The Fremantle Trust

Fremantle Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 5 and 6 September 2016. It was an unannounced visit to the service.

We previously inspected the service on 4 March 2015. The service was meeting the requirements of the regulations at that time.

Fremantle Court provides residential and nursing care for up to 90 people. This includes care of people with dementia. The home was full at the time of our visit.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been in post for six weeks and would be submitting an application for registration in due course.

We received positive feedback about the service. People said they were treated with kindness and compassion and staff were respectful towards them. Comments included "The staff are kind and caring," "All the staff are lovely and very caring" and "I find the care very good and the staff very caring."

Healthcare professionals expressed positive views of the service. One told us said "Everyone I have dealt with has been helpful and with regards to watching them interact and care for residents, this has been with respect and with their best interests at the centre of their care. I always find Fremantle welcoming, clean and a pleasure to visit." Another healthcare professional told us "It's really clean and people are friendly there. I'd be quite happy for my relative to be there." A third healthcare professional said people were consulted and staff "Checked with residents to see what they wanted," in terms of options for treatment. They added "They speak to people like equals."

People were protected from the risk of harm. There were safeguarding procedures and training on abuse to provide staff with the skills and knowledge to recognise and respond to safeguarding concerns. Risk assessments had been written and were followed, to reduce the likelihood of injury or harm to people during the provision of their care.

The service did not always carry out appropriate checks to make sure relatives had the legal authority to make decisions on behalf of people who lacked capacity. We have made a recommendation about checking who can legally make decisions on people's behalf. People who did have capacity told us staff asked for their permission before they carried out tasks. The Care Quality Commission had not been informed about the outcome of applications to the local authority to deprive people of their liberty. This meant we were unable to evaluate what restrictions were placed upon people and how the service managed these.

We received mixed responses to whether there were enough staff to meet people's needs. Some people felt

weekends were more stretched. However, we found people received the care they required whilst we were at the service. Staff received appropriate support through a structured induction, supervision and training. There were good communication systems at the home to make sure information about people's health and welfare was documented and shared with staff. Robust recruitment procedures had not been carried out when recruiting nurses. Checks had not been made of their nursing qualifications and registration with the Nursing and Midwifery Council, to ensure they had the appropriate qualifications to provide care and treatment.

People were supported with their healthcare needs and were referred to external healthcare professionals as required. We found people's nutrition and hydration needs were not always met effectively by staff. This meant some people were at risk of weight loss or dehydration. We found people's medicines were not always given to them in accordance with their prescriptions. Medicines were not always promptly returned to the pharmacy for disposal, or stored safely.

We found staff did not always follow good hygiene measures. We have made a recommendation about infection control practices.

The building was well maintained and complied with gas and electrical safety standards. Equipment was serviced to make sure it was in safe working order. Evacuation plans had been written for each person, to help support them safely in the event of an emergency.

The provider regularly checked quality of care at the service through visits and audits. There were clear visions and values for how the service should operate and staff promoted these. Records were maintained to a good standard and staff had access to policies and procedures to guide their practice.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to medicines practice, staff recruitment and meeting nutritional needs. We also found a breach of the Care Quality Commission (Registration) Regulations 2009. This was in relation to notification of the outcome of applications to deprive people of their liberty. You can see what action we told the provider to take at the back of the full version of this report.

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's medicines were not always managed safely and in accordance with their prescriptions.

Robust recruitment procedures were not always used by the service to ensure people were cared for by staff with the right skills and qualifications.

People were not always protected from the risk of infection as staff did not consistently follow good hygiene measures.

Is the service effective?

Requires Improvement

The service was not always effective.

Decisions made on behalf of people who lacked capacity were not always made in their best interests, in accordance with the Mental Capacity Act 2005.

People's nutritional needs were not consistently met, which placed people at risk of weight loss or dehydration.

People were referred for specialist healthcare advice where needed to keep them healthy and well.

Is the service caring?

Good

The service was caring.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care. End of life care was provided in a dignified way.

People were treated with kindness, affection and compassion.

People were supported by staff who engaged with them well and took an interest in their well-being.

Is the service responsive?

Good

The service was responsive.

People were able to identify someone they could speak with if they had any concerns. There were procedures for making compliments and complaints about the service.

People received appropriate care and treatment, to help ensure they remained independent.

