Alexandra Care (Leicester) Limited

Dane View Care Home With Nursing

Inspection report

165 Glenfield Road
Leicester
Leicestershire
LE3 6DP

Tel: 07564527333

Date of inspection visit:
09 July 2019
10 July 2019

Date of publication:
30 August 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Dane View Care Home with Nursing is a residential nursing home providing personal and nursing care, for up to 41 people aged 18 and over. Accommodation is over three floors and provides support to older people, people with a physical disability, sensory impairment and younger adults. At the time of the inspection 15 people were using the service.

People's experience of using this service and what we found:
Medicines were not always managed safely which meant sometimes people did not receive their medicines as prescribed.

Although care plans were in place they provided limited information to describe the care and support people needed. They did not always include some important information individual to the person or include people's preferences for their end of life care. People did not always receive care that met their needs and preferences.

Staff were aware of risks to people however information about risks and how to manage them was inconsistent. The electronic care planning system made accessing information about people difficult.

Governance systems and processes needed improvement as the current systems did not identify the concerns we or the provider identified.

People told us they liked living at Dane View however felt there were not enough staff to meet all their needs. Staff, although compassionate, kind and caring were under pressure to meet people's physical needs and were less able to meet their emotional needs.

Although not all staff had received training in safeguarding, they understood their responsibilities, how to recognise the signs of abuse and knew the processes to follow to manage any allegations of abuse.

Accidents and incidents were recorded, investigated but it was not always clear if trends were identified or learning shared with staff.

Staff had not always received appropriate training, induction and supervision. We made a recommendation about this.

Potential risks to people's health and welfare had been assessed, there was limited guidance for staff to reduce risks. Risk assessments had not always been updated in a timely manner when people's needs or health had changed.

Recruitment procedures were not always robust. Systems were not in place to report practice amongst

nursing staff that fell short of their professional standards.

The environment did not support people living with dementia to remain as independent as possible. We made a recommendation about this.

People told us they did not feel there were enough activities and they were bored. People liked the meals and were provided with a choice of food and drinks. People were supported to see healthcare professionals when they needed them.

Care plans did not always identify how people were to be supported to have maximum choice and control of their lives. However, staff understood the importance of supporting them in the least restrictive way possible and in their best interests.

A complaints procedure was displayed. People and relatives knew how to raise concerns and were confident these would be dealt with appropriately.

The provider had recognised the service was not meeting the regulated standards prior to our inspection and had taken action to make improvements. They had done this by employing a new manager and providing support and resources to make the necessary improvements. The They were proactive in keeping CQC informed when changes were made.

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

Rating at last inspection:
This service was registered with us on 22 November 2018 and this is the first inspection.

Why we inspected:
This inspection was brought forward due to concerns received about the standard of care people were receiving.

We have found evidence that the provider needed to make improvements. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations in relation to safe handling of medicines and ensuring people received person centred care. You can see what action we told the provider to take at the back of the full version of this report.

We will request an action plan for 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?

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.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Dane View Care Home With Nursing

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, a specialist advisor who was a nurse with expertise in end of life care and dementia care and an Expert by Experience. An Expert by Experience is a person who has personal experience of using similar services or caring for older family members.

Service and service type:
Dane View Care Home with Nursing is a care home with nursing. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided. However, the provider had recruited a manager who had started the process of registering with CQC.

Notice of inspection:
The first day of the inspection was unannounced. We told the management team we would be returning for the second day.

What we did before the inspection
Before the inspection the provider completed a Provider Information Return. Providers are required to send

us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We took this into account when we inspected the service and made the judgements in this report. We reviewed the information we held about the service. We also looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We sought information 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 six people who used the service and six relatives to gain their views on the care provided. We spoke with the two directors, one of whom was the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the manager, the clinical nurse lead, one nurse, one senior carer, three care staff, two cleaners, the maintenance person, kitchen assistant, head of day care and day care assistant. We reviewed a range of records including four people's care records. We looked at 15 staff recruitment files, staff training records, accident, incident and complaint reports, 13 documents relating to the management of medicines and quality monitoring records.

After the inspection
We continued to seek clarification from the manager to validate evidence found. The manager sent us regular updates of progress in improving safety and standards within the service.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

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.

Using medicines safely

● People did not receive their medicines as prescribed. For example, we saw a letter from a GP instructing the service to stop administering a medicine to a person. However, medicine administration records (MAR) indicated the person was still receiving this medicine on 8 July 2019. We brought this to the attention of both the clinical lead and the manager and arrangements were made to stop the medicine.

