Brooklands Care Home Ltd

Brooklands Nursing Home

Inspection report

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Date of inspection visit: 7 December 2015 and 8 December 2015
Date of publication: 03/02/2016

Ratings

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

Overall summary

Brooklands Nursing Home provides accommodation and personal care for up to 45 older people, people living with dementia and people who require nursing care.

The inspection was completed on 7 and 8 December 2015. There were 44 people living at the service when we inspected. This was the provider's first inspection since the service was newly registered on 14 July 2015.

A registered manager was 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.

We found that the provider was not always meeting the requirements in relation to sufficient staff available to meet people's needs and this meant that care was not always person centred or responsive to meet their needs. We identified that the dining experience for some people required improvement. In addition, although quality monitoring systems were in place, they had not

Summary of findings

highlighted the areas of concern we had identified at this inspection. Checks were not effective to monitor and ensure pressure mattresses and ensure these were set at the correct setting each day. Records were not properly maintained, for example, in relation to staff supervision, food and fluid monitoring and end of life care. Some aspects of care practices required improvements. These related to assisting people to eat and drink, communication with people living at the service and care and support to be less routine and task focused. Issues had not always been followed up where raised and identified from questionnaires.

Appropriate assessments had not been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected.

Risks to people's health and wellbeing were appropriately assessed and managed. People had good healthcare support and accessed healthcare services when required. The management of medicines within the service ensured people's safety and wellbeing.

Staff had a good understanding and knowledge of safeguarding procedures and were clear about the actions they would take to protect the people they supported. Appropriate recruitment checks were in place which helped to protect people and ensure staff were suitable to work at the service. Staff told us that they felt well supported in their role and had received a proper induction and opportunities for formal supervision.

People were treated with kindness and care by staff. Staff had a good relationship with the people they supported.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Although the deployment of staff was appropriate at the time of the inspection, people told us that there were not always enough staff available to support people safely.

Staff had a good understanding of safeguarding procedures to enable them to keep people safe.

People's assessed healthcare risks were not always managed safely.

Staff recruitment processes were thorough and ensured that staff were suitable people to work in the service.

The management of medicines ensured people's safety and wellbeing.

Is the service effective?

Requires improvement

The service was not consistently effective.

The dining experience for people was variable and not always appropriate to meet people's individual nutritional needs.

Staff did not have a good knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people lacked capacity, although decisions had been made in their best interests, these were generic and not person centred.

In general people were well cared for by staff that were well trained and had the right knowledge and skills to carry out their roles.

People were supported to access appropriate services for their on-going healthcare needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's choices for their end of life care was not recorded. The service had provided no information for staff on how to manage people's choices and wishes for their end of life care and staff had not received appropriate end of life care training.

Staff interactions were variable as the majority of interactions were task led and communication by staff with people who used the service required improvement.

People told us that the staff were kind, caring and respectful.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

People were assessed prior to admission. Although in general people's care plans detailed their care and support needs and how these were to be met by staff, improvements were required for those people who could become anxious or distressed.

Relatives had the opportunity to contribute and be involved in their member of family's care and support.

Effective arrangements were in place for the management of complaints.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Although systems were in place to regularly assess and monitor the quality of the service provided, they were ineffective as they had not highlighted the areas of concern we had identified.

Systems were in place to seek the views of people who used the service and those acting on their behalf.

Brooklands 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 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 7 December 2015 and 8 December 2015 and was unannounced.

The inspection team on day one of the inspection consisted of one inspector, a Specialist Advisor whose specialist area of expertise related to end of life care and an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia. On the second day of inspection the inspection team consisted of one inspector.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We 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.

We spoke with 10 people who used the service, 10 relatives, seven members of staff, the registered manager, the provider and Head of Care.

We reviewed 10 people's care plans and care records. We looked at the service's staff support records for six members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Requires improvement

Is the service safe?

Our findings

In general staff knew the people they supported and risks were identified to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers. However, people's assessed healthcare risks were not always managed safely.

