Dolphin Property Company Limited

Heather House

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced inspection carried out on 16 November 2015.

We last inspected Heather House in November 2013. At that inspection we found the service was meeting all the legal requirements in force at the time.

Heather House provides accommodation and personal care for up to 13 adults who have a learning disability. This includes care for one person who is supported by staff in a bungalow which is separate from the main building. Nursing care is not provided.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

People said they were happy and felt safe. We had concerns however that there were not enough staff on duty at all times to promote choice and provide individual care to people.

Risk assessments were carried out that identified risks to the person. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. People received their medicines in a safe and timely way. People had access to health care professionals to make sure they received appropriate care and treatment.

Staff received regular training, supervision and appraisal.

Heather House was in the process of meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Records were not in place as required by the Mental Capacity Act (MCA) 2005 to show best interest decision making when people were unable to make decisions themselves.

People were supported to be part of the local community. They were provided with some opportunities to follow their interests and hobbies. People received meals cooked by staff. However, systems were not in place to ensure people received a choice of food.

Staff knew the people they were supporting well. Care was provided with patience and kindness and people's privacy and dignity were respected. People were not offered choice in all aspects of their care.

People we spoke with said they knew how to complain but they hadn't needed to. Staff said the manager was supportive and approachable. People were consulted and asked their views about aspects of service provision.

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

Not all aspects of the service were safe.

People did not always receive their care and support in an individual and timely way because staff carried out ancillary duties that were not related to direct care.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected. Staff were appropriately vetted to make sure they were suitable to work with people who lived at the service.

Policies and procedures were in place to ensure people received their medicines in a safe manner.

Is the service effective?

Requires improvement

The service was not always effective.

Records were not available to show if people had capacity to make decisions and to document people's level of comprehension.

Staff had received the training they needed to ensure people's needs were met effectively. Staff were given regular supervision and support.

People received appropriate support to meet their healthcare needs. Staff liaised with GPs and other professionals to make sure people's care and treatment needs were met.

People nutritional needs were met.

Is the service caring?

Good

The service was caring.

People we spoke with said staff were kind and caring and were very complimentary about the care and support staff provided.

People's rights to privacy and dignity were respected and staff were observed to be patient and interacted well with people.

Staff were aware of people's individual needs, backgrounds and personalities. This helped staff provide individualised care to the person.

Is the service responsive?

Requires improvement

The service was not always responsive.

Support plans were in place to meet people's care and support requirements. People were not always offered choice and opportunities to be involved in decision making in some aspects of their daily lives.

Summary of findings

People were provided with a range of opportunities to access the local community.

Is the service well-led?

Requires improvement

The service was not always well-led.

A registered manager was in place. Staff told us the manager was supportive and could be approached at any time for advice. The registered manager had promoted some involvement and choice for people who used the service but this was not always effective in ensuring people had enough choices.

People who lived at the home told us they enjoyed living at the home and we saw the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

Heather House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We did not receive any information of concern from them.

This inspection took place on 16 November 2015 and was an unannounced inspection. It was carried out by an adult social care inspector.

We undertook general observations in communal areas and during a mealtime.

As part of the inspection we spoke with eight people who were supported by Heather House staff, seven support workers, a visiting health professional, the registered manager and operational manager. We observed care and support in communal areas and checked the kitchen, bathrooms, lavatories and six bedrooms after obtaining people's permission. We reviewed a range of records about people's care and checked to see how the home was managed. We looked at care plans for four people, the recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits the manager completed.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Heather House. People's comments included, "I love living here," "The staff are great," and, "I can speak to the staff if I'm worried."

The registered manager told us staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting people could be increased as required. For example, a person who lived in the bungalow had recently had their support staff increased from two to three support workers during the day.

We had concerns not enough ancillary staff were employed to meet the operational requirements of the service.

The main house which accommodated ten people was staffed by four support workers and a senior support worker from 3:00pm until 10:00pm and two waking night staff from 10:00pm until 10:00am. The bungalow in the grounds accommodated one person who was supported by three staff. No support staff were rostered in the main house between 10:00 am and 3:00pm as everyone was out of the main building. We were told one person did not attend a day service and they received one to one hours on some days.

The registered manager told us, and this was confirmed by the staffing roster that the domestic member of staff worked 14 hours over four days of the week to clean the main house and the bungalow. This meant domestic cover was not available each day to ensure the standards of cleanliness were maintained in the home. We saw some areas of the home such as stairs and the landing were not clean and there was an odour in some bedrooms. Some communal areas of the bungalow were not clean and the carpets were soiled. We were told by the registered manager the care staff on duty, and night staff carried out any urgent domestic tasks in the absence of the domestic member of staff. The registered manager told us the service involved people to help them acquire some daily living skills to retain their independence. However, due to people's different dependency levels and increasing age we had concerns there were not enough domestic hours allocated to ensure an adequate standard of cleanliness around the building and to thoroughly clean each area to ensure an effective level of cleanliness. When support workers carried out ancillary tasks they were also unable to provide direct care and support to people.