● Records also indicated medicines were missing or they had been given more times than prescribed. We also saw where people had not received a prescribed medicine as the service had failed to get the prescription in a timely manner.

● Where people received their pain relief via a patch there was no chart to record the sites for administration and removal of the previous patch. This is important to reduce the risk of accidental overdose from residual medicines still in the patch. The manager confirmed following the inspection systems were in place to ensure this took place.

The provider failed to ensure people received their medicine as prescribed and in a timely manner. This indicates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

● Medicines were stored correctly. Staff received medicines training and had their administration competency assessed by the clinical lead when they started at the home.

Systems and processes to safeguard people from the risk of abuse

● In general people told us they felt safe. One person told us, "It feels safe."

● Some staff told us they had received safeguarding training but not all. We were told, "The previous manager had signed up staff to an E training system but it only allowed 20 staff on. They needed to expand it to allow new staff to access it. That didn't happen."

● We discussed this with the manager who told us they would take action to ensure all staff received the training they needed. Following the inspection the manager confirmed all staff had been booked on safeguarding training.

● Staff we spoke with all knew what to do and who to report concerns to if they suspected abuse or had concerns about people using the service.

● The manager had a detailed understanding of their responsibility to ensure all safeguarding concerns were reported to the local authority and CQC.

Assessing risk, safety monitoring and management

● The service operated an electronic care plan system. This system did not always show clearly where a risk had been identified or provide detail for staff to minimise risk.

● Risk assessments were not always reviewed. For example, one person experienced a fall and sustained a head injury, as a result they were admitted to hospital. On their return to the home several days later the falls risk assessment was not reviewed until the following day. We were told this was because an agency nurse was in charge when the person returned.

● We saw that some aspects of the environment were not safe. For example, there were stairs accessing the upper and lower floors which were not gated to minimise the risk of people falling down these areas. Following the inspection the new manager confirmed all the areas we identified had been or were in the process of being made safe. They had also employed a clinical support person to improve the quality of the care plans. This was to ensure care plans reflected people's needs and provided staff with the information they needed to support people as they wished to be supported.

● Systems were in place to ensure fire safety was monitored. Records showed staff received fire safety awareness training and fire evacuation procedures were practiced.

● People had personal emergency evacuation plans in place to ensure their safety should an emergency occur at the service.

Staffing and recruitment

● Effective recruitment systems were not in place. We found some staff files had gaps. For example, where the service had recruited qualified nurses there was no system to check their NMC registration. (The Nursing and Midwifery Council is the national regulator for all nurses).

● People told us they did not think there were enough staff to support them. One person told us, "I would say in my opinion that they are short staffed." They added, "[Staff] have to get [person] into their hoist and wheelchair for the toilet it sometimes takes time for them to come, they need two."

● Although we saw dependency assessments in place they did not appear to reflect the needs of people living at Dane View Care Home or the design and layout of the service. For example, we saw a person who chose to walk up and down the corridor throughout the day. A staff member accompanied them when they did this. This meant there the communal lounge only had one member of staff present and there were periods when there were no staff as they may have gone to assist someone. This potentially left people in the communal areas at risk.

● Staff confirmed they felt understaffed. One staff member told us, "I walk miles in a day, this place is very large." Another staff member said, "We are limited in what we can do, we really can only carry out the main tasks, we would like to be able to talk more with people but there isn't the time."

● We noted staff were very busy and there were frequent times when there were no staff in the communal lounge.

● We discussed this with the manager and the directors who told us they would look at staffing levels and recruitment as a matter of urgency.

● Following the inspection, the manager confirmed the human resource manager for the organisation was recruitment and plans had been put in place to improve staffing levels throughout the day and night.

Preventing and controlling infection

● There were several environmental health issues during our inspection. For example, flooring in a bathroom was not correctly sealed, making it difficult for this area to be effectively cleaned. The director acted immediately to have this area repaired.

● We saw one bedroom, which had not been effectively cleaned after the person had been supported with their personal care. The manager responded immediately and the room was cleaned.

● Staff told us they had access to personal protective equipment such as gloves and aprons, we saw this

readily available at various points throughout the service and staff using them.
● There was an infection control policy in place and staff understood their responsibility to maintain the cleanliness of the service.
● People and their relatives did not raise concerns about the cleanliness of the service. A relative commented, "It's excellent here, so clean, a great facility."