Some people were assessed as at high risk of developing pressure ulcers. We checked the setting of pressure relieving mattresses that were in place to help prevent pressure ulcers developing or deteriorating further and found that four out of six people's equipment was incorrectly set in relation to the person's weight. For example, the setting of one person's pressure mattress was observed to be set on '2' [54KG] and yet the person's actual weight was 37.3KG and should have been on setting '1'. This meant that the amount of support the person received through their pressure mattress was incorrect. Additionally we found that records to confirm that people's pressure relieving equipment was monitored and correctly set each day according to their weight were inconsistently completed, for example, not recorded each day. We discussed this with the provider and registered manager. An assurance was provided that all pressure relieving equipment would be reset and discussions with staff held so as to ensure that the monitoring forms were completed each day in the future. On the second day of inspection we found that people's pressure mattress settings had been correctly reset.

We saw that one person was laid flat in bed. We discussed the latter with the member of staff who provided support and they told us that it was the person's choice to lie in bed whilst eating. However, when we checked the person's care plan this confirmed that the person required assistance and lots of encouragement to eat and drink whilst sitting in an upright position. This meant that the member of staff was unaware of the potential risks posed and the increased risk of choking to the person they supported.

In general people told us that there was enough staff available to support them during the week and at weekends. However, there were occasions when care provided to people living at the service was compromised and people did not receive care that was person centred or responsive. One person told us, "Although I feel nice and safe here, often the call bells take ages to be responded to, which is not good when you need the toilet but can't get to it." People's relatives and staff told us that there were occasions whereby there were insufficient staff on duty and staffing levels as told to us by the registered manager were not maintained. One relative told us that they were concerned that as a result of staff shortages their member of family did not always have their personal care needs attended to in a timely manner. They told us that the impact of staff shortages had resulted with their member of family not receiving all of their care and support as they should.

Although the deployment of staff on both days of inspection was observed to be appropriate, the staff rosters showed that staffing levels as told to us by the registered manager had not always been maintained. We discussed this with the registered manager and they confirmed that this was due to staff sickness at short notice, staff with childcare problems and 'bank' staff not able to provide the necessary cover.

People told us that staff looked after them and that their safety was maintained. One person told us, "I feel safe here." Another person told us, "I think it's an extremely safe home for my relative. I always feel comfortable when I leave here. The staff are excellent."

We found that people were protected from the risk of abuse. Staff were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Staff were confident that the provider and the registered manager would act appropriately on people's behalf. Staff also confirmed they would report and escalate any concerns to external agencies such as the Local Authority or the Care Quality Commission if required.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for staff appointed since our last inspection showed that the provider had operated a thorough recruitment procedure in line with their policy and procedure. This showed that staff employed had had the appropriate checks to ensure that they were suitable to work with people.

People told us that they received their medication as they should and at the times they needed them. The arrangements for the management of medicines were safe. Medicines were stored safely for the protection of people who used the service. There were arrangements in place to

Requires improvement

Is the service safe?

record when medicines were received into the service, given to people and disposed of. We looked at the records for 10 of the 44 people who used the service. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed.

Observation of the medication round showed this was completed with due regard to people's dignity and personal choice. Records showed that staff involved in the administration of medication had received appropriate training.

Requires improvement

Is the service effective?

Our findings

Although comments about the quality of the meals were positive and in general staff had an understanding of each person's nutritional needs and how these were to be met, staff's practice required improvement so as to ensure that people's nutritional needs were appropriate to meet their needs. One person told us, "The food is very nice." One relative told us, "The meals are really excellent here. We've no complaints about the food."

People were not always supported to eat and drink enough. We found that people who were cared for in bed were not always encouraged or given the choice or opportunity to get out of bed for lunch. The rationale for why people remained in bed throughout the day was not recorded within their care file. Additionally, where people refused a meal, alternatives to the menu were not routinely offered and/or provided by staff. For example, one person was observed to refuse their breakfast and lunch. Although the person was offered drinks during the morning, no alternatives to either meal were suggested or presented. Records showed that the person was at risk of losing weight and food and fluid charts were to be completed each day. The latter was viewed and these showed that there were gaps. This meant that we could not always be assured that people routinely received a satisfactory diet that met their needs. The same person's care plan detailed that they required a fortified diet. This describes meals, snacks and drinks to which additional nutrients have been added through foods to provide a higher calorific value. We discussed this with the service's chef and found that they had a poor understanding of the meaning of 'fortified' and which people living at the service this applied to.

People's nutritional requirements had been assessed and documented. However, where people were at risk of poor nutrition, this had not always been identified and appropriate actions taken by staff to provide. Where appropriate, referrals had been made to a suitable healthcare professional, such as, GP and Speech and Language Team [SALT] following a discussion with the person's GP.

