Knights Care Limited

Drovers Call

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
Drovers Call is a 'care home'. It provides accommodation for older people including people living with dementia, providing personal and nursing care. The home can accommodate up to 60 people. At the time of our inspection there were 56 people living in the home. Accommodation is provided on three floors divided into five units.

People's experience of using this service and what we found
Organisational governance and quality assurance systems had not been effective in monitoring and improving the quality and safety of the service. We found systemic failures with oversight and quality assurances processes, which posed significant risk to people.

There were indicators of a closed culture where chemical and physical restraint was disproportionately used. Staff had a lack of support or guidance on how to support people to lead inclusive and empowered lives.

The service failed to protect people from poor care and abuse. Staff had failed to identify, record and report incidents, additionally, the provider had failed to monitor the safety and quality of the service resulting in poor care and outcomes for people, with potential incidents of a safeguarding nature occurring.

Risk management was poor. A lack of support plans and assessments in place meant people's needs were not identified assessed or managed effectively. Ineffective care planning led to people experiencing increased periods of distress, restrictive practices and hospital admissions.

People did not always receive person centred care to meet their needs and preferences. Care files did not always have necessary support plans in place.

The service did not have enough staff, a high number of agency staff were used, significantly increasing the risk of inconsistent care.

People and their relatives provided mixed feedback, raising concerns with communication and staffing, but also highlighted they felt their relative received good care.

The service did not always follow or act in accordance with the Mental Capacity Act (MCA). The registered manager failed to apply for Deprivations of Liberty authorisations, meaning people were being deprived of their liberty without the legal authority and an infringement of their human rights.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection
The last rating for this service was requires improvement (published 15 May 2021).

Why we inspected
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.

The inspection was prompted in part due to concerns received about the use of restrictive practices, mental capacity assessments, governance and leadership. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Drovers Call on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, restrictive practices, safeguarding, leadership and governance at this inspection and placed urgent conditions on the provider's registration.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Drovers Call

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 4 inspectors across 3 days 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
Drovers Call 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. Drovers Call is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was 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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 14 members of staff including the provider, registered manager, manager, deputy manager, clinical lead, training lead, care navigator, complex senior lead, activities coordinator, cook and carers.
We looked at around 30 people's care records in detail and records that related to how the service was managed including staffing, training, medicines and quality assurance. We spoke to 20 relatives and 4 people who use the service and 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.

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

- People were not kept safe from avoidable harm. We found support plans either had limited information or were not in place, meaning staff did not have adequate information to support people with their risk behavioural needs. Consequently, incidents had occurred resulting in injury to people, staff and damage to the environment.
- There are indicators of a closed culture at the service where restrictive and punitive measures were used to manage people's distressed behaviour. We reviewed daily notes and found that staff were using restrictive interventions without appropriate care plans and authorisations. For example, a daily log detailed a person was, 'let free because they promised to calm down'.
- We found restrictive practices were used for people limiting their freedoms. For example, a person was regularly restrained by 2 staff whilst a 3rd staff member completed personal care. Restraint was not subject to care planning to show it was a necessary and proportionate measure. We found multiple support plans for people living at Drovers Call were not in place for the use of restraint or restrictive practices. Furthermore, we found evidence of records were restraint or restrictive practices were used by staff and had not been raised as an incident.
- We found chemical restraint (use of medicines to manage distress behaviours) had been used disproportionately, this again was not subject to care planning or appropriate authorisations. For example, a person was chemically restraint a total of 11 times in one month. We found no record of why this was administered. Care notes contained no detail of agitation or that chemical restraint was required.
- Staff and management had training on safeguarding, however, they did not know how to recognise and report abuse. Restraint, chemical and physical was not subject to care planning to show it was a necessary and proportionate measure to prevent significant harm and used as the last resort. This placed the people at significant risk of injury or harm and infringement of their human rights.

Systems systematically failed to safeguard people; this placed people at risk of significant harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- During our inspection we found the registered manager and provider had consistently failed to assess and mitigate a wide range of potential risks to people's health, safety and welfare, in areas including behaviour management, safeguarding, health conditions, accidents and incidents and organisational learning.
- Records showed a person's health was directly impacted and they were subjected to avoidable harm. Over a 3 month period the registered manager and provider failed on multiple occasions to seek medical professional advice or escalate concerns regarding missed medicines, high blood sugar levels, vomiting and

complaints of abdominal pain resulting in an hospital admission. This meant the person was placed at significant and actual risk of their health deteriorating and negative impact on their general wellbeing due to poor diabetes management.

● During the inspection we reviewed medical administration records and found epilepsy medication and emergency medication for status epilepticus for a person. However, we found no record in any care file this person had the medical condition epilepsy. Additionally, another person had epilepsy logged as a medical condition within their medical care plan, however, we found no epilepsy care plan in place. Epilepsy management systems were inadequate which meant individual risks to people's safety had not been properly assessed, planned and reviewed, creating significant risks to people's health, safety and welfare.

