Prime Care (GB) Limited

# Marina Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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
Marina Care Home provides accommodation and personal care for up to 33 people. The building is a large adapted house with four floors and lift access to all floors. There were 24 people living in the home, some of whom were living with dementia.

People's experience of using this service and what we found
People were not safe because not enough suitably qualified staff were available to support them. The former registered manager, deputy manager and several care staff had left the home in close succession. The provider had not ensured agency staff brought in to replace them, had enough information about people's needs to support them safely.

People were not protected from the risk of abuse and avoidable harm because not all incidents had been investigated to avoid reoccurrence. Not all incidents reportable to the local safeguarding authority and CQC had been reported. We found evidence of unhygienic conditions and practices, which placed people at risk of infection. People's medicines were not always given as prescribed because not enough trained staff were available, improvements proposed in the provider's action plan from the previous inspection had not been implemented. At the time of inspection, the local authority was actively working with the provider to address safeguarding concerns.

People's needs had been assessed and care plans developed to guide staff on how to support people which included their preferences. However, the electronic care plans were not available to agency staff who made up the majority of the staff team. The provider had not ensured enough information was available for agency staff. Care records were incomplete because either no system was in place for agency staff to record care interventions, or the system in place had not been followed.

People assessed as needing staff support to drink did not get regular drinks. Staff did not keep adequate records of drinks provided. Food was not always served at the correct texture or temperature. We raised these concerns with the provider, who started to address them during the inspection.

Not everyone who was unable to consent to live in the home had a Deprivation of Liberty authorisation (DoLS) in place and there was no system in place to ensure these were applied for and renewed. People's capacity to make decisions had not been consistently assessed in relation to the use of bed rails and sensor mats.

Staff were caring and interacted with people kindly. However, staff were often very busy and were unable to take time to provide the standard of care and attention people needed, which affected people's dignity.

Information on people's preferences about their care and life histories had been included in care records. However, people did not receive person-centred care because the information had not been shared with

agency staff. People's needs had not been consistently reviewed and some changes in their needs had not been responded to.

The provider had failed to ensure they had oversight of the service. They had not addressed consistent failings in the management of the home in a way that promoted effective care which achieved good outcomes for people. Quality audits had not been completed in line with the provider's policies. The premises were unsanitary and there was evidence of long-term failings to maintain basic cleanliness.

Rating at the last inspection and update
The last rating for this service was requires improvement (published 24 January 2022)

Previous breaches
At the last inspection we found breaches of the regulation in relation to safe care and treatment and governance. 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 not all actions identified by the provider had been completed and they remained in breach of the regulations.

Previous recommendations
At our last inspection we recommended that the provider included all relevant information in staff recruitment records. At this inspection we found some staff records remained incomplete.

Why we inspected
The inspection was prompted in part due to concerns we received about staffing levels, safeguarding and cleanliness. A decision was made for us to inspect and examine those risks. During the course of the inspection we found evidence to support wider concerns and it was agreed to open the inspection to include all five key questions.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to; Safe care and treatment, Medicines, Infection control, Governance, Staffing, Safeguarding people from abuse, Nutrition and hydration, Consent, Person Centred Care, Dignity and Respect.

In response to serious concerns we identified during inspection, we took enforcement action to impose conditions on the registration of the provider using our urgent powers identified under s.31 of the Health and Social Care Act 2008.

CQC continued to monitor the quality of care at the home through regular meetings with the local authority and with full cooperation from the provider.

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.

The overall rating for this service is 'Inadequate' and the service is therefore, 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?**<br>The service was not safe<br>Details are in our safe findings below | **Inadequate** |
| **Is the service effective?**<br>The service was not effective<br>Details are in our effective findings below | **Inadequate** |
| **Is the service caring?**<br>The service was not always caring<br>Details are in our caring findings below | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive<br>Details are in our responsive findings below | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led<br>Details are in our well-led findings below | **Inadequate** |

# Marina 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. 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. 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
Marina Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Marina Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

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 all this information to plan our inspection.

During the inspection
We spoke with 12 people who lived in the home and the relatives of nine people. We spoke with the interim manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with a further nine members of care staff, two domestic staff and the cook. We looked around the building including bathrooms, 21 bedrooms and communal areas. We reviewed a range of records relating to care, recruitment, training, staffing and governance.

Inadequate

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

●We found examples where people had experienced neglect which had led to harm and the risk of harm. This included failure to provide appropriate levels of personal care for people who needed full support from staff.