People were supported to take part in activities to increase their stimulation.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The Care Quality Commission had not been informed about the outcome of applications to the local authority to deprive people of their liberty. This meant we were unable to evaluate what restrictions were placed upon people and how the service managed these.

People were cared for in a service which had clear visions and values about how it should support them.

People's care was monitored by the provider to make sure it met their needs and requirements.

Fremantle Court

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 5 and 6 September 2016 and was unannounced.

The inspection was carried out by one inspector, a specialist advisor and an expert by experience on the first day. The specialist advisor's area of expertise was nursing care and care of people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was carried out by one inspector and an inspection manager.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted 19 health and social care professionals and the local authority, to seek their views about people's care.

We spoke with the manager and eleven staff members. This included the provider's head of clinical services, care workers, nurses and the chef. We checked some of the required records. These included ten people's care plans, 30 people's medicines records, six staff recruitment files and eight staff training and development files.

We spoke with 13 people who lived at the home and one visitor. Some people were unable to tell us about their experiences of living at Fremantle Court because of their dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People medicines were not always managed safely and in accordance with their prescriptions. We saw staff had not always followed correct procedures when they administered medicines. When we checked medicines at lunchtime in one part of the home, we found two people had not been given one of their morning tablets. These were to treat osteoporosis. We were told night staff would usually give these tablets but for some reason had missed them. This was not picked up when other medicines had been given later by day staff.

We saw five types of medicine had not been given to another person the previous day. These included medicine to treat angina and high cholesterol levels. Staff had signed the administration record as 'refused.' We could not see how the person could have been offered the tablets as they were still in the blister pack. If they had been refused, there was no record of staff trying later, when the person may have been more agreeable to taking medicines. We also noted the medicines fridge was unlocked in an unlocked treatment room. The contents of the fridge included insulin and an antipsychotic medicine.

In another part of the home, we found a tablet to control thyroid functioning was signed as given to someone the previous day, but it was still in the blister pack.

Medicines which required destruction had not always been returned to the pharmacy promptly. In one controlled drugs cabinet there was a bag of tablets, individually wrapped and dated and a label which stated whether they had been dropped, came loose from the pack or other reason. Some dates went back to March this year.

These were breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not always returned promptly and stored safely. Additionally, people did not consistently receive medicines according to their prescriptions.

Prompt action was taken by the head of clinical services when these issues were brought to their attention.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored appropriately within the treatment rooms. When a controlled drug was administered, the records showed the signature of the person who administered the medicine and a witness signature. Stock checks were completed regularly. We checked controlled drugs in one part of the home and found the records were accurate.

The service did not always use robust recruitment processes to ensure people were supported by staff with the right skills and qualifications. We found checks had not been made to confirm nurses employed by the service were registered with the Nursing and Midwifery Council (NMC). This meant people could not be certain they were supported by staff with the appropriate qualifications to provide their care and treatment.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Checks were made with the NMC whilst we were at the service and these confirmed all nurses were appropriately registered.

People we spoke with told us they felt safe living at Fremantle Court. Comments included "I have been here for more than a year and I can't think of a time when I felt unsafe," "The staff are very good and I feel safe here" and "I feel safe because there are people to take care of you if need be."

There were procedures for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff received training as part of their induction about safeguarding and raising concerns. This was refreshed as part of on going staff development. Staff we spoke with had a good understanding of what they needed to do if they suspected abuse. One care worker told us "We are very careful when we deliver care and have been trained to report anything such as bruising or neglect to the senior staff and management. I have been here for two years and I have never had to report any abuse. If it happens I will always report it because I care."

People were protected form the risk of unsafe premises. The building was well maintained. There were certificates to confirm it complied with gas and electrical safety standards. Checks were carried out for other hazards such as Legionella disease. Appropriate measures were in place to safeguard people from the risk of fire. We saw emergency evacuation plans had been written for each person, which outlined the support they would need to leave the premises. Equipment to assist people with moving had been serviced and was safe to use.

People were protected from the risk of harm. Risk assessments had been written to assess situations such as people's likelihood of developing pressure damage and their risk of falls. Moving and handling risk assessments had also been completed. Most risk assessments had been reviewed regularly to make sure they still reflected people's current needs. However, in one part of the home we found moving and handing risk assessments were reviewed monthly until 20 January 2016 then there was no further review. In one case, the person's file also contained an individual risk assessment for mobility which stated they needed two staff to support them. This information was different to the moving and handling risk assessment, which stated only one member of staff was needed to support the person. When we spoke to staff about this, they said this was an oversight as the member of staff who used to complete these had left the service in January 2016. We noted only one person's needs in this area had changed since January. We were told by the senior care worker these risk assessments would be reviewed and amended as appropriate straight away.