A support worker was responsible for cooking the meals as a cook was not employed. We observed the evening meal was not served until 6:00pm but people had been waiting and expecting their meal between 4:00pm and 5:00pm. We were told the delay was because there had been a problem making the pastry for the quiches. As the meal was late one person who had distressed behaviour, because of a fixation about food, had to be given a packet of crisps to distract them. This snack was to also allow their medicine to still be administered at the correct time as food was required before they received their medicines. We also observed staff had to remember to check ahead to make sure the ingredients required for a meal two days in advance was out of the freezer. We had concerns as staff did not start duty until 3:00pm it did not give them enough time to prepare and cook the evening meal in a timely way. It also meant as there were no designated staff employed to carry out cooking and domestic duties sufficient numbers of support staff were not available to provide care and support to people when they were carrying out these ancillary tasks. The registered manager and operational manager agreed and said it would be addressed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We checked the management of medicines. People received their medicines in a safe way. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed in the handling and administration of medicines. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines. The registered manager told us any reported medicine errors were reviewed and action was taken to strengthen systems and help protect people with regard to medicines management.

Medicines were given as prescribed and at the correct time. The senior support worker told us medicines would be

Is the service safe?

given outside of the normal medicines round time if the medicine was required. For example, for pain relief. We saw there was written guidance for the use of "when required" medicines, and when these should be administered to people who showed signs of agitation and distress.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were aware of the provider's whistle blowing procedure. They told us they currently had no concerns and would have no problem raising these if they had any in the future. Staff told us, and records confirmed they had completed safeguarding training. Staff members comments included, "I've received local authority safeguarding training, "I'd inform the manager if I had any concerns," "I'd speak to my line manager or inform safeguarding myself," and, "I'd tell my manager or the senior in charge if I had any concerns."

The registered manager was aware of potential safeguarding incidents that should be reported. A log book was in place to record minor safeguarding issues which could be dealt with by the provider. Seven safeguarding referrals to the local authority safeguarding adult's team had been raised since the last inspection and had been investigated and resolved.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the registered manager so that appropriate action could be taken to prevent further incidents occurring.

Assessments were undertaken to assess any risks to people and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. These assessments were also part of the person's care plan. There was a clear link between care plans and risk assessments addressing for example, distressed behaviour, nutrition, epilepsy, mobility needs and risks.

Care plans were in place to show people's care and support requirements when they became distressed. Information was available that detailed what might trigger the distressed behaviour and what staff could do to support the person. Care records provided detailed and up to date information for staff to provide consistent support to people and help them recognise triggers and help de-escalate situations if people became distressed and challenging. For example, one care record stated, "(Name)'s behaviour changes. When (Name) is happy they will dance and smile. They will say, 'Hiya'. When sad, (Name) will jump up and down and hand bite."

A system was in place to deal with people's personal allowances and any money held on their behalf for safe keeping. We had concerns however, as the registered manager told us they believed the organisation was appointee for people's monies rather than an external arrangement being in place independent of the organisation. The area manager said this would be checked and addressed if the organisation was appointee for people's money.

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Documents verifying people's identity were available on staff records. Copies of interview questions and notes were available to show how each staff member had been appointed.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building. Routine safety checks and repairs were carried out such as checking the fire alarms and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances.

Requires improvement

Is the service effective?

Our findings

Staff told us they were kept up to date with training. People's comments included, "We do face to face and e learning training," "I have said I want to do a National Vocational Qualification (NVQ) at level three." (This is now known as a diploma in health and social care.), "There are opportunities for training," and, "We get loads of training."

Staff told us and the staff training records showed us they had opportunities for training to understand people's care and support needs. They said training was appropriate. Two new staff members told us when they began work they had completed an induction. They told us they had the opportunity to shadow a more experienced member of staff. This made sure they had the basic knowledge needed to begin work. The registered manager told us new starters were to study for the Care Certificate as part of their induction to equip them with some of the required skills to work with people.

The staff training records showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as, equality and diversity, risk assessment, diet and nutrition, dementia awareness, dealing with difficult situations and dignity in care.

CQC monitors the operation of Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found that as a result eleven applications were currently being processed to check if people living at the home were to be subject to such restrictions. Staff had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Records were not available to show assessments had been carried out, where necessary of people's capacity to make particular decisions. Records were not available that contained information about the best interest decision making process, as required by the Mental Capacity Act. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Information was not available to show if people had capacity to make decisions and to document people's level of comprehension. Staff, because they knew people well, could tell us about people's levels of understanding.

