at the action the service had taken to ensure that people using the service were safe and that they were protected from the risk of abuse. We found that staff had received training since the last inspection on safeguarding and understood their responsibilities and could describe how they would report any allegations of abuse, both internally and outside of the organisation.

There was a detailed policy and procedure in place in relation to safeguarding which had been reviewed in April 2014 and this demonstrated that the service was continuously reviewing and updating their policies in this area. We found there was also a policy in place in relation to the use of restraint at the service. This policy recognised people's rights to freedom and choice and described restrictions which may compromise people's human rights.

We found that one person using the service was subject to a deprivation of liberty safeguard. We looked at this in detail and found that it had been appropriately applied for and that the person was being protected as necessary. We found that mental capacity assessments were in place for people when needed and that best interest meetings had been held and documented as appropriate. This was being done in relation to making decisions about people's care and treatment where they may have lacked the capacity to make decisions for themselves. People's mental capacity was being assessed on an on-going basis to ensure that people's best interests were being represented.

We looked at the care plans and risk assessments in place for six people using the service. We found these to be detailed and to contain information for staff on how to minimise any risks associated with the delivery of people's care and treatment. We found that although the risk assessments were detailed, they were task focussed and lacked detail about people's individual needs and preferences.

We looked at how medicines were being managed at the service to ensure that people were protected from the risks associated with the unsafe use and management of medicines. We found that the service was managing people's medicines well. We looked at the medicines charts in place for people and found these to be correctly and fully completed with any gaps in recording explained. We observed a medicines round during our inspection and saw medicines being administered to people safely and in line with their care plans. We found that medicines were being stored as required. Staff were adequately trained in this area and the registered nurse at the service administered the medicines during our inspection. We found that steps were taken to consider people's mental capacity and their ability to consent to taking their prescribed medicines. This had been done to ensure people's best interests and human rights were being considered in relation to their medicines. There was a

Are services safe?

policy in place which stated that medicines would not be used to control people's behaviour and we saw that this was being put into practice from the care plans and medicines charts we looked at. The manager carried out regular medicines audits to check that medicines were being administered safely and recorded accurately. People were having their medicines administered to them safely by staff who were appropriately trained to manage and administer medicines to people.

People we spoke with who used the service told us they felt safe living at the home. Nobody expressed concerns about their safety and how their care was being managed. One person said, "Staff treat me with respect and observe my dignity and they respond positively when I tell them about any concerns I might have. I feel safe living here."

Are services effective?

(for example, treatment is effective)

Our findings

We looked at how people were being protected from the risks of hydration and nutrition during our inspection. We looked at the choice of food and drink available to people and how the service was communicating this to people. We found there to be a lack of fresh fruit and vegetables on offer at the home and found that there was little choice for people. Menu logs at the home were kept by kitchen staff and were written into a diary. We asked how people were made aware of what was on offer for meal times and were told that this was given to them verbally each morning. There were no menus displayed at the home and no visual aids used to assist people in understanding their menu choices each day. We looked at the menu records and found that the same food was being prepared each week. The same meals were served and there was little evidence that people were given a range of meals. There was one hot meal option each day and people would have to request an alternative if they were not happy with this. We found, on the day of our inspection, that the alternative for that day was a ready-made curry. This was not a nutritious alternative for what was being offered.

We spoke with staff about the food at the home and they told us that improvements could be made in this area. One staff member said, "There could be a bit more variety." Another member of staff told us, "I think more of an effort could be made. A bit more variety might be an idea." We found that although food supplies were sufficient for people there was little fresh fruit and vegetables on the premises to ensure that people received a healthy and nutritious intake of food. This was particularly of concern for people's whose nutrition may be compromidsed due to their health or dementia related needs.

People who used the service commented about the lack of choice on offer and told us that they felt there could be variety. One person said, "Some of the food is very nice but there is not enough choice." Another person commented, "Food is okay, the choice is limited but it's always hot when served and we get enough hot and cold drinks."

We saw that regular drinks trollies came round to people and found that people's nutritional risk was assessed. People were weighed on a weekly basis and health professionals were referred to when needed in relation to people's dietary needs. However, as there was a lack of choice on offer to people in terms of their daily meals we found there to be breach of regulation 14 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

People we spoke with were aware of their care plans but told us that their relatives were the people who were consulted about them on an on-going basis. Care plans we looked at reflected this and we saw little evidence that people were involved in the care planning process. Care plans were task orientated and focussed on people's care needs, rather than considering people's personal likes and dislikes and providing a social history for people. We found little evidence that people were involved in the care assessments, however, the assessments were written to meet people's care needs and to address any risks related to their care delivery. We found that care was not being delivered to people as individuals and that some improvement could be made in the way the service treated people on an individual basis.

We spoke with five people who used the service about their experiences of living at Becket House. Two of the five people we spoke with told us that their views were taken in consideration in relation to their care and treatment. Three people did not comment to us about this aspect of their care.