During the two days of the inspection we observed there were enough staff to support people. Although staff were busy, people received care according to their care plans and the atmosphere in the home remained calm and unrushed. Staffing levels had been determined from carrying out dependency level assessments for each person. We observed people's needs were met in a timely way with call bells answered promptly.

We received mixed responses when we asked people if there were enough staff to meet their needs. One person said "No. When people are in bed they need more care. When I first came and the home was not full, we had a fantastic service. Now there are more people there are more agency staff that don't know you. At times they don't speak English and communication is difficult and thus needs are not met. The main staff are wonderful but they don't get the support when they are on." Another person said "No, because they are always rushing about and it's worse at weekends." Three people expressed more positive views. One told us "At times there aren't (enough staff) especially at weekends, although the staff are very good." Other person commented "I think so…I am well looked after" and "They have enough staff on duty at night as well as in

the day."

A member of staff told us "The staffing levels are appalling and there is a high use of agency staff. Staff are often moved from their unit to cover other units." They said there were times when they were one member of staff down in another part of the home they worked in. However, they added staffing had been more consistent in the last few months.

We saw staffing rotas were maintained at the service. These showed people were supported by a mix of care and nursing staff. A senior member of staff was on duty to co-ordinate each shift and respond to situations such as arranging doctor's visits and dealing with emergencies.

We noted some infection control concerns. We saw a soiled duvet had been placed in a laundry bag on top of a trolley in a sluice room. The bag was open and part of the duvet was touching a pack of incontinence pads. At lunchtime we observed staff wore blue aprons when they served food. However, one member of staff had long hair which was not tied back. We saw they touched their hair to move it away from their neck two to three times in between serving people their meals.

We recommend staff are reminded of good infection control practices to prevent the spread of infection at the home.

Requires Improvement

Is the service effective?

Our findings

People's care and treatment was not always provided with the consent of the relevant person. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked the see whether the service had complied with the principles of the MCA. Some care plan files stated the person's relative had power of attorney to make decisions on their behalf. In these cases, the service had not obtained copies of the power of attorney document, to confirm who could make these decisions and if they covered the areas in question. Without this document, the service could not be certain it involved the right people when it consulted them about people's care and that they were legally authorised to act on their behalf.

We were told action had already been taken with regards to this, as letters had been sent to relatives to request copies of power of attorney documents.

We recommend the service follows best practice by obtaining copies of power of attorney documentation to make sure authorised persons are consulted.

Staff told us they had training in the Mental Capacity Act 2005. They showed a good understanding of consent, assessment of capacity and how to act in the person's best interests. One member of staff told us "Sometimes we experienced difficulties with the relatives of people who have capacity in that the relatives want us to do something that is contrary to the wishes of the person. In those circumstances, we always support the wishes of the person."

Staff did not always follow good practice in meeting people's nutritional needs. We found there was no formalised system to make sure catering staff were told about people's nutritional needs. For example, details of any allergies, likes and dislikes were not promptly communicated to catering staff either before or as soon as people were admitted to the home. The home did not have a form for staff to complete about people's needs, such as a checklist of allergies and foods which caused sensitive reactions.

People's risk of malnutrition had been assessed and kept under review. However, we had concerns when we observed lunchtime in one part of the home which provided care to people with dementia. We saw practices which may indicate that people did not receive sufficient calories to prevent weight loss. For example, we saw staff used two types of milk to make drinks, full fat and semi skimmed. We asked staff who had which milk. They were unable to provide a clear response to say who needed semi skimmed milk. We saw someone had asked for a salad for their lunch, which was provided for them. The plate of food looked bland and did not contain any carbohydrate or high calorie nutrients. The person was not enjoying it and did not

finish the meal. They only picked at their food after encouragement from staff and the provision of a salad dressing to go with the meal. In both examples, we had concerns staff had unknowingly restricted calorie intake for people who did not need to reduce the amount they consumed. This placed people at risk of weight loss.

Fluid intake charts were in place where people required monitoring. In some parts of the home, a target amount was not indicated for each person and the amount they had consumed over 24 hours was not calculated. This meant monitoring was ineffective.