This was a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff told us and staff records showed they received regular supervision from the management team, to discuss their work performance and training needs. They also received an annual appraisal to review their work performance. A senior staff member commented, "I'm responsible for some of the staff supervisions." Staff said they could approach the management team at any time to discuss any issues. They said they felt well supported by colleagues and worked as a team.

Staff told us communication was effective and a written handover was available from each shift to keep staff up to date with the current state of people's health and well-being. Staff members' comments included, "Communication works really well. We have a verbal handover at 3:00pm from the registered manager when staff come on duty," and, "Handover lasts about twenty minutes, we have them every day, each morning and each afternoon."

We checked how the service met people's nutritional needs and found that systems were in place to ensure people had food and drink to meet their needs. People identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised tool, the Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss.

Care plans for people's nutrition were in place. For example, one person's care plan stated, "Make all of their drinks and meals for them as (Name) doesn't have the ability to do so themselves." Risk assessments were in place to identify if the individual was at risk when they were eating or had specialist dietary requirements. For example,

Requires improvement

Is the service effective?

"(Name) needs staff to sit beside them at meal times to prompt them to slow down when they eat to ensure they don't choke." We saw the evening meal was quiche, salad and chips. It looked appetising and well-presented but an alternative to the meal was not available. We were told people could have something else if they did not like the main meal but an alternative meal was not advertised on the menu.

Records showed the health needs of people were well recorded. Information was available in their records to show the contact details of any people who may also be involved in their care. Care records showed that people had access to a General Practitioner (GP), dietician, speech and language therapist, occupational therapist and other health professionals. For example, staff had written in one care plan, "I need staff to support me to talk to the GP and other professionals." The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. For example, psychiatrists and clinical staff from the behavioural team. We spoke with a visiting health care professional who told us, "I'm pleased with the support provided to (Name) by staff. The registered manager was very encouraging as they said, I want us to get to the bottom of this difficult behaviour."

Good

Is the service caring?

Our findings

During the inspection there was a happy, relaxed and pleasant atmosphere in the service. Staff interacted well with people, joking with them and spending time with them when they had the opportunity. Camaraderie was observed amongst the people who used the service and they were supportive and caring of each other. Some people told us they had moved into the service when it opened approximately twenty years ago. People were supported by staff who were warm, kind, caring and respectful. Staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. This guidance was also available in people's support plans which documented how people liked and needed their support from staff. For example, "(Name) would like staff to continue giving them choices throughout the day."

Not all of the people were able to fully express their views verbally. Support plans provided information to inform staff how a person communicated. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. A care record stated, "(Name) cannot tell staff if they are feeling unwell. Staff need to observe any changes in their behaviour," and, "(Name) will slap and nip when they are not happy." This meant staff had information to inform them what the person was doing and communicating to them. People were encouraged to make choices about their day to day lives and staff used pictures, signs and symbols to help people make choices and express their views. We saw information was available in this format to help the person make choices with regard to activities, outings and food.

Care records detailed how people could be supported to make decisions. For example, one person's support plan stated, "(Name) needs staff to continue using their picture cards Picture Exchange Communication (PEC) and Makaton (sign language)." Records showed people were able to make other choices such as what to wear and what to eat. For example, "(Name) likes to choose their clothes. They don't like wearing belts and trousers with buttons" and, "(Name) likes to choose what they want to eat for breakfast and supper." Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well.

People's privacy and dignity was respected. Staff knocked on the door as they entered people's rooms. They could give us examples of how they respected people's dignity. Information was available in people's care plans with regard to people's wishes about choice of male or female carer. For example, "(Name) is supported by a female member of staff when in the shower/bath."

Care records also showed people's privacy was respected. For example, "(Name) sometimes likes to have five minutes to themselves in the shower. They like to stand and splash water in their face, and, "(Name) prefers to have medicines given to them in their own bedroom." We saw a person's privacy was not respected currently in the bungalow as the person removed the curtains and blinds from their bedroom window and lounge. These windows were overlooked by neighbour's windows. The registered manager told us they were trying to find a window glazing that would allow the person to look out of the windows without people being able to look in. This would then protect the person's privacy.

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. The registered manager told us no one required an advocate currently but if necessary a more formal advocacy arrangement would be put in place. Advocates can represent the views of people who are not able to express their wishes.

Requires improvement

Is the service responsive?

