Care Quality Commission

Four Seasons (Evedale) Limited

Tudor Grange

Inspection report

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25 October 2019

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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

Summary of findings

Overall summary

About the service
Tudor Grange is a residential care home providing personal care to 21 people at the time of the inspection. The service operates within an adapted building and can support up to 33 people.

People's experience of using this service and what we found
People lived in an environment that was not always safe, and the provider's safety monitoring checks were not always effective. Repairs were not always carried out in a timely manner and the cleanliness of the kitchen equipment and utensils was not satisfactory. Other communal areas and people's bedrooms were clean, and staff understood how to prevent the spread of potential infections by following their infection control training.

People did not always receive their medicine in the way it had been prescribed, and the recording of controlled medicines was not always done correctly.

People were supported by staff who understood how to protect them from abuse. There were enough care staff available to meet people's personal care needs. However, people were not always supported to access healthcare services in a timely way, and some relatives told us that they had needed to point out to care staff when a person required a visit to a GP. Care staff had not received training on how to support people's oral healthcare needs.

Some people were not able to give their consent to live at the care home, but the records relating to the decision, taken on their behalf, were not always clear.

Notices, and written information, were not always easy for people to see and understand; or could be confusing for some people. Some relatives told us they wanted to be more involved in the planning of their relative's care. The care home had electronic devices available that people could use to give feedback to the provider about the service; but some relatives told us they were not aware of the devices and did not know how to use them.
People enjoyed the food and drink provided; and were pleased with the variety offered to them. Care staff knew how to support people and had access to updated care plans to refer to if needed.

Care staff supported people with respect and kindness, and in ways which protected their dignity and independence. Relatives could visit people at any time and the care team encouraged people to maintain links with their families.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 20 October 2018).

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report.

Following the inspection, the provider has taken effective action to reduce the potential risks to people caused by some of the environmental issues we found. This included improvements to kitchen cleaning and a repair to a faulty shower.

Enforcement
We have identified breaches in relation to the hygiene and maintenance of the property, the administration of prescribed medicines, and the provider's processes for ensuring the quality of the service. Please see the action we have told the provider to take, at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Care Quality Commission

Tudor Grange

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Tudor Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection visit on 24 October 2019 was unannounced. We returned, announced, on 25 October 2019 to complete the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and five relatives/friends about their experience of the care

provided. We spoke with ten members of staff including the registered manager, deputy manager, care staff, catering staff, admin worker, regional manager and resident experience support manager. We observed care staff interactions with people throughout the inspection.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also looked at training data provided by the registered manager.

Based on our observations, we notified the local borough council food safety service about the cleanliness issues we found in the care home kitchen.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● The care home environment was not always safe, and safety monitoring audits had not identified the hazards found during the inspection.

● Water temperatures were not always safe. One person's ensuite shower could reach scalding temperatures. The provider's maintenance records showed the shower unit had been faulty for three months prior to the inspection. This was brought to the registered manager's attention who immediately took the shower out of use. It was repaired the following day.

● Some kitchen equipment was not clean. Food residue remained on crockery and utensils that had been washed and put aside for re-use. The food warming unit, and deep fat fryer, were not clean. These issues were brought to the catering manager's attention who arranged for the items to be cleaned immediately. After the inspection we notified the local borough council food safety service about what we had found.

● Two areas of carpet in corridors were damaged and created potential tripping hazards for people with mobility support needs. The registered manager took action during the inspection to address this issue, by arranging for repair tape to be placed over them.

● The provider had a fire risk assessment in place and effective systems to carry out regular fire safety checks. However, a path outside a fire exit door was blocked by a garden bench. This was brought to the registered manager's attention who arranged for the bench to be removed.

We found no evidence that people had been harmed. However, the premises and equipment used by the service provider were not always properly maintained; and the catering equipment was not maintained to the standards of hygiene appropriate for the purposes for which they were being used. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff had received fire safety training, and personal emergency evacuation plans were in place, so people could be supported to exit the care home in an emergency.

Using medicines safely

● The provider did not always follow safe procedures for the monitoring of controlled medicines. Care homes should keep accurate records of controlled drugs. The controlled drugs record book was not always used correctly. This meant people's prescribed controlled drugs were not always monitored effectively, which placed people at risk of harm.