●People were not safe from the risk of abuse and avoidable harm because the provider had not followed their own policies and procedures.

●Incidents which should have been raised with the local authority and CQC as safeguarding; including injuries, had not been raised on several occasions since the last inspection in January 2022.

● Opportunities to learn lessons from incidents had been missed. Not all incidents, including those where people received injuries during moving and handling, had been fully reviewed to avoid reoccurrence.

We found evidence of harm and the risk of further avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated activities) Regulations 2014.

Assessing risk, safety monitoring and management

● We found people's assessed risks had not been managed in relation to pressure care. We found staff had failed to follow guidance from health staff in relation to the frequency of turns for some people.

●People's assessed risks had not been managed in relation to constipation. One person was not monitored for 12 days and again for 16 days. There was no record staff had raised this with health professionals, as stated in the person's care plan.

●The provider had failed to ensure people were protected from risks associated with fire. Fire evacuation information was unclear. We found some bedrooms had two different fire plans on the back of the bedroom door.

● Staff did not have a clear understanding of the fire evacuation procedure. We asked eight staff how they would respond if the fire alarms sounded. Only one staff member was able to describe the correct procedure.

●Not all fire doors closed properly when released. We raised this with the provider on the first day of inspection, but this had still not been addressed 13 days later. We found two fire doors propped open with furniture on the first day of the inspection, we raised this with the provider but found the same two doors propped open on the final day of the inspection. The fire service had visited prior to the inspection and issued a fire enforcement notice which the provider was in the process of addressing. Though the deadline for meeting the demands of the fire service enforcement notice had not passed. We found risks were enhanced due to the lack of regular staff.

● We found the risks related to domestic activities had not been assessed or managed. We saw staff using a

vacuum on the stairs leaving the wires trailing at the entrance to the dining room at a mealtime. This posed a trip hazard to people's who had to step over the wire. We found a four-gang extension socket on the floor of a bedroom between the bed and the side table. The person was cared for in bed and could have spilled drinks onto the exposed electric sockets which was a fire hazard.

●We saw staff place a hot meal on one person's knee in the lounge, the person was not able to manage this and was at risk of being burned. Another member of staff intervened in time.

We found evidence of harm and the risk of further avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staffing and recruitment

● Not enough suitably qualified and competent staff had been deployed to provide safe care. The provider had needed to rely on agency staff to provide the majority of care but had not requested profiles from the agency to satisfy themselves the staff would be suitably competent. This was remedied during the inspection. A relative told us, "Sometimes there is no staff around, it is worse at weekends. My (name) becomes distressed."

●Agency staff had not had a suitable induction to familiarise them with the home and people's needs.

●We sought assurances about staffing levels from the provider, though we received these, on several occasions we found fewer staff were on duty than indicated on the rota.

●We found some gaps in the recruitment records for staff employed at the home. Two staff members did not have full employment histories and one staff member did not have a reference. We raised this with the provider who agreed to address this.

People were at risk of harm because not enough suitably skilled staff had been deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Preventing and controlling infection

●People were not protected against the risks from infection. We found areas of the home to be unhygienic. Furniture in several bedrooms and communal areas was heavily soiled. The soiling appeared to be long standing.

●Not enough domestic staff were deployed. Cleaning routines and checklists were not in place or were not robust enough to maintain acceptable levels of cleanliness in the home. Additional cleaning staff were deployed from an agency to improve cleanliness, this had not been completed during the inspection.

● Personal protective equipment (PPE) was available for staff and visitors. We found staff were not consistent when wearing face masks.

●People were not supported to clean their hands before mealtimes. On the first day of inspection there were no napkins on the table and we saw a person trying to flick food off their fingers.

Systems were either not in place or not robust enough to protect people from the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Using medicines safely

At our last inspection (published 24 January 2022) we found the provider had failed to ensure medicines were stored and disposed of safely. Protocols were not in place for medicines to be given 'when required' and there were no body maps to guide staff where to apply medicine patches. This was a breach of Regulation 12(2). At this inspection we found some improvement had been made however, the provider remained in breach of the regulation.

●Not enough staff were trained and competent to give people their medicines. Reliance on staff from a sister home had led to some minor errors because, staff told us, they were exhausted.
●Monthly reviews of protocols for 'as required' medicines which the provider had identified in their action plan in response to the previous inspection had not been completed.

