Four Seasons (Bamford) Limited

Priory Park Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Priory Park Care Home is a nursing home registered to provide accommodation and personal care for 40 people with either nursing or residential care needs. Care is provided between two floors with people living with dementia on the second floor and people requiring residential and general nursing care on the first floor. At the time of the inspection, 34 people lived at the home.

People's experience of using this service and what we found:
People told us they felt safe and staff were kind and caring. However, our observations showed that people did not always receive safe care and treatment. Practices in the home did not always demonstrate that staff understood how to safeguard people from neglect and abuse. People's safety had been compromised due to lack of adequate numbers of staff to support them with their care needs. We found a significant number of incidents of people being left unsupervised and causing harm to each other. Risks to receiving care were poorly managed and planned for. People were not always offered their medicines in a safe manner and medicines administration practice exposed them to risks.

People were not always monitored following a fall or incident. The provider had not adequately analysed accident and incidents to identify themes and trends and reduce re-occurrences. There were no lessons learnt processes to show how staff had learnt from events. This led to a repeat of incidents that exposed people to risk. The registered manager and staff had not always followed safeguarding protocols to ensure all reportable concerns were reported to the local authority.

People were not always supported by staff who had received induction, supervision or had the right skills and competence to carry out their role safely. People were not always supported to have maximum choice and control of their lives. Staff had not always sought consent before delivering care. People's ability to make their own decisions was not always assessed. People received support to maintain good nutrition and hydration, however they were not effectively monitored for deterioration or changes in their needs.

Our observations during the inspection, were of positive and warm interactions between staff and people who lived in the home. However, we also found evidence which showed people were not always treated with dignity and respect because their needs were not always responded to appropriately. Some people told us staff treated them with dignity and were respectful. However, two people felt this was not always the case with some of the staff. People's dignity had been affected by the shortages of staff. Staff promoted people's independence, but this lacked consistency.

People's care records contained personalised information on their health and communication needs plus their likes and dislikes. We found care records were not always up to date and did not provide staff with adequate guidance on how to support people and reduce risks around them. People and family members knew how to make a complaint and they were confident about complaining should they need to. They were confident that their complaint would be listened to and acted upon quickly. Previous complaints had been

investigated however outcomes had not always been used to improve care delivery.

There had been a rapid decline in the quality of the care at the home due to lack of leadership and oversight. Staff had not been given adequate leadership and oversight which led to poor care delivery. There had been instances when people had suffered injuries and deterioration of their conditions. Staff had not always recognised a deterioration in people's conditions and provide them with the right clinical support. The system did not proactively monitor areas where the care delivered was not safe or meeting standards.

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

Rating at last inspection and update:
The last rating for this service was requires improvement (published 24 October 2018) and there was a breach of regulation in relation to medicines management. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found further deterioration in medicines management, no improvements had been made and the provider was in continued breach of the regulation.

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

Enforcement:
We have identified multiple breaches in relation to the arrangements for keeping people safe from harm, the management of medicines , seeking consent and staffing levels. We also found breaches in relation to dignity and respect, record keeping, staff training and supervision, failure to submit notifications and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always 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
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Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Priory Park Care Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by two inspectors on the first two days and an expert by experience, one inspector and a pharmacy inspector on day three. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Priory Park Care Home 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 accommodates up to 40 people.

The manager was registered with Care Quality Commission. This meant they and the provider were legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did before inspection:
Before the inspection, we reviewed all the information we held about the service such as notifications. These are events that happen in the service the provider is required to tell us about. We also sought information from the local authority's contract monitoring team and safeguarding team. We used our planning tool to collate and analyse the information before we inspected.

We did not ask the provider to complete a Provider Information Return (PIR) in advance of this inspection.

The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection:
During the inspection, we spoke with five people who lived in the home, three relatives, six members of staff, the administrator, the maintenance person, the registered manager, the deputy manager. We also discussed our findings with the acting regional director and the regional manager. We looked at the care records of 10 people who lived at the home, looked around the premises and observed staff interaction with people. We also examined a sample of records in relation to the management of the home such as staff files, medicines administration records, quality assurance checks, staff training records and accidents and incidents. 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.

After the inspection:
We continued to seek clarification from the provider to validate evidence found and seek assurance that urgent action had been taken to address the significant concerns we found. We looked at training data and quality assurance records. We had a meeting with the local authority and the clinical commissioning group regarding the concerns we identified during the inspection and spoke to several professionals who regularly visited the home.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to safely manage people's medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a further deterioration at this inspection and the provider was still in breach of regulation 12.