Learning lessons when things go wrong
● Although the previous registered manager had recorded accidents and incidents, it was not always clear if trends were identified and if staff were informed of what lessons could be learnt from any incidents.
● We discussed this with the manager who told us they would introduce systems which would ensure incidents would be fully monitored and information would be shared with staff through team meetings and handover.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments had been carried out by the previous manager, however they lacked detail to inform care planning. This meant staff may not be provided with the information they needed to care for people.
- Assessments did not always ensure staff had the skills needed to meet people's assessed needs. For example, one person admitted to the service was diagnosed as living with dementia. The statement of purpose did not show the service provided to support to people living with dementia. This meant staff may not have the skills to meet this person's needs. We brought this to the manager's attention who told us they were introducing a more detailed method of gathering information when carrying out the initial assessment. They would also be amending their statement of purpose to include dementia care. We received an amended statement of purpose shortly after the inspection visit.

Staff support: induction, training, skills and experience

- Nurses and care staff had not always received appropriate training to carry out their roles.
- There was some question regarding the physical and practical skills of the nurses at the service. Two people who had a commissioned nursing package of care were receiving services from community nurses for wound care and another for catheter care, this is not usual practice in nursing homes. We discussed this with the manager who said they would investigate the reasons for this.
- One member of the care staff told us they felt the training had been "rubbish."
- We found some nurses recently recruited had not passed their probationary period. One nurse had repeatedly failed her medicines competency assessment. Another nurse also failed her medicines assessment and was also falling asleep whilst on duty. The clinical lead was unsure what disciplinary procedures had been followed as the previous manager had dealt with the issues.
- We brought this to the directors' and the manager's attention. They told us they would investigate these matters further and ensure the correct procedures were followed. They would also investigate the training for all staff to ensure the skills and training of staff were suitable for their role. Staff support: induction, training, skills and experience
- Nurses and care staff had not always received appropriate training to carry out their roles.
- There was some question regarding the physical and practical skills of the nurses at the service. Two people who had a commissioned nursing package of care were receiving services from community nurses for wound care and another for catheter care, this is not usual practice in nursing homes. We discussed this with the manager who said they would investigate the reasons for this.

● One member of the care staff told us they felt the training had been "rubbish."
● We found some nurses recently recruited had not passed their probationary period. One nurse had repeatedly failed her medicines competency assessment. Another nurse also failed her medicines assessment and was also falling asleep whilst on duty. There was no evidence in the personnel file to demonstrate that the service had referred these cases to the NMC due to concerns relating to fitness to practice. The clinical lead was also unable to confirm what follow up action was taken as the previous home manager had dealt with both cases.
● We brought this to the directors' and the manager's attention. They told us they would investigate these matters further to ensure correct procedures were followed. They would also investigate the training for all staff to ensure the skills and training of staff were suitable for their role. Following the inspection the manager confirmed all staff were to be retrained by the end of August 2019. They had also employed a clinical nurse to mentor, train and develop staff roles.

We recommend the service finds out more about training and induction for staff, based on current best practice, in relation to the specialist needs of people.Following the inspection the manager confirmed all staff were to be retrained by the end of August 2019. They had also employed a clinical nurse to mentor, train and develop staff roles.

We recommend the service finds out more about training and induction for staff, based on current best practice.

● Staff confirmed that they had received supervision meetings. However they had not felt well supported by the previous manager.

Adapting service, design, decoration to meet people's needs
● The home was not dementia friendly; there was no directional signage to communal toilets or directional signage to bedrooms to promote independence in moving around the home. This meant people who were unfamiliar with the service or a new person moving to the service could struggle to find their way to their bedroom or toilet facilities.
● During our tour of the service a director told us of their plans to make the garden area more accessible for people living at Dane View. The garden was open to the car park and therefore would present a high risk for people living with dementia. We discussed this with the both directors who told us their plans included ensuring the garden was secure. Following the inspection, the manager confirmed the garden would be fenced by 10 August 2019.

We recommend that the provider seeks guidance on best practice for suitable environments for people living with dementia.

Supporting people to eat and drink enough to maintain a balanced diet
● People had adequate food and drink to meet their dietary needs. Food was fresh and homemade. People were mostly positive about their meals. One person told us, "I like the food, they ask me at breakfast time. Sometimes they show me the menu. I enjoyed my lunch it was steamed smoked fish, it was excellent and sponge and custard pudding." Another person commented, "The food's quite good and there's plenty of food and drink."
● Records indicated people's weight was routinely monitored. We saw people who had been assessed as being underweight had increased their weight since moving to the service.
● One person did comment, "I like Indian food, here it is English." We spoke with the kitchen assistant who told us the cook discussed people's meal preferences when they arrived and if a person expressed a wish for

a type of food it could be catered for.
● People had a choice of two options at each meal time. Staff asked people what they wanted to eat each day. People living with dementia were not enabled to make an informed choice using pictures, photographs or plated foods to help them decide which one they wanted. We brought this to the manager's attention who told us they would look at ways to help people make informed choices.
● Kitchen staff had a good understanding of fortifying food to enrich it to support people who were at risk of malnutrition. Information was provided to kitchen staff to ensure they had a good understanding of people's dietary needs such as who was diabetic, what allergies people had and what texture of food people who had been assessed at risk of choking required.