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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Although staff told us they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training, staff were not able to demonstrate that they were knowledgeable and had a good understanding of MCA and DoLS and how these should be applied. Records showed that where appropriate people who used the service had had their capacity to make decisions assessed. However, information relating to the exact decision that needed to be made, the action that needed to be taken and why it was in the person's best interests had not always been recorded. Additionally, the majority of records were generic in content and not individualised. Appropriate applications had been made to the local authority for DoLS assessments. Where these had been agreed the Care Quality Commission had been notified accordingly.

Staff were trained, which enabled them to deliver appropriate care to the people they supported. Staff confirmed that they received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs to an appropriate standard. Staff told us that the training provided by the registered manager was very good and ensured that their knowledge was current and up-to-date. The staff training matrix provided by the registered manager confirmed what staff told us. Although on the whole the latter was accurate, the registered manager confirmed that 24 out of 44 people at the service had been identified by the GP as requiring 'end of life' care and support. We discussed this with the registered manager and they confirmed that they had applied for a place on the Gold Standards Framework. This is accredited training to all staff providing end of life care to ensure better lives for people and recognised standards of care.

The registered manager confirmed that the provider's arrangements for newly employed staff to receive an induction included an 'orientation' induction of the premises and training in key areas appropriate to the needs of the people they supported. The registered manager was

Requires improvement

Is the service effective?

aware of the new Skills for Care 'Care Certificate' and how this should be applied. Records showed that staff had received a robust induction and staff spoken with confirmed this. Additionally, the registered manager told us that opportunities were given to newly employed staff whereby they had the opportunity to shadow a more experienced member of staff for several shifts. Staff spoken with confirmed this happened and that they had found it to be very useful.

Staff told us that they received day-to-day support from work colleagues and formal supervision at regular intervals. We discussed with the registered manager that supervision records viewed were mostly generic in content, not individualised and mainly used as a learning and/or teaching session. The registered manager confirmed that they were aware that improvements were required and advised that a new supervision format was to be shortly introduced. Staff told us that they felt supported by the registered manager and other senior members of staff.

People told us that their healthcare needs were well managed. One person told us, "I get to see the doctor when I need to. Also, whenever I need to see the optician or chiropodist this is arranged by staff." People's care records showed that their healthcare needs were clearly recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital appointments and to see their GP. Relatives confirmed that they were kept informed of their member of family's healthcare needs and the outcome of healthcare appointments.

Requires improvement

Is the service caring?

Our findings

People's preferences and choices for their end of life care were not clearly recorded, communicated, kept under review. The registered manager confirmed that there were 24 out of 44 people identified by the GP as nearing the end of their life. We found that the needs of people approaching the end of their life and associated records relating to their end of life care needs were either not up-to-date or not recorded. For example, the care plans provided little or no information detailing people's pain management arrangements and the care to be provided so as to provide comfort to the person. No information was recorded to identify who may have a few months, weeks or days to live; in order to aid care planning arrangements and discussions with the person and those acting on their behalf. In addition, no Preferred Priorities for Care [PPC] documents were in use. This is designed to help people prepare for the future and gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life. This may lead to inappropriate hospital admissions or people's wishes not being followed. We viewed the provider's 'end of life' care policy and procedure and this referred to four key documents being in place within people's care files. We discussed this with the registered manager and they confirmed that these were not being used. This meant that people's 'end of life' wishes were not recorded, in line with the provider's own policy and procedure or in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE]. The latter places emphasis for a more individualised approach to 'end of life' care.

No information explaining what treatment should be provided for their health if they were no longer able to make decisions for themselves was recorded (Advanced Directive). This demonstrated that people and those acting on their behalf were not involved in the assessment and planning for their end of life care or supported to make choices and decisions about their preferred options.

Although the above was noted, the registered manager confirmed that the involvement of appropriate healthcare professionals, such as, District Nurse services and the local Palliative Care Team were available as and when required and following discussions with people's GP.

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

We observed that staff interactions with people were variable with some interactions positive and others routine and task focused, for example, some staff only spoke with people or interacted with them when providing personal care or assisting them to eat and drink. Staff's communication with people living at the service was also variable, for example, some staff were seen to kneel down beside the person to talk to them or to sit next to them and staff provided clear explanations to people about the care and support to be provided in an appropriate way. Other members of staff were observed to have difficulty communicating with people and understanding their needs, such as, not enabling people the opportunity to make choices or providing clear explanations to a person prior to undertaking a specific task. Although a menu was displayed detailing the meal options available to people, we found that on both days of inspection, this was not reflective of the actual meals provided and despite this being drawn to staffs attention. This meant that this could be confusing to people living with dementia.