During our last inspection we found that improvements needed to be made in relation to staff support at the service. We looked at supervision and appraisal records to ensure that staff were being adequately supported. The manager told us that they had recently implemented a new schedule of supervisions and appraisals. We saw that this was in place and that staff had started to have supervisions with the manager. These had been held recently. Most staff had only had one supervision session since our last inspection. The manager needed to ensure that these sessions were held regularly for staff members. We saw there was a plan in place for this. Staff told us that they felt supported and they found the supervision process to be helpful. We spoke with four members of staff during our inspection and they all reported they felt supported. One staff member told us, "It's a lot better since the new manager's been here. It's much more structured now."

We looked at staff training records and found that staff were trained in delivering safe and appropriate care to people. Staff training was continuously monitored to

Are services effective?

(for example, treatment is effective)

ensure that staff remained up-to-date with their training. Staff reported that they felt they could approach the manager should they need further training in any area of care delivery.

Are services caring?

Our findings

We observed, and people told us that staff were busy and not able to spend any meaningful time engaging people in activities. People were seated not doing very much throughout our inspection and often in the same position. We observed one person being moved using a hoist during our inspection and saw that the staff undertaking this task did not speak to the person or explain what they were doing and why throughout this process. Staff were not communicating with this person to ensure they understood what was happening. We raised this with the manager during our inspection who told us that they would address this. Although people's needs were responded to and their requests for care acted upon by staff, there wasn't always the time for staff to engage with people and spend time with them.

Staff told us that they lacked time to spend with people but said that they knew everyone's individual needs and did their best to engage with them when they could. One staff member told us, "When I first came it wasn't how I thought it would be. I thought you'd be able to talk to people. It has got better." When we inspected the home there was one registered nurse on duty and two care workers. We observed staff to be focussed on meeting people's care needs and found that there was little time for them to engage with people and spend time with them.

We looked at the care records of six people who used the service. Again, we found these to focus on the tasks that staff needed to carry out in relation to meeting people's care needs. There was little detail in the care plans we looked at in relation to people's social history and their personal likes and dislikes. This meant staff may not have the information needed to care for people in the way they wished to be cared for. This is particularly important for people with dementia care needs who may lose the ability to communicate this information to staff. It was difficult to know the person the care plan concerned as there was little detail about them as a person. The language used in the care plans we looked at described tasks such as, "feeding", "turning" and "washing." There was little evidence of how people were being assisted in these tasks and of how people were being actively encouraged to remain independent. We raised this with the manager during our inspection who told us that the care plans were in the process of being revised to ensure they contained more information about people's personal life histories and their likes and dislikes.

There were no meetings held for people who used the service. Systems were not in place for the manager to obtain the views of people who used the service. Although questionnaires had been issued to relatives to obtain their views about how the service was run no such process had been put into place for people who lived at the home. The provider needed to ensure that there were processes in place to obtain the views of people that used the service. The manager told us that staff regularly talked to people about their views and opinions, however, we found little evidence of this in the documentation we looked at during our inspection. No records were being made of people being able to feedback about their experiences of using the service. As we found little evidence of how people were consulted and encouraged to express their views about how their care and treatment was delivered we found there to be breach of regulation 17 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

During lunch-time at the home we observed people being given their meals on the chairs they had been sitting in for most of the morning in the lounge area of the home. People did not sit at the dining room table and the arrangements for this to happen were inadequate. People were not being encouraged to sit at a table to eat their food. We asked the manager about this who told us that people preferred sitting in their lounge chairs and that people would have needed to be hoisted in order to them to sit at the dining table. It was not clear how this decision had been made for the majority of the people that used the service. People were not being encouraged to remain independent and their choices and wishes in relation to mealtimes were not being considered. The service had not asked people where they would like to eat their meals.

All of the people using the service we spoke with told us that they felt staff treated them with kindness and that they understood and responded to their needs. One person said, "Staff are always busy but they are equally always pleasant. They couldn't be any better, they are all very nice." Another person told us, "The staff will help us with

Are services caring?

anything we ask for." We saw staff caring for people in the communal lounge at the home. We saw staff respond to people's request for care. Staff treated people with respect and kindness throughout our inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During our inspection we spoke with five people who used the service. People told us that their individual care needs were met, however, people felt that staff were rushed and did not always have the time to spend with them. People told us that there was an absence of activities for them to participate in at the home. There were no activities taking place at the time of our inspection and we observed people sitting in the same positions for long periods of time. People did not appear to have access to meaningful activities they would enjoy. One person told us, "I can't remember the last time I had some fresh air, I sit in this seat from morning till I go to bed at night and there are no activities during the day." The home had pleasant grounds which were well tended to. However, there was only one person who accessed these at the time of our visit despite it being a very warm and sunny day. There was no garden furniture available to allow people to spend time outside. One person told us, "I have no restrictions. I'm able to go into the garden when I want and they've put some plants on a stand for me to tend and look at through my window, but I feel they could make better use of the gardens by putting some garden furniture for us to use".