● People were exposed to significant risks of harm and poor outcomes because staff had not followed safe and best practices in medicines management. One staff member recorded that people had received their medicines when they had not been given. Another person had not been given the correct dose of medicines. This had resulted in a deterioration of this person's health
●Staff did not always offer people their pain relief medicines. One person had experienced multiple falls and injuries and had been seen by staff to display signs of pain. However, they had not been offered the pain relief medicines which they were prescribed. We observed a nurse recording that a person had refused pain relief medicines, but they had not offered this or spoken to the person. We raised a safeguarding alert regarding this.
● Staff did not follow national guidance on how to administer medicines that required to be given covertly. Covert administration is when medicines are administered in a disguised format in agreement of the pharmacist or other health professionals in people's best interest.
● Concerns identified during medicine audits were not acted on in a timely manner including where medicines were unaccounted for. There were instances of poor practices. This included poor management of thickening powders, poor storage of medicines including controlled drugs and staff being asked to administer medicines on behalf of other staff which is against best practice guidance.

We found evidence that people's welfare had been affected by unsafe medicines administration practices, systems were either not in place or robust enough to support safe medicines management. This placed people at risk of harm.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed they had reviewed staff's competences and put measures in place to address the concerns we found.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not protected from the risk of harm because there were poor arrangements for assessing and monitoring risks. We found a significant number of incidents where people had been exposed to harm due to lack of adequate staff supervision. There were no risk assessments or protection plans that staff could follow to reduce the risk or consideration whether the home continued to be suitable to manage the risks.

● Staff had not robustly monitored people's clinical needs to identify when people's needs had changed. Staff had not taken action to maintain their welfare and reduce further deterioration. One person had experienced a fall and aggravated a previous fracture.

● People with behaviours that could challenge were not effectively managed. People who were restricted to their beds had been exposed to risk of harm from others. We asked the provider to take immediate action to protect these people and they put measures in place.

● The procedures in the home did not facilitate the effective sharing of concerns with external agencies such as safeguarding team and local Clinical Commissioning Group. Concerns we found had not been reported appropriately for further investigation. Staff did not fully understand their responsibilities to protect people from avoidable harm or abuse. There had been delays in ensuring people received the care they required and reporting on significant incidents including unexplained injuries to people this is now subject to a whole service safeguarding investigation.

● On the day of the inspection relatives told us they had no concerns about the safety of their family members. Our evidence showed this was not always the case.

● The provider's protocols for facilitating lessons learnt were not robust and not adequately implemented. The lessons learnt processes carried out following incidents had not been used to improve practices in the home.

We found evidence that people had been harmed because systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

There was a failure to assess the risks to the health and safety of service users. There was also a failure to report safeguarding concerns to authorities. These were breaches of Regulation 12 (Safe care and treatment) and Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had arrangements to carry out safety checks on electrical and gas installations as well as equipment in use at the home.

Staffing and recruitment

● The provider did not ensure there were adequate numbers of suitably qualified staff to meet people's needs. People's needs had not been effectively met in a timely way due to staff shortages. There had been times when the provider's staffing arrangements were one nurse and one carer to support 20 people with complex needs at night. This left people inadequately supervised.

●The provider had a system to determine staffing levels. However, this did not always take into consideration people's changing needs and staff had been reduced at times when people's needs had increased. The provider's representatives who took action to increase staffing levels immediately.

● The provider was actively recruiting nursing staff following a high turnover. The staff turnover had resulted in a significant use of agency staff. This had impacted on the consistency of the care provided to people. People had experienced poor outcomes because of staff shortages. This placed people at risk of harm.

There was a failure to deploy adequate numbers of suitably qualified staff. This was a breach of Regulation

18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider followed safe recruitment procedures to make sure staff were of a suitable character to work in a care setting.

Preventing and controlling infection
● People were protected against the risk of infection. The home was visibly clean. Bedrooms were cleaned before new people were admitted.
● We observed staff used personal protective equipment (PPE), when providing care and support to people. Staff confirmed there was enough PPE, such as disposable gloves, hand gels and aprons to maintain good standards of infection control.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 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. The application procedures for this in care homes and hospitals are 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 were being met.

● The provider and staff did not consistently work within the principles of the MCA. People's capacity to make decisions was considered as part of their assessment of needs. However, this was not consistent. There were no mental capacity assessments or best interest decisions for the use of restraint and for the use of covert medicines where this was required to maintain people's safety.
● We observed staff speaking with people and gaining their consent before providing support or assistance. However, we noted consent was not recorded in four of the records we reviewed. This included consent to photography and storage of medicines. Staff had inadequate knowledge and understanding of the MCA/DoLS principles and how they apply to people living in the home.