Systems were not robust enough to ensure people received their medicines as prescribed. This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Visiting in care homes
●The provider was facilitating visits for people living in the home in line with current government guidance.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

- People assessed as needing staff support to drink did not have enough to drink and had to wait long periods for staff to provide drinks. On the first day of inspection we found people were not offered a drink until breakfast, some people had been up for over three hours. Fluid records showed gaps of up to 17 hours between drinks being offered. A few people told the inspector they had to wait for drinks.
- People did not get food at the correct texture and there was a lack of information to guide staff on people's needs and preferences. We saw a person assessed as needing a soft textured diet was given undercooked vegetables. We saw food which was too large and undercooked for a fork to go into it. One person told us they could not eat it.
- People were served food which was too hot. We saw three people drop their spoons when they tried their porridge and say, "It's too hot". We raised this with the interim manager on our first visit, but saw the same thing happened on our next visit. We saw one person had a hot meal placed on their lap in the lounge but they were unable to manage this and another staff intervened to prevent the person burning themselves.

Systems were not in place or robust enough to ensure people received enough to eat and drink or at the correct texture. This was a breach of Regulation 14 Meeting nutritional and hydration needs, of the Health and Social Care Act 2008. (Regulated activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Not enough staff had received training to enable them to provide safe and effective care. Only one night staff was trained to give people their medicines.
- Staff support and supervision had not been completed in line with the providers policies.
- The provider was reliant on agency staff to provide most of the care, but they had not followed their own policy to ensure all agency staff had an induction. This meant agency staff did not have enough information about the home or people's needs to provide effective care.
- The provider had not ensured they received profiles of agency staff prior to them starting work and therefore, did not know whether they had the right training, skills and knowledge. This was remedied during the inspection.

Systems were not in place or robust enough to ensure staff had the skills and knowledge necessary to provide safe effective care. This was a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

●Where information from community-based health professionals had been included in people's care plans, their advice had not always been followed. One person needed regular turns and bed rest to reduce the risk of pressure damage. We found this care had not been provided.

●People's needs had been assessed and care plans developed to guide staff how to support people. Care records were electronic and not accessible to agency staff who provided the majority of people's care.

●Agency staff did not have access to important details about people's needs in relation to moving and handling, personal care, dressing, pressure relief and nutritional needs. Handover records did not include sufficient details to ensure continuity of care. This meant people were at risk of not having their assessed needs met. We raised this at the beginning of the inspection and were assured single page profiles would be developed. We asked for three examples to be sent to us but did not receive them.

Some people experienced harm and the risk of harm because there was no system in place to ensure staff could access care assessments and care plans. This was a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated activities) Regulations 2014.

●Information about people's health needs and communication needs had been recorded in a hospital passport to ensure a smooth transition between services, if for example a person needed to go into hospital.

●District nurses visiting the home said they were contacted by staff when they had any concerns in a timely way.

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 MCA 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.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

●The provider was not compliant with DoLS. We found there had been no reapplication for DoLS for one person following an urgent DoLS being authorised. Not everyone who needed a DoLS in place had one.

●People's capacity to make decisions had not been properly assessed. We found one person's records indicated they had consented to a Do Not Attempt CPR (DNACPR) despite the capacity assessment stating they were not able to consent.

●The provider had failed to complete best interest decisions in relation to the use of all bedrails and sensor mats.

This was a breach of Regulation 11 Need for consent, of the Health and Social Care Act 2008.(Regulated activities) Regulations 2014.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
●People's dignity was not protected because staff did not have enough time to support them to meet their personal care needs or did not know what support people needed. Several people who had been supported by staff to get up and ready for the day were unkempt; their hair was not brushed, some men were unshaved. Over the course of the inspection some people's appearance had deteriorated.
●People did not always have their own clothes. Relatives told us their relations own clothes had gone missing and they found them wearing clothing which belonged to others.
●Some people's independence had not been promoted. We saw staff tell a person trying to get themselves a drink to 'sit down and stop trying to do everything yourself'.

We found some evidence people had been harmed and others were at risk of not receiving dignified or respectful care, this was a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008. (Regulated activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
●People's communication needs had been assessed and their preferred communication methods recorded in care records. Not all staff had access to this information and there was a risk agency staff would not know how best to communicate with people and support them to make choices.
●Relatives told us they felt their relations were listened to, comments included; "I feel my (name) has a voice there and is listened to." And, "They encourage (name) to tell stories from the war. They do listen to (name) when they ask to go somewhere quieter."