● Records, of the disposal of controlled drugs, were not in line with safe procedures. The record, of when controlled drugs were returned to the pharmacy, was only signed by one person; and a receipt was not

obtained from the pharmacy. This meant there was a potential for controlled drugs to be unaccounted for.
● Medication training was not effective in relation to controlled drugs records. All senior care staff received medication training, including information about controlled drugs. The provider had carried out a medication competency assessment and had confirmed the senior staff were competent to administer medication safely. We found that not always to be the case.
● Medicine was not always administered as prescribed. For example, one person's prescribed medicine should have been taken with, or after, food. We found the person had been given their morning medicine without having anything to eat on two occasions. Additionally, prescribed skin creams were not always administered, and records of administration were not always made. A relative told us, "[Person] should have skin cream put on. They have [a medical condition], but the staff don't do it. Their skin sometimes looked raw."

The provider failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Occasionally senior care staff had worked for 24 consecutive hours, due to staff absences. Senior care staff administered prescribed medicines to people. This was discussed with the registered manager, because we were concerned about the increased potential for medication errors caused by senior care staff working such long hours.

Staffing and recruitment
● Staff rota records were not accurate. We found no evidence that the care home had operated with unsafe numbers of care staff on duty, but the rota records did not always reflect the reality of which staff members were at work.
● There were enough staff available to support the personal care needs of the 21 people who lived at the care home at the time of the inspection; although there were periods when no staff were present in the communal lounge. The manager told us they planned to provide an additional care staff member; which would increase the level of supervision available in the lounge area at key times of the day.
● The provider had a recruitment policy and procedure in place. Staff pre-employment checks had been carried out. However, not all staff records included a full work history. The registered manager told us they would obtain full employment history records for all care staff.
● When agency care staff had been occasionally used, the provider ensured appropriate pre-employment checks had been carried out by the agency. Those details were held on file at the care home. This helped to ensure agency care staff were safe to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. Care staff had received safeguarding training, were aware of the safeguarding procedure, and knew how to use it. There were safeguarding adults' policies in place, which care staff had access to.
● The registered manager understood their responsibilities for keeping people safe, including reporting safeguarding issues to the relevant authorities. These arrangements ensured people were protected from the risk of abuse.

Preventing and controlling infection
● People's rooms, bathrooms and communal areas were clean, which reduced the risk of infections spreading.
● Most care staff had completed infection control training, which ensured care staff understood how to

prevent and control the spread of infections.
● Personal Protective Equipment, such as disposable gloves and aprons, was readily available throughout the service and used by care staff. This protects people, and care staff, from acquiring infections.

Learning lessons when things go wrong
● The registered manager reviewed incidents and acted when needed. For example, they had identified areas for improvement after instances of missed medical appointments; caused by people opening their own mail and not telling care staff. Changes were implemented and that helped ensure people's medical appointments were not missed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were not always supported to access healthcare services in a timely manner. The service had links with GPs, district nurses and other health care professionals. However, a relative told us, "There have been occasions when I had to insist they call the GP. [Person] had been confused, and it could have been because of an infection. So, I had to tell them to call the GP. I have to prompt staff a lot, when they should be spotting these things themselves." The GP appointment resulted in the person receiving treatment for a suspected infection.
● People were not always supported to access dental healthcare support. A person told us, "I can't eat some of the things here, because I don't have dentures that fit me anymore." We raised this with the registered manager who told us they would arrange for the person to have access to a dentist.
● Care staff had not received specific training in how to support people to maintain good oral healthcare. A member of care staff told us, "People just tell us how they want help. We haven't had any training in oral healthcare." Support to maintain oral health is important because of the potential effect on people's general health, wellbeing and dignity.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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 had the appropriate legal authority and were being met.

● One person was deprived of their liberty to leave the care home, without the necessary formal authorisation being in place. The registered manager had applied, to the local authority, for an appropriate

DoLS authorisation. However, two years later, an authorisation had still not been received, and the registered manager had not chased that up.
● Additionally, contradictory records in the person's care plan suggested the person did have the capacity to decide whether they wanted to live at the care home or not. The registered manager told us the careplan records were incorrect, and the person lacked the capacity to make that decision. Although the person's relatives also confirmed the person could not make the decision themselves; their ability to consent to receive support from the care home had not been formally established as required under the MCA.

Supporting people to eat and drink enough to maintain a balanced diet
● Records were not reviewed to determine whether people had drunk enough fluid each day. The registered manager told us they would introduce a revised recording sheet which totals up the fluids drunk by each person, and records any action taken if a person had not drunk enough during the day.
● People were supported to eat and drink safely and maintain a balanced diet. For example, where the need for support had been identified to prevent potential choking, or to increase calorie intake, the kitchen staff prepared food in the way advised by health care professionals.
● Care staff had a good knowledge of people's food preferences and the provider had appropriate systems in place to monitor people's weight. That helped ensure people were supported to eat enough.
● People were offered a variety of food and drink they enjoyed, and alternatives were available if people preferred something else. A person told us, "The food here is lovely. Always something different every day."