There was a failure to ensure care and treatment was provided with the consent of the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of the inspection applications to deprive people of their liberties for their safety had been submitted to the local authority for consideration and some had been authorised.

Staff support: induction, training, skills and experience
● Staff were not adequately supported with induction and supervision. Staff were not always provided with induction at the beginning of their employment. This included agency nurses and agency care staff. We

could not be assured that people received effective care support due to the lack of familiarity.
● Staff had not received supervision in line with the providers' policy. Supervision and appraisal records showed significant shortfalls..
● Staff had completed online training in a number of areas, but there was a lack of adequate skill and expertise to meet the needs of people living with dementia and management of their risks.

There was a failure to ensure that all staff had received appropriate support and training to enable them to carry out the duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had been referred to various specialists including dieticians and mental health professionals. However, two people's needs were not adequately met because staff had not provided them with robust clinical checks following episodes of falls or a deterioration in their conditions.
● People and their relatives told us staff supported them to live a healthier lifestyle. Comments included; "I think they've called the doctor out a couple of times. Anything untoward, they always ring me up and tell me." And; "The staff] were on the ball when [my relative] was poorly.
● During the inspection the registered manager showed us records to show they had started to take action to ensure people who required specialist support were referred to the appropriate health and social care professionals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs, and choices were not effectively assessed. The registered manager had not assessed people's changing needs. This included the lack of assessments when people had acute conditions such as infections.
● People's care, treatment and support was not always delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes. This included areas such as behaviour management and pain assessments for people living with dementia and medicines management.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they were satisfied with the food and they were given choice. Comments from people included, "The food is quite nice. There's plenty of choice and you can order what you like." A relative commented, "[Relative] was always a good eater and is still." However, one relative raised concern regarding the monitoring of food and drinks, they said, "Drinks are being left with [person] and nobody's checking they're having them. This is a reinforced drink because their weight is falling off. We bring [specified snacks] that the dietician told us to bring but they're not being offered, they're still unopened when we get here." We asked the registered manager to address this.
● We observed the meal time arrangements and noted people had mixed experiences. Staff interacted with people throughout the meal and we saw they supported people in a sensitive way. However, one person who was at risk of choking had been left eating unattended. We raised this with the registered manager and observations have been increased since our inspection.
● People's weight and nutritional intake was not robustly monitored. While referrals were made to healthcare professionals, ongoing risks of unintentional weight loss were not always monitored or robustly managed. We raised a safeguarding alert with the local authority regarding this.

Adapting service, design, decoration to meet people's needs

● The sitting area in the nursing dementia unit was not adequately adapted to prevent confrontations between people. Attempts had been made to ensure the premises were suitable for people living in the home including decorations and provision or memory boxes to aid with reminiscence.

●Some people had brought their own furniture and personalised their own bedrooms.

Requires Improvement

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 now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● During the inspection we observed positive and warm relationships between people and staff. They understood, and supported people's communication needs and choices. They maintained eye contact and listened patiently and carefully when speaking with people to ensure their needs were understood and met. However, we found instances when people's dignity had been compromised due to lack of staff to respond to their needs in a timely manner to preserve their dignity especially where people were not appropriately dressed.

● People told us, and family members confirmed, they were treated with kindness and were positive about the caring attitudes of staff. However, our findings showed that people's human rights had not always been observed. Comments included, "I like [name of a carer]; the other carers are okay." And, "The staff are very friendly and helpful; [my relative] seems very comfortable with them."

● People who were cared for and restricted to their beds were not assured of their privacy. We found a significant number of incidents where other people had climbed into other people's beds while they were asleep or resting without staff knowledge. The failure to provide people with adequate monitoring had resulted in people's privacy, dignity and safety being compromised.

There was a failure to ensure that people using the service were treated with respect and dignity and their human rights observed at all times while they were receiving care and treatment. There was also a failure to support people in line with their protected equality characteristics, specifically pertaining to their disability. This meant that the provider was breaching the Equality Act legislation 2010 and also Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, along with relatives, had been given the opportunity to share information about their life history, likes, dislikes and preferences. Staff supported people to meet their cultural and religious needs with regular visits by local priests.

● People were supported to remain as independent as possible, we observed people eating and drinking independently and walking around the home freely. Comments from people included, "They encourage me to be independent, I have a cup with a lid so I can have a drink without help.", And "You can move around freely and you can go out, but it would have to be with a staff member."

Supporting people to express their views and be involved in making decisions about their care

● Some people and/or their relatives told us that they were involved in discussions about their care. One

relative told us, "We have talked about the care plan and about end of life matters. A lady from the doctors came and went through things with us; the deputy manager was there too."