These were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people's nutritional and hydration needs were not always met.

We asked people about the quality of meals. Comments included "Plenty to eat and drink. The food is not great. The menu looks wonderful but it seems to me that to satisfy 90 odd people is not easy and so it's poor; but there is plenty of it." Another person told us "You get enough but not always what you like, even though there is a menu." Other comments included "The quality of the food is good" and "The food is alright, it could be better and there could be more variety." Additional comments included "Food is so so, we complain when we need to," "The food is okay. They do their best and there is always a choice. I have never had to complain about the food" and "The food is okay and we can feedback to the chef, although they don't know how to make a good curry."

People were supported with their healthcare needs. Care plans identified any support people needed to keep them healthy and well. We saw a range of healthcare professionals were or had been involved in people's care. This included dietitians, speech and language therapists, occupational therapists and physiotherapists. People told us they received the healthcare support they required. Comments included "They arrange for the GP, dentist and optician to visit if you need them" and "They would call a GP if needed."

A healthcare professional told us how effective nursing staff had been regarding someone's care. They said nurses had monitored the person's condition and communicated with staff on other shifts to make sure they provided accurate information on their progress.

People received their care from staff who had been appropriately supported. New staff undertook an induction to their work. They were enrolled onto the nationally-recognised Care Certificate. The Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way.

Staff received supervision from their line managers. Frequency of supervision meetings varied and we noted nurses did not currently receive clinical supervision as a senior member of staff was on sick leave. However, we saw staff meetings took place to keep staff up to date with developments within the home and the organisation. We saw staff came to the duty office to speak with senior staff about any concerns or queries and these were promptly addressed.

There was a programme of training to ensure staff had up to date skills and knowledge to meet people's needs. We saw several courses were booked to refresh training which was due for renewal.

We observed staff communicated effectively about people's needs. Relevant information was documented in daily notes and communicated to senior staff. There were handovers between shifts to share relevant information about people's health and well-being. We observed these included updates about people's

progress and any areas which required particular attention or follow up.

People lived in a home which was designed with appropriate adaptations to promote their independence. For example, corridors, bathrooms and bedrooms were spacious enough to accommodate wheelchairs. There was space to manoeuvre hoists and other equipment people needed; a passenger lift provided access between floors. Sensory nodules had been fitted to grab rails in corridors, to assist people with visual impairments. There was level flooring throughout the building and around the garden, to enable people to move around safely.

Good

Is the service caring?

Our findings

We received positive feedback from people about the caring approach of staff. Comments included "The staff are kind and caring," "All the staff are lovely and very caring" and "I find the care very good and the staff very caring." Another person told us "I have my good days and bad days here but staff are very supportive." One person told us "There is a particular member of staff who can read my mind and she is always right as far as I am concerned. I think she can read my body language. She knows when I want to go out in the lounge and in the garden or want to rest in my room and then she just gives me the choice. She is wonderful."

We asked people if they were treated with kindness and compassion by staff. Comments included "They are very kind and nothing is too much trouble for the core staff," "The girls are good. For example, today I have had a carer that couldn't do enough for me." Other comments included "They are all kind" and "Yes, always." One person told us "To do this job one needs patience and skills and the staff here show it. Most of them are genuine."

People told us staff were respectful towards them and treated them with dignity. One person said this was particularly so when they were supported to bathe. Another person told us "Staff do ask if the door is to be open or closed." Another person said "The staff always draw the curtains when they attend to me."

Staff knew about people's personal histories, for example, where they had lived, their family composition and where they had worked. We observed staff treated people with respect and took an interest in them. For example, we heard a member of staff when they spoke with someone at lunchtime. They offered them a napkin and asked the person "Would you like to pop a napkin on your lap, save your pretty skirt?" In another example, staff asked a person how their legs were and commented on how the skin had improved. They asked the person if they would like to be taken to their room to lay down and rest them and helped them to their room when they said yes.

Staff listened to people and spoke with them appropriately. We observed staff took time to listen to what people said and tried to get close to them by kneeling in front of them so they could hear the person and they could hear them. People told us staff took time to explain the actions they would take before doing something. This meant people knew what was going to happen and staff provided them with opportunities to express themselves.

People's wishes about how they wanted to be supported with end of life care were documented in their care plans. We saw staff provided high standards of end of life care which promoted people's dignity and kept them comfortable. For example, they provided good oral care, repositioned people to prevent pressure damage and kept family members informed.