Where interactions were positive, staff rapport with people living at the service was observed to be friendly and cheerful. This was clearly enjoyed by people and there was positive chit-chat between both parties.

Although staff understood people's care needs and the things that were important to them in their lives, for example, members of their family, key events, hobbies and personal interests, there was little evidence during the inspection to show that people were actively encouraged to make day-to-day choices, informed choices and that their independence was promoted and encouraged where appropriate and according to their abilities.

People and their relatives spoke positively about staff's kindness and caring attitude. One person told us, "The care here is very good. I have no complaints." Another person told us, "I am very happy with the care and support. The staff are marvellous, they are saints. I cannot fault the care I receive." One relative told us, "Everything is lovely here. They [staff] treat our relative with kindness and respect."

The manager told us that where some people did not have family or friends to support them, arrangements could be made for them to receive support from a local advocacy service. Advocates are people who are independent of the service and who support people to have a voice and to make and communicate their wishes. Information about local advocacy services and other useful information for

Requires improvement

Is the service caring?

people and those acting on their behalf to access were displayed on a noticeboard in the main foyer. People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times.

Requires improvement

Is the service responsive?

Our findings

Appropriate arrangements were in place to assess the needs of people prior to admission. This ensured that the service were able to meet the person's needs. In general people's care plans included information relating to their specific care needs and how they were to be supported by staff. Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for becoming anxious and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had the information required to support the person appropriately.

Care plans were reviewed at regular intervals and where a person's needs had changed the care plan had been updated to reflect the new information. Staff told us that they were made aware of changes in people's needs through handover meetings, discussions with the qualified nurses and the senior management team. Staff told us that they knew when to refer to another person for advice and support to ensure people received appropriate care. Some staff felt that the quality of the handover meetings could be better and required improvement. Staff told us that there was not always a handover meeting in the afternoon and the quality of the information provided depended on the person providing this. This meant that there was a risk that not all staff may have had the necessary information required so as to ensure that people who used the service would receive the care and support they needed.

People did not always receive care in a person centred way because staff shortages at times meant staff's approach was task focused. One person told us that they had enjoyed talking with the inspectors as they did not get the opportunity to talk with staff. They told us, "It's good to have a chat with you, as I don't get to talk with many people here."

During mealtimes positive verbal encouragement by staff so as to enable people to eat and drink, was not always provided. For example, we observed two people being assisted to eat and drink during the lunchtime meal on the first day of inspection. No verbal conversation was noted by either member of staff during the entire meal with the person who received assistance. This was not an isolated incident. One relative told us that they had witnessed staff spend variable amounts of time assisting their member of family to eat and at times they felt that the care and support provided by staff had been rushed. This had left a general feeling that their member of family was unimportant and did not matter.

We also found that some people were being routinely got up early by staff and this was not in line with people's personal preferences. For example, the personal care records for three people were viewed and these showed that they were regularly washed and dressed by night staff between 5.10 a.m. and 6.30 a.m. in the morning but were asleep again shortly afterwards when checked by day staff. The care records suggested that neither person liked to get up early. One person told us that although they were given a choice by staff and could lie in bed in the mornings, they told us that night staff liked them to be in bed by 9.00 p.m. We discussed this with the registered manager and they confirmed that the above was not good practice. They also provided an assurance that they would address the issues by completion of unannounced early morning visits to the service and meetings with staff.

People told us they had the choice as to whether or not they joined in with social activities at the service. Some people confirmed that they preferred to spend time in their room. People's comments about activities were variable but following discussions with the registered manager, we were advised that the main person responsible for providing activities had been on long term sick leave since October 2015 and this had led to a reduced activity programme being provided. One person told us, "Shame that the activities person isn't around. They used to take us down the pub but we don't do that now." One relative told us, "The activities person has been off sick for some time and although the carers are picking some things up, there's not much on in the way of activities." Another relative told us, "It's a shame that the activities person is off sick as there are fewer activities."