Staff working with other agencies to provide consistent, effective, timely care
Supporting people to live healthier lives, access healthcare services and support
● When people's needs changed, this was discussed at staff handover to ensure any referrals were handed over and followed up.
● People were supported to access healthcare services. They said they received regular visits from healthcare professionals such as chiropodist and optician and this was confirmed in care records we reviewed.
● Records showed staff were responsive to fluctuations in people's physical and mental health with involvement of other professionals such as dietician, speech and language team and GP.

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.

● MCA assessments were inconsistent as they were not always decision specific. We brought this to the manager's attention who told us they were reviewing all care plans with the intention of improving the MCA assessments.
● Applications for DoLS had been applied for and the service were waiting a response from the local authority.
● Some staff had completed training in the MCA and DoLS, but most were aware of and understood the implications of the Act.

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.

This is the first inspection for this newly registered service. This key question has been rated 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
- A visitor told us, "It's a bit haphazard and a lot of agency staff, but they understand [person] they know when [person] doesn't like something."
- Staff we spoke with told us they did not feel they had enough time to have positive interactions with people as there were not enough staff in the communal areas.
- One person told us, "I feel they [staff] should have an understanding around food and a cultural appreciation with a good attitude towards difference." We brought this to the directors and manager's attention who told us they would ensure this was followed up.

Supporting people to express their views and be involved in making decisions about their care
- A relative told us, "I have confidence in them and I have peace of mind." They added, "I visit regularly and like to help [person] with their meals." Another relative said, "We moved [person] recently and we have already seen a better level of care."
- Visitors told us they were made to feel welcome and there were no restrictions on when they could visit.
- We observed staff seek consent when offering to provide support with personal care. For example, staff asked, "Can I help you with that?" and "Are you comfortable?"
- The manager and directors told us as part of their general review of standards of the service they would ensure staffing levels were increased to promote people's involvement in their care.

Respecting and promoting people's privacy, dignity and independence
- We observed most people being treated with kindness and respect by staff. However, this was not the case for every person living at the service. For example, we saw some people were left with little or no positive interaction. However, we did see one carer notice a person crying and gently talk with them to offer reassurance.
- People told us they did not feel they were supported to be independent. One person commented, "I am frustrated and trapped, we stay in the lounge practically all day."
- Staff told us they struggled to promote people's independence as they did not have enough time to support people to do the task themselves.
- Staff were observed to knock on people's doors before entering and be discreet when people needed assistance. They gave reassurance to people when they were providing support.
- People mostly looked well-presented, clean and cared for. However, we did see two people whose nails

were long and unkempt.

● The service had private space if people wanted to talk with their visitors away from the main communal areas. Most bedrooms were spacious and offered a comfortable and private space if people wished to stay in their rooms for any reason.

● Information was stored securely. People could be assured their confidential information was only accessible to people who had the right to access it.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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
Meeting people's communication needs

- Although care plans were in place to describe the care and support people needed, they lacked detail and were not user friendly. This meant important information about people was not always provided and staff struggled to access it.
- The service used an electronic care planning system. One staff member told us they found the system cumbersome to use. This was a concern as the service used a high number of agency staff and as it was difficult to navigate the system they may not be able to access the information they needed to provide safe and timely care to people. We discussed this with the manager and directors who told us they would look at how to improve the information held in the system.
- Care plans were not person-centred and did not tell staff how and when people preferred to receive their care. Some parts of the care planning system had not been completed. For example, 'My life history' had not been completed for the care plans we looked at. This could mean staff may not have the information about people's interests to engage them in conversation.
- Staff we spoke with did speak about people in a person-centred way and knew people's likes and dislikes as well as their personal routines. One staff member said, "You have to know the residents really well as some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right".
- Care plans were reviewed monthly but did not ensure the plan continued to be relevant to people's needs or contained meaningful information.
- Advice from professionals was not always followed. For example, an occupational therapist (OT) had assessed a person as requiring exercises twice daily for 20 minutes. The care plan did not describe what the exercises were or how they should be carried out. The was no chart to evidence that the exercises were carried out. The OT reviewed the person's care in June 2019. The OT had recorded they were considering raising a safeguarding as the person was not receiving the exercises. The daily notes do record on some occasions the person had refused to participate in the exercises. There was no evidence that staff returned later to encourage them. There was no analysis of the information or a care plan to guide staff on how to manage this.