Our findings

People were positive about the opportunities for activities and outings. They all said they went out and spent time in the community. People's comments included, "I like baking," "We do karaoke," "I've been out for a meal," "and, "I like making things." A person showed us their arts and craft magazine. We saw several people were supported by a staff member to make decorations for Christmas from the magazine. People showed us examples of decorations they had already made over the weekend. Other people were engaged in their own interests. For example, doing a crossword, watching a quiz show, looking at magazines, spending time in their room with their DVD collection and talking to staff. We saw photographs of activities and outings that had taken place during the year. The home's monthly newsletters also showed the various outings that were available. For example, to the Baltic art gallery, Beamish Museum, Saltwell Park and Alnwick Gardens.

We had concerns people did not always receive person centred care that offered them choice in all aspects of their care.

Most people had lived at the service for twenty years and the registered manager told us their care arrangements had not been reviewed by the commissioners for some time. We had concerns people's care was not always person centred care. For example, everyone apart from one person attended a day service placement. As the arrangement had not been reviewed for some time we had concerns this reduced people's choice in case they did not want to attend. We were told people had to attend a service every day rather than have the choice if they wanted of not attending, attending part time or being involved in other community based activities. People's ages varied up to 62 years of age. We were told if anyone became ill and needed to return from their day service, a member of staff from the day service would escort them and provide the care and support to them as no support staff would be available at the home. We were told more ancillary staff were not employed as people who used the service were involved in carrying out tasks such as vegetable preparation, setting tables, washing up, cleaning their rooms and being involved in other domestic tasks and household activities. This was to help people learn new skills. However, the arrangement did not offer people a choice as they were expected to do it and the arrangement did not take into account people's age and level of dependency. Our meal time observation and menus showed people were not offered choice as an alternative to the main meal was not available. The menu also recorded the lunchtime meal option did not vary for people as they took a packed lunch to work each day as they had their main meal in the evening rather than be offered the choice of having a cooked meal at the day service if they wished.

This was a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort.

Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs.

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, "I do not like to be away from home overnight," and, "Mrs Brown's Boys makes me laugh a lot. I have a very good sense of humour." Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service.

A daily record was available for each person. It was individual and in sufficient detail to record their daily routine and progress in order to monitor their health and well-being. This was necessary to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences.

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. For example, "(Name) has a sister and brother-in-law who regularly pick (Name) up from the home and take them out for the day for long walks and to

Requires improvement

Is the service responsive?

the pub for family birthdays when they have a meal together." Many people had visitors every week. The registered manager told us some people went to spend time at home on 'home leave'. A person told us, "I ring my mother every night."

We were told meetings took place with people monthly to consult with them about activities and menus and to keep people up to date with the running of the home. The registered manager told us two resident and relative meetings took place each year. These were held at the request of family members who would inform the registered manager when one should be held. This was an opportunity for the registered manager to give the meeting any updates about the service and to receive feedback from people about the running of the home.

People had a copy of the complaints procedure that was written in a way to help them understand if they did not read. A record of complaints was maintained. No complaints had been received since the last inspection. A person commented, "I'd speak to staff if I was worried."

Requires improvement

Is the service well-led?

Our findings

A registered manager was in place who had been registered with the Care Quality Commission.

The registered manager promoted some involvement to keep people who used the service involved in their daily lives and daily decision making. However, in some aspects of people's care their choice was limited. Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves.

The atmosphere in the service was friendly. Staff said they felt well-supported. Comments included, "The manager is very approachable," "Very approachable manager," and, "An 'open door' policy in place so I can call in any time when the (manager) is not busy."

Staff told us staff meetings took place regularly. Meeting minutes showed health and safety meetings took place monthly. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff had discussed health and safety, service issues, training, accidents and incidents and needs of people who used the service. Meeting minutes were made available for staff who were unable to attend meetings

Records showed audits were carried out regularly and updated as required. Daily audits included checks on finances, medicines management and the environment. Weekly checks also took place that included medicines. Monthly audits were carried out and they included for medicines, health and safety, catering and infection control. The operational manager visited monthly to provide an independent view of the service. Their monthly visit was to speak to people and the staff regarding the standards in the service. They also audited a sample of records, such as care plans and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

The registered manager told us the provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service. Survey results were not available for the last completed survey. The registered manager told us they had adapted the organisation's general survey/ questionnaire currently used in older person's services. We did see the questions were written in an easy read format and asked people's views about the temperature of the home, security and the cleanliness of the home. The registered manager had already identified the areas surveyed were not really relevant to a service that provided care and support to people with learning disabilities as they had different priorities. Such priorities included activities and outings and menus and so the registered manager had devised a monthly survey to capture the views of people who used the service. They were in the process of developing another annual survey questionnaire with people who used the service to find out what was important to them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured sufficient numbers of staff to ensure the smooth running of the service and to ensure people had their care and support needs met in a timely way. **Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated Code of Practice. **Regulation 11(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured people received choice in all aspects of their care and nutrition. **Regulation 9 (3)(d)(h)(i)**