Ensuring people are well treated and supported; respecting equality and diversity
●We saw staff were kind and caring when supporting people.
●Relatives told us they found the staff to be caring and kind. Comments included; "The caring and the way they look after (name) is good." And "(name) says they are lucky, and staff listen to them."
●People's diversity and equality needs had been recorded in care records and one relative told us staff supported their relation to sing in their own language.

Requires Improvement

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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; 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's needs and their preferences about how they were met had been recorded. However, people did not always receive person centred care because staff did not have access to enough information about their needs and preferences.
- The provider had not always responded to changes in people's needs. We found one person had been injured on five occasions when being supported by staff in a wheelchair. The person's legs had been caught against door frames or the foot rests on their wheelchair. The moving and handling plan had not been updated in response to these injuries.
- Reviews of care needs had not always completed frequently enough in line with the provider's policies to ensure they were able to continue to meet people's needs. Several people were reviewed by the local authority during the inspection and some of those were moved to more appropriate care services.

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

- Information about people's life history, experiences, hobbies and interests had been recorded in care records together with information about the people who were important to them and their contact details. Some relatives told us they were happy with the activities their relations had access to. Comments included, "I am more than satisfied, they took my mother out and I thought it was outstanding." And "Staff pay attention and keep people occupied. (Name) was encouraged to help with chores." And "They really make of fuss of (name) on their birthday."

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 provider was not meeting this standard.
- People's communication needs had been recorded and information about how to support people to communicate was included in care plans. Examples included, preferred language, hearing and sight needs and giving people time to respond. However, this information had not been available to agency staff who were providing the majority of care. There was a risk people would not be able to express themselves.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy and procedure to address any complaints or concerns raised.
- Some relatives told us they had not raised any formal complaints but felt their concerns had been responded to. However, some relatives had not been satisfied with the response to their concerns because they had to raise the same concerns repeatedly. One relative told us, "My (name) fingernails are disgusting and the carers only clean them when I ask.

End of life care and support

- People had been supported to consider their wishes in relation to care at the end of their lives. People's wishes had been recorded.
- One person was identified as being at the end of their life during the inspection. Some of their needs had not been met in relation to personal care, this was raised with the provider and the person's needs were addressed with compassion. However, a lack of trained staff to give people medicines had meant there was no one in the building overnight on one night which could have meant the person did not receive their 'when required' medicines if they needed them. We have addressed this in the safe and effective domains of this report.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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

At our last inspection (published 24 January 2022), we found systems were not robust enough to demonstrate leadership and quality assurance had been effectively managed. This was a breach of Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider remained in breach of this regulation.

●Regular audits and oversight of the quality of care practice and care records had not been completed as frequently as the provider's policy stated. This meant there was a lack of effective managerial oversight.
●The provider had not followed the action plan they had developed in response to the last inspection. There had been consistent failures by the previous registered manager and provider to maintain the quality of care, care records and the premises.
●Issues found during our inspection; and the findings of other agencies during their visits to the service had not been identified by the provider. These included the local authority, infection prevention and fire service.
●Opportunities to improve care had been missed on several occasions. The provider had failed to address consistently poor practice in relation to the management and oversight of the home.

We found some evidence of harm and the risk of further harm. This was a breach of Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider had failed to notify the local authority and CQC of incidents which were notifiable. This included serious injuries needing hospital treatment.
●Relatives told us they felt they had been kept informed. Comments included, "The home communicates well, they always keep us informed." and "Their communication is good, they contact me if there are any issues."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●Care records included person-centred information about people living in the home, what was important to them and what they wanted to achieve. However, people did not achieve good outcomes because the systems in place to guide staff and record information was not accessible to the majority of staff. Despite assurances made by the provider to ensure concise and clear information was available for all staff this did not happen.
●Staff were committed to achieving good-quality care but were limited by a lack of oversight and effective response to the management of the home by the provider.
●Staff we spoke with felt lack of oversight of the home and lack of engagement with staff had led to them feeling unvalued.

We found some evidence of harm and the risk of further harm. This was a breach of Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some relatives told us they felt the service engaged with them well.

Continuous learning and improving care; Working in partnership with others
●The provider had responded positively to input from partners, including the local authority quality team, CQC and consultants they had commissioned to support them. However, we did not find the proposed improvements had been sustained.