● People were supported to access advocacy services. People can use advocacy services when they do not have friends or relatives to support them or want support and advice from someone other than staff, friends or family members.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care and support was not consistently personalised to meet their needs. Whilst people told us they received the care they needed, and staff responded to their requests made for assistance, we found this had not always happened. The majority of the records we reviewed were not up to date and did not reflect people's current needs. Known risks were not documented to guide staff on how to reduce further incidents.

● We also noted some people's care plans contained limited information about their needs and risks. Care records for people's behaviour management were insufficient and not adequate to provide staff with guidance.

● There were cases where staff had either failed to identify a deterioration on people's conditions or failed to monitor people and take action to seek support in a timely manner.

The provider had failed to provide care records that were fit for purpose. There was also a failure to support people in a person-centred manner. These were breaches of regulation 17 (Good governance) and Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 develop and maintain relationships. Families could visit them regularly with no restrictions. They told us they had opportunities to participate in daily activities however there were no activities taking place during the inspection. Comments from people included, "I like painting and one of the care staff brings something for me to paint. There's always something on at Christmas." And; "The priest comes once a week and [my relative] gets communion. The home organised it."

● During the inspection people were not provided with meaningful activities to occupy them. The registered manager informed us the activities co-ordinator was away on holiday. However there had been no alternative arrangements ensure people continue to receive support to provide them social stimulation.

● The provider had considered the use of technology to help with the delivery of care. People were supported by the use of sensor equipment, when they were deemed at risk of falling. The home also had broadband facilities.

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 understood their responsibility to comply with the Accessible Information Standard and people could access information regarding the home in different formats to meet their diverse needs.
● Staff understood people's communication needs and these were recorded in people's care plans.

End of life care and support
● The provider had arrangements to support people to plan for their end of life care and to share their preferences to ensure they could have a comfortable, dignified and pain free death. However, care files we reviewed did not always have end of life care plans. The registered manager told us they would review all care records and seek people's preferences going forward.

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure which had been shared with people and their relatives. We saw the complaints procedure was clear in explaining how a complaint could be made. People were confident they could raise concerns with confidence.
● We saw complaints that had been dealt with in line with regulations and measures had been put in place to address the complaint satisfactorily. However, one of the complaints had not been used to improve practices in the home as we found ongoing concerns regarding lack of monitoring of people due to staff shortages.

Inadequate

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 now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Managers and staff were not clear about their roles. There had been a lack of clear direction and understanding of quality in the home. Staff had not been provided with robust leadership and oversight on the day to day running of the home as the registered manager had been deployed to another home owned by the provider. A significant number of shortfalls had not been dealt with due to the lack of a registered manager.
- Instances of poor practice were not always challenged which resulted in the deterioration of the standards of care provided.
- The provider's quality assurance systems were inadequate. Although there was a governance system and policies and procedures, staff and the management team had failed to effectively implement the systems to support the continuous monitoring and improvement of the care provided.
- The provider had failed to address shortfalls and areas of non-compliance with regulations in a timely fashion to ensure prompt action was taken. The quality monitoring systems failed to promote and support the delivery of high-quality, person-centred care. Where audits had been carried out, the findings were not used to improve the safety and quality of care.
- Systems for learning from incidents and near misses were not effectively implemented which meant staff could not demonstrate whether they had reviewed what could be learnt from events to reduce re-occurrences.

There had been a deterioration of the quality of care provided and the provider had failed to sustain changes they made at our last inspection. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider's governance arrangements and the culture in the home did not promote the provision of high-quality, person-centred care. Systems for supporting staff including inductions, supervision, appraisals and training were not adequately implemented to support the delivery of safe care.
- The provider had not submitted notifications to the Care Quality Commission and a significant number of concerns and safeguarding concerns had not been shared with the local authority. The failure to submit notification meant that CQC could not undertake its regulatory function effectively.

This was a breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The registered manager encouraged feedback from people to improve the home. However, the surveys from staff and feedback from staff had not been used to review the quality of care provided. Staff had raised concerns regarding the quality of the care. However, the provider had not investigated the concerns.
- The provider had failed to ensure peoples equality characteristic of disability in respect of dementia care were being considered and supported in line with their needs and there were failures in the culture in respect of peoples' dignity being supported.
- The registered manager had developed close links and good working relationships with a variety of professionals to enable effective coordinated care for people. The home had also been previously monitored through the local authority quality improvement programme and supported by the local clinical commissioning group. However, the changes made had not been sustained due to lack of stability in the leadership at the home.