Adapting service, design, decoration to meet people's needs
● The facilities at the service met people's needs. There were enough bathrooms and toilets available, and there was a lift for people who lived on the upper floor. The care home also had a stair lift, but that was not in use as a replacement safety belt was required.
● Some people had personalised their bedrooms. However, the numbered bedroom doors had few other visual identifying characteristics which would support people with dementia to orientate themselves. This meant there was an increased likelihood that some people might become confused when trying to locate their bedroom

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager created care plans which were updated as people's needs changed. This meant care plans were available to guide care staff to effectively meet people's needs.
● A care worker told us, "The care plans are in the office. We know what people's needs are, and any changes are discussed at handovers." This meant care staff understood how to support people effectively and where to find further information if required.

Staff support: induction, training, skills and experience
● New care staff completed induction training, which included working alongside experienced care staff. Care staff told us that they received the training needed to meet people's individual needs. We observed care staff using their skills to support people effectively and sensitively.
● The provider had a training plan to identify care staff training needs, and arrangements were in place to ensure care staff were kept up to date with essential training.
● Care staff told us that they have regular handover sessions, team meetings and supervision meetings. This meant there was effective communication within the care team.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- People were treated with respect. A relative told us, "The care from the staff is excellent. [Person] loves the staff and gets good care from them."
- People told us that the care staff were kind. A person told us, "I'm glad I moved in. As soon as I got here I knew that the staff cared."
- All staff had received equality and diversity training, supported by the provider's equality, diversity and human rights policy, which set out how the care home operates to support people, and staff, from diverse backgrounds.

Supporting people to express their views and be involved in making decisions about their care
- Resident's meetings were held and people discussed things which the registered manager then acted on.
- One relative told us they were less involved in care planning, and care discussions, than they would like to be. We raised this with the registered manager who told us they would contact all the relatives again and invite them to take part in care plan reviews if they wished.

Respecting and promoting people's privacy, dignity and independence
- Care staff were attentive to people's needs and supported people with kindness. We saw care staff support people in a dignified manner which respected their privacy.
- Care staff supported people to make everyday choices about their care and support, for example about what clothes they wanted to wear and how they wanted to spend their time. This enabled people to maintain their independence.
- Relatives and friends could visit at any time, meaning people could maintain important relationships.
- People's dignity and independence was maintained. A care staff told us, "When I'm showering someone I cover them with a towel, close the door and curtains. I ask them how they prefer me to help them. Treating people like we would like to be treated ourselves, basically."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The registered manager was not fully aware of the requirements of the AIS, and we discussed that with them. They told us they would review how they presented information to people so that it was more accessible.
● Information was not always readily available to people in formats that were accessible to them. For example, the activity notice board was in a corridor, outside the lounge, where people did not spend much time. The posters on the notice board did not stand out and were hard to read from a distance. Menu sheets in the dining room were written in relatively small print and contained the menu for the whole week.
● The care home had an 'orientation board' in the dining room which indicated the day, date, and weather conditions. We observed that the details on the board were incorrect and were not changed until mid-afternoon. That had the potential to confuse people.

End of life care and support
● The service had not always explored people's preferences and choices in relation to end of life care. That meant care staff may not always know the person's wishes at that important time.
● People did not all have end of life plans in place, although some people had 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) documents in their care plans. DNACPR is a document issued and signed by a doctor. The form is designed to be easily recognised and verifiable, allowing medical professionals to make decisions quickly.
● Some care staff told us they had received end of life care training, although that was not included on the routine training plan given to us by the provider.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Care workers were not always attentive to changes in people's behaviours. A relative told us, "One thing we are critical of is the lack of responsiveness from the staff sometimes. They don't seem to spot things, or take action to get them addressed, unless we tell them to."
● People's care plans had been developed when they first moved in and contained personalised information, so staff could understand people's support needs. A relative told us, "The move in went really well. We were involved in the original care planning with [senior care assistant] and we signed them all when

we were happy with the care plans."

● Care plans were comprehensive and included areas such as mobility, personal care and nutritional needs.
● People, and their relatives, were encouraged to provide information about their history, their spiritual needs, preferred names and what they enjoyed doing. This information was added to people's care plans.
● People told us they were supported to take part in activities if they chose to do so. One person told us, "We do baking sometimes, making scones. Or we paint and play dominoes. We also go across to the [Royal British] Legion club as well."
● The registered manager told us that they supported people to use internet video streaming to communicate with relatives, if they wished. This enabled contact with family and friends to be maintained.