People using the service were not being encouraged to remain independent and there was a lack of activities for people at the home. We were told that an activities co-ordinator came into the home regularly. However, people using the service told us there was little on offer for them to do. One person told us, "I can have a walk to the local pub and sit in the garden for some fresh air but there's not much to do for the others during the day". The service needed to ensure they were encouraging people to remain independent and assisting them in accessing the local community. We observed people sitting for long periods of time with no stimulation or activity. Several people we spoke with told us that this was how they spent their time. We found there to be a breach of regulation 17 of the Health and Social Care Act 2008 as people were not being encouraged to remain independent or to access the local community. There was a lack of interaction with people and a lack of opportunities for people to remain independent and autonomous. The action we have asked the provider to take can be found at the back of this report.

There were policies and procedures for staff to follow when people lacked the mental capacity to make decisions about their care and treatment. These were in place to ensure people's best interests were represented. We saw that one person was under a Deprivation of Liberty safeguard in order to ensure their human rights were being protected in relation to their care at the home. This had been applied for in a timely manner in order to protect the person using the service. There were robust systems in place that ensured that people's mental capacity was assessed when needed and arrangements put into place to involve the relevant people in any best interest decisions that may have needed to be made in relation to their care.

We looked at how complaints and concerns were handled at the service to ensure that these were investigated and responded to appropriately. We found there was a complaints policy in place and people were given information about how to make a complaint should they wish to. We asked to see a record of all complaints received over the last 12 months and were told that no written complaints had been received. We were told that this was because any issues were dealt with as they arose.

Are services well-led?

Our findings

At the time of our inspection there was not a registered manager at the service. This was due to a change in management. The manager in post did have an application, for their registration with CQC as the manager of the service, in the system however and this was being processed.

We spoke with staff working at the service. They were all positive about the how the service was being managed. They told us that they felt supported and that they could approach the manager should they need to. One staff member said of the manager in post, "She's on the ball. She's good, she's approachable and she deals with any issues straight away. She's very good." The manager had implemented a number of changes since starting at the service, including a programme of supervisions and appraisals for staff. We saw that this process encouraged staff to be open in their communications with managers and that support was provided to staff when needed. We saw minutes from staff meetings which provided evidence that staff were able to openly express their views and opinions and that these were being listened to and acted upon by the registered manager.

Staff were less positive about staffing numbers at the home and two care workers told us that they could, at times, benefit from more staff. On the day of our visit there were three care workers on duty and a registered nurse. Thirteen people required nursing care and five people were receiving personal care. We observed staff to be very busy during our inspection and did not see evidence that staff were able to spend time engaging with people. People that used the service told us that, at times, staff were very busy and that this impacted on the amount of time they could spend with people. We found that at night there was one care worker on duty and one registered nurse. We looked at call bell response times and found that these were answered in a timely manner both at night and during the day. However, staff were not able to spend time engaging with people as they were task focussed due to staffing levels. We spoke with the manager about how staffing numbers were determined. We were told that there was currently no dependency tool used at the service but that this was something the manager was looking to implement. To improve the quality of care being delivered to people staffing levels could be increased to ensure people receive care from staff who are able to respond to people's individual needs and preferences. There were no systems to assess and monitor staff numbers. This was an area which could be improved upon.

There were a number of areas in which the manager still needed to implement changes and improvements. The manager indicated to us that they were aware of the changes that needed to be made and that they were planning to implement these in due course. However, we did not see evidence of systems being in place to identify and address the concerns we had found during our inspection. The concerns we found in relation to staffing levels, nutrition and people's involvement in their care, as well as the lack of activities for people had not been identified by the home manager. Due to the lack of monitoring in these areas, identified during our inspection, we found there to be a breach of regulation 10 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

There were plans in place to deal with any foreseeable emergencies which may have affected the running of the service. We found that plans were in place in people's individual care plans to deal with any emergencies which may affect them.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 How the regulation was not being met: There were not effective systems in place to regularly assess and monitor the quality of the service provided. 10 (1) (a)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: There were not effective systems in place to regularly assess and monitor the quality of the service provided. 10 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: There were not effective systems in place to regularly assess and monitor the quality of the service provided. 10 (1) (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

Compliance actions

How the regulation was not being met: People were not being given a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs. Regulation 14 (1) (a)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting Nutritional Needs How the regulation was not being met: People were not being given a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs. Regulation 14 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting Nutritional Needs How the regulation was not being met: People were not being given a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' 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 How the regulation was not being met: People were not involved in decisions about how their care and treatment was being planned and delivered to them. People were not being encouraged to remain independent and were not being supported to access the local community. Regulation 17 (2) (f) (g)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and Involving People who use Services How the regulation was not being met: People were not involved in decisions about how their care and treatment was being planned and delivered to them. People were not being encouraged to remain independent and were not being supported to access the local community. Regulation 17 (2) (f) (g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and Involving People who use Services How the regulation was not being met: People were not involved in decisions about how their care and treatment was being planned and delivered to them. People were not being encouraged to remain independent and were not being supported to access the local community. Regulation 17 (2) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Notification of other incidents How the regulation was not being met: The service had not notified the commission of an incident as required by law. Regulation 18 (1) (e)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Notification of other incidents How the regulation was not being met: The service had not notified the commission of an incident as required by law. Regulation 18 (1) (e)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Notification of other incidents

How the regulation was not being met: The service had not notified the commission of an incident as required by law. Regulation 18 (1) (e)