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.

● Care plans had limited information regarding people's communication needs and how staff should ensure they understood what their care was. We did see in one person's care plan who had sensory needs they were supported to access the optician and dentist and diabetic eye screening.
● People told us they were restless and bored at times. They informed us they didn't get out much and were not able to tell us of any activities. One person told us, "Sometimes they take you out but mostly they don't. One week we went out once and one week we went out twice. I would like more chances to go out if the weather is nice."
● The television was positioned on a wall in the communal area but not facing anybody. It was on all day, but we did not see anyone actively watching it.
● The manager showed us a room which was designated a cinema room but was not routinely used to show films for people. We were told they planned to add this to the activities programme.
● Following the inspection the manager confirmed entertainment activities had been booked for the rest of 2019.

The provider failed to ensure people were provided with care which met their assessed needs. This indicates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

● One person told us their relative was involved in their care plan.

Improving care quality in response to complaints or concerns
● There were systems in place to record and respond to complaints following a complaints procedure. The procedure was displayed in the service and a copy was shared with people and their representatives.
● There were no complaints recorded. In discussion with staff small 'concerns' such as items of laundry going missing were not routinely recorded as they were not considered to be complaints. We discussed this with the manager who told us they would record all concerns to identify any trends and ensure quality was improved.
● The service had received several positive comments from relatives who were happy with the care their loved one had received whilst living at Dane View. One commented on the weight gain their loved one had made and how they were no longer in need of pain relief as a result of the support staff had provided.

End of life care and support
● There was currently no one living at Dane View who was considered to be at end of life.
● Not all 'end of life' plans were completed in people's care plans. This means should a person need end of life support staff may not have the information they need to understand the person's preferences.
● We saw another person had been prescribed anticipatory medications for end of life but did not have an end of life/advanced plan for how they wished to be supported at that stage of their life.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The providers had a clear vision for Dane View Care Home. This was to provide a high standard of care in a high-quality environment.
- The provider informed us prior to our inspection on 18 June 2019 they had, over the previous few months identified shortfalls in the way the registered manager had been managing the service. As a result, they created a detailed action plan for them to follow to bring the service up to standard. As this had not been successful the provider took decisive action and a new manager was employed, starting on 8 July 2019. The manager had started their application process to become the registered manager of the service.
- Following the inspection the manager confirmed the provider was being very supportive whilst they made improvements, including ensuring there were sufficient resources available.
- The provider and the manager had identified where the issues were in the running of the service and action was being taken to make improvements.
- Staff we spoke with told us under the previous manager they had not felt valued or supported. We brought this to the manager and provider's attention to provide support to staff.

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 was fully aware of their responsibility to be open and honest, as was the manager.
- The provider was very open with us during the inspection and shared their concerns. They also confirmed they would not admit any new person to the service until they felt the necessary improvements had been made.
- As part of the manager's review of the service they had contacted the local authority and local CCG to engage with the contracts monitoring teams to advise them of the issues they had identified.
- Following the inspection the manager also sent an update to CQC of actions achieved in ensuring the safety of people living at Dane View. This included ensuring sufficient staff were recruited to support people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The systems in place to check the quality of the service including reviewing care plans, incidents and accidents, medicines, safeguarding, maintenance, room audits and health and safety were not effective as

they had not identified the issues both the provider and we identified. The manager told us they would be introducing a new audit process that would be more effective. This needed to be sustained and embedded in practice.
● The manager also confirmed they were introducing policies and procedures that were already in place from the provider's other services to ensure consistency across the organisation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The manager told us they were introducing a quality questionnaire and had started with the staff due to low staff morale.
● The manager confirmed following the inspection they had created links with the local authorities to ensure standards were improved within the service.
● The provider was aware the service had not been performing as it should have been and had acted to ensure they involved people in the running of the service. They were aware the equality characteristics should be considered when providing a service and would be monitoring the manager's progress in this area.

Continuous learning and improving care
● The manager kept up to date with best practice and developments. For example, they were signed up to CQC updates and were aware of changes in legislation which would impact on the people who lived at Dane View Care Home.
● The provider was also aware of the importance of keeping up to date with changes and the need to constantly improve care.

Working in partnership with others
● Staff working at Dane View Care Home were aware of the importance of working with other agencies.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not always ensured the care of all service users was appropriate, met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not always ensured the proper and safe management of service users' medicines.