People appeared happy and contented. We saw staff had supported people to look well presented and care was taken of their hair and clothes. People had personalised their rooms and made them look homely and comfortable with items such as plants, pictures, photographs and ornaments.

The home was spacious and allowed people to spend time on their own if they wished. There were quiet areas people could make use of around the building. Staff respected people's wishes if they chose to spend time in their rooms.

The service promoted people's independence. Risk assessments were contained in people's care plan files to support them with, for example, their mobility and to reduce the likelihood of falls and injuries.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs. Comments included "They would call a GP if needed" and "I haven't felt unwell but I think they probably would respond," and "I think that if I need it they will get the GP." Other people told us "I always get the help I need when I need it. The only thing that bothers me is that sometimes I have to wait." Another person told us "I have been here for six months. I get assistance with my shower and to get dressed. I get the help as I like it. The staff are different but professional and they know their job, variety is the spice of life."

We received positive feedback from a healthcare professional about the way the home responded to changes in people's health and well-being. They told us "The nurses and care staff are always very attentive to changes with their residents' needs. They are quick to refer to our service and always follow any advice and recommendations correctly."

The service supported people to take part in social activities. People told us "There are activities every day but I choose not to join because when I went it did not suit me…the activities person is very good," "It's good and I enjoy them," "I join in with things and I enjoy them. Well organised" and "There is enough to do." We saw posters displayed around the building to advise people what was taking place that week. This included indoor bowls, gentle exercises, Holy Communion, a knitting and natter group and an entertainer. There was also an arts and crafts session and examples of people's art work was displayed for all to see.

People had their needs assessed before they received support from the service. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Care plans were personalised and detailed daily routines specific to each person. For example, there were sections about people's preferred daily routines. Personal profiles about people's histories and backgrounds had been completed in the files we read. These provided important information to help ensure people received individualised care. Staff were able to describe to us the support needed for the people they cared for.

There were procedures for making compliments and complaints about the service. We looked at how three complaints had been handled and discussed these with the manager. We saw appropriate action had been taken in response to these. People told us they would speak with care staff or go to the office if they were worried or had any concerns.

Staff took appropriate action when people had accidents. For example, we looked at how a fall had been responded to. This included checking the person for injury and testing their blood sugar levels (the person was diabetic.) When they saw the person's blood sugar levels were low, they provided appropriate food and drink, settled the person into bed as they were tired and observed them. In another example, staff called an ambulance after someone fell, as staff suspected a fracture.

Requires Improvement

Is the service well-led?

Our findings

Providers and registered managers are required to notify the Care Quality Commission of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. This includes notification about the outcome of applications made to deprive people of their liberty. In the PIR, the manager told us 36 people were subject to deprivation of liberty authorisations. We had not been notified about any of these authorisations.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service did not have a registered manager in post. The current manager had worked at the service for six weeks at the time of our visit. They were an experienced manager who had been registered in their previous role and understood the responsibilities of registration. They would be submitting an application to register with the CQC.

The service had a statement about the vision and values it promoted. It included values such as choice, fulfilment, autonomy, privacy and social interaction. These were displayed in the entrance area. We found staff promoted these values in the way they provided care to people.

We identified there were some issues with record keeping during the inspection, such as fluid monitoring charts and staff recruitment records. Other records we looked at were well maintained and were located promptly. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, restraint, and safe handling of medicines. These provided staff with up to date guidance.

Staff were advised of how to raise whistleblowing concerns during their training on safeguarding people from abuse. Whistleblowing is raising concerns about wrong-doing in the workplace. This showed the home had created an atmosphere where staff could report issues they were concerned about, to protect people from harm.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The provider regularly monitored the quality of care. This was done through visits by senior managers to assess care practice, self monitoring by the manager and themed audits of practice. A comprehensive audit was carried out in July this year with a detailed action plan to improve standards of care.

We found there were good communication systems at the service. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications had not been submitted to the CQC regarding the outcome of applications to deprive people of their liberty. Regulation 18 (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs had not always been met as fluid intake was not effectively monitored where required. There was no standard process for informing catering staff about people's nutritional needs. Staff did not always ensure people received sufficient calorie intake to prevent weight loss. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured recruitment procedures were operated effectively to ensure staff had the qualifications, competence, skills and experience necessary for the work to be performed by them. Regulation 19 (1) (2)