Our observations throughout the inspection showed that there were few opportunities provided for people to join in with social activities. However, the registered manager had recently selected a member of staff to the role of activities person within the last week and prior to our inspection. On the second day of inspection communal activities were undertaken within the main lounge which people seemed to enjoy. Reduce the paragraph make this succinct.

Requires improvement

Is the service responsive?

The registered manager told us that relatives had the opportunity to contribute and be involved in their member of family's care and support. Where life histories were recorded, there was evidence to show that, where appropriate, these had been completed with the person's relative or those acting on their behalf. This included a personal record of important events, experiences, people and places in their life. This provided staff with the opportunity for greater interaction with people, to explore the person's life and memories and to raise the person's self-esteem and improve their wellbeing. Where reviews had taken place there was evidence to show that these had been conducted with the person and those acting on their behalf.

Meetings with people living at the service were also held so as to enable people to have a 'voice' and express their views about the care they received. Minutes of these meetings were available and confirmed the topics raised and discussed. Where actions had been highlighted, an action plan had been completed.

Information on how to make a complaint was available for people to access. People spoken with knew how to make a complaint and who to complain to. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team and staff on duty. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. The registered manager confirmed that since the service had been newly registered in July 2015, there had been no complaints. A record of compliments was in place identifying and capturing the service's positive achievements. One compliment recorded, 'I would like to express our sincere thanks for the care that was given to my relative."

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager in post. We were aware that the registered manager was also registered for another service and divided their time between both services, for example, the registered manager confirmed that up until recently on average two to three days were spent at the 'sister' home. It was apparent that this arrangement had had a negative impact on the day-to-day running of this service and the effectiveness of the provider and registered manager to comply with the fundamental standards and regulatory requirements.

The registered manager was able to demonstrate to us the arrangements in place to regularly assess and monitor the quality of the service provided. This included the use of questionnaires for people's relatives and staff employed at the service. In addition to this the management team monitored the quality of the service through the completion of a number of audits at regular intervals, for example, medication, health and safety, infection control and clinical audits relating to pressure ulcers and skin tears, falls and people's weight loss and gain. Although these systems were in place, they had not highlighted the areas of concern we had identified at this inspection. Checks were not effective to monitor and ensure pressure mattresses and ensure these were set at the correct setting each day. Records were not properly maintained, for example, in relation to staff supervision, food and fluid monitoring and end of life care. Some aspects of care practices required improvements. These related to assisting people to eat and drink, communication with people living at the service and care and support to be less routine and task focused. We discussed this with the registered manager and were assured that suitable arrangements would be put in place for corrective action.

The provider promoted a positive culture that was person centred, open and inclusive. Staff felt that the overall culture across the service was open and inclusive but that communication required improvement. Although people felt listened to, some improvements were needed where formal questionnaires were used to gain people and staff's views of the service. People acting on behalf of those living at the service had completed an annual satisfaction survey in February and March 2015. The results showed that of 45 surveys sent out 10 completed surveys were returned and these suggested that people were happy and satisfied with the overall quality of the service provided. No areas for corrective action were recorded. In addition to the above, a staff survey had been completed to seek staff's views. Whilst the majority of comments recorded were favourable, others were not so positive and required further investigation and action. For example, comments had been raised in relation to inadequate staffing levels and some people being gotten up early in the morning. No action plan was completed detailing the steps taken to review and address the issues raised. As part of our inspection we looked to see if there was substance to the issues raised.

Staff meetings were held at regular intervals and gave the staff the opportunity to express their views and opinions on the quality of the service. Minutes of these meetings were available and confirmed the topics raised and discussed. Where actions had been highlighted, no action plan had been completed to evidence the service's accomplishments and the dates these were concluded. We discussed our findings with the registered manager and they provided an assurance that this would be addressed as a matter of priority.

People knew who the provider and members of the management team were. Staff were clear about the provider's, registered manager's, and qualified nurse's expectations of them and staff told us they received appropriate support from the provider and registered manager. One staff member told us, "I do feel supported by the management team. I always speak up if I feel there's a problem and the manager is easy to talk with."

It was clear from our discussions with the registered manager; head of care and from our observations that they were clear about their roles and responsibilities. The management team were able to demonstrate an awareness and understanding of our new approach to inspecting adult social care services and the fundamental standards, which was introduced in October 2014.

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 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered provider had not ensured that people's care, preferences and choices for their end of life had been clearly recorded. This was in breach of Regulation 9(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.