Improving care quality in response to complaints or concerns

● Complaints were not always resolved in a timely way. A relative told us a person's shower room had previously been out of action due to a drain problem. The repair had taken over two months to complete and the person had been considerably inconvenienced. Another relative told us a repair to a person's carpet retaining strip had been carried out in a way which created a tripping hazard; which they had then complained about.
● The care home had an electronic feedback gathering device situated in the entrance hallway. The registered manager showed us that the results from the device appeared to demonstrate people were satisfied with the service. However, two groups of relatives we spoke with were unaware of the device and what it was for.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to maintain contact with their relatives. One person used a computer device to receive emailed messages from their relatives. Other people contacted their relatives using the care home phone. Supporting people to maintain contact with their relatives is important and helps prevent social isolation.
● People took part in activities at the care home. People told us they enjoyed the art and music activities that were provided occasionally.
● People were supported to access activities in the local village, and the registered manager had supported a person to obtain a bus pass; which was important to them.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Improvements in the quality of care were not being driven by the provider's quality monitoring systems. Tudor Grange had been rated as requires improvement at the previous two CQC inspections. Action taken by the provider had not been effective in improving the quality and safety of the services being provided.
● Quality audits were not always effective. For example, routine maintenance checks identified a shower unit was faulty, but no action was taken to repair it until the inspector discussed it with the registered manager. Similarly, other issues, such as the poor cleanliness in the kitchen, potential tripping hazards, and obstructed fire escape, had not been identified by the provider's quality monitoring checks. This meant people were not always protected from potential harm by the provider's quality monitoring and improvement action systems.
● Not all incidents were reported to the registered manager by staff. For example, on one occasion, the wrong medication was sent with a person who moved to an alternative care home. That had not been recorded as a medicine error and the manager was unaware of the incident until it was identified by the inspector.

The provider failed to ensure that the systems and processes in place to assess, monitor and improve the quality and safety of the services provided were fully or consistently effective. This was a breach of regulation 17 (Good Governance) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager understood their responsibility for reporting deaths, incidents, injuries and other matters that affected people using the service. Notifying the CQC of these events is important so that we are kept informed and can check that appropriate action had been taken.
● All the staff we spoke with understood their roles within the service and the registered manager had a good understanding of regulatory requirements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager supported the care staff to provide person centred support which achieved good outcomes for most people. However, some relatives told us care staff were not always proactive in spotting issues and acting when people's care needs changed. This meant support was not always person centred.

● The registered manager, deputy manager, and all the staff we spoke with and observed, told us they were committed to providing person centred, high quality care. A care worker told us, "It is lovely working here. Everyone has care at heart. The people here are like our grandparents."
● The ratings from our previous inspection were displayed so that visitors could see and read our report. The rating was also displayed on the provider's website.
● The registered manager provided supportive leadership. Care workers told us the registered manager, and deputy manager, were approachable and they felt supported by them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood, and acted on, their duty of candour responsibility by contacting relatives, after incidents involving family members occurred. This ensured that relatives were notified of the incident and made aware of the causes and outcome.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider asked people and relatives to contribute their views on the service through satisfaction surveys which the registered manager reviewed and acted on. However, we found that not all relatives were aware of how to give feedback using the electronic devices the provider had installed in the care home.
● People's equality and diversity characteristics were identified during the initial assessment process and recorded in each person's care plan. This was available to guide care staff and was supported by the provider's equality, diversity and human rights policy.

Continuous learning and improving care
● The registered manager understood the importance of learning lessons from incidents. However, potential root causes of incidents were not always fully considered. For example, following a person's fall the incident report had been reviewed by the registered manager, but the fact the person was observed to be potentially dehydrated was not identified as a causal factor.
● The registered manager was supported by the provider's resident experience support managers who had previously visited the service to identify areas requiring improvement. That resulted in a list of required improvements which the registered manager was working through. However, the necessary improvement actions had not all been carried out, and there had been limited improvements in the quality of service provided to people.

Working in partnership with others
● The registered manager and care staff worked in partnership with other professionals and agencies, such as GPs and community health services to support people to receive the care and support they needed.
● The registered manager worked in partnership with people and their relatives to ensure people's views about the care being provided was listened to.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises and equipment, used by the service provider, were properly maintained; and the catering equipment was not maintained to the standards of hygiene appropriate for the purposes for which they were being used. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that the systems and processes in place to assess, monitor and improve the quality and safety of the services provided were fully or consistently effective. This was a breach of regulation 17 (Good Governance) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.