● People were not protected from the risk associated with weight loss. We found people were not being weighed and when weight loss was identified swift action was not taken to monitor this. For example, records showed a person had lost a significant amount of weight in a month. Where advice had been sought from the GP this was not always updated on care plans.

● We found environmental concerns, which increased the risk to people. For example, dishwasher tablets were found in an unsecure cupboard in a communal area, broken window restrictors in lounges and broken light fittings, when inspectors touched these fittings, plastic shards broke off onto the floor. The registered manager and provider failed to identify and assess these risks, which put people at risk of harm.

Using medicines safely

● Medicines were not managed safely. We found the use of antipsychotics had not been assessed and managed appropriately. Stock and storage of medicines was not managed effectively.

● We reviewed medicines administration charts [MAR] and found multiple examples of antipsychotics administered stating only 'agitation', however, we found no care records or incidents in relation to these administrations. For example, a person had 23 administrations of antipsychotics in a 2 month period. Inappropriate or overuse of antipsychotic medicines placed people at significant risk, with a potential negative impact to the health and wellbeing.

● We found thickening powder not stored appropriately and accessible to people. Thickening powder was in an unsecure cupboard in communal areas on 2 floors. A patient safety alert has been issued by NHS England to raise awareness of the need for proper storage and management of thickening powder in 2015. This increased the risk to people due to inappropriate storage of high risk products.

● We found multiple discrepancies with people's stock of medicines. This meant it could not be clear if people were receiving too much or too little of their prescribed medicines. 'As and when' [PRN] protocols were not always in place meaning staff did not have any guidance of when to administer medicines. The registered manager and provider failed to establish an effective system to monitor and mitigate risks relating to the administration and storage of medicines for people.

Preventing and controlling infection

● Several areas of the environment were unclean which posed a risk of infection and compromised the effectiveness of cleaning. Equipment in the kitchenettes was unfit for purpose, temperatures to ensure safe storage of food had not been completed, we also found thermometers not working in fridges.

● We found bodily fluids in lounges and corridors. These communal areas were frequently used by most people living in the home and mainly accommodated people who were unable to ensure their own safety. This posed a significant risk of harm due to poor environmental safety and impacted on effectiveness of cleaning.

● Some areas of the home had strong malodours and indicated cleaning had not taken place. For example, a bathroom had a strong odour of urine and broken equipment in the room.

● Additionally, dedicated domestic staff were not in place for all areas of the care home to ensure cleaning processes were completed each day. We were informed staff had dual roles alongside caring duties. This

meant cleaning was not planned for or maintained. This placed service user at risk of infection from poor cleaning standards.

Learning lessons when things go wrong

● There was limited evidence of learning from incidents. As detailed above, concerns with behaviour management, use of restraint, risk management environmental safety, medicines management and Infection control were found.

● The provider failed to ensure staff reported and recorded incidents appropriately, we found 100's of logs on the provider's electronic system, which had not been subject to review or monitored to prevent reoccurrence. Systems were either not in place, needed embedding or robust enough to address the concerns identified during the inspection. Due to systematic failures the registered manager and provider failed to ensure the safety of people meaning they were at risk of harm.

● During this inspection we have issued urgent enforcement twice. Following the first enforcement, the registered manager and provider had failed to consider additional risks at the care home. Consequently, we found additional urgent concerns on the 3rd day of inspection. This demonstrated that the registered manager and provider did not always learn lessons when things go wrong.

The provider systematically failed to assess and manage a wide range of risks which placed people at risk of avoidable harm and was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The service did not have enough staff. Agency staff were heavily relied upon. We reviewed rota's for a 4 week period and found a total of 204 day shifts completed by agency staff, with one week 31 different agency staff completing a shift. This meant people were at increased risk of experiencing inconsistent care and treatment.

● During the inspection a safeguarding incident occurred which involved an agency staff member. We spoke with the registered manager about these risks and they told us further work was required to ensure agency staff were deployed appropriately to ensure the skill mix was adequate for each unit within the care home to meet people's needs.

● Records showed the provider had recruited staff and a number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the staff concerned did not have criminal convictions.

Visiting in care homes

● The service facilitated visiting in line with national guidelines.

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.

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.

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, 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.

- We found the service was not working within the principles of the MCA.
- The inspection was prompted due to the registered manager informing us DoLS were not in place for the use of restraint. The registered manager had failed to consider DoLS authorisations were required for the use of restraint chemically and physically. They had also failed to fully consider other restrictions for people including but limited to covert medicines. Covert administration is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them.
- We reviewed mental capacity assessment which the registered manager had put into place during the inspection due to the CQC's intervention regarding restraint. These were of poor quality, failed to consider the persons individual needs and did not follow the 5 principles of the mental capacity act. Additionally, a review of people's care files found mental capacity assessments were not always in place.
- There was little evidence the registered manager understood their responsibilities in regards of MCA and DoLS, the provider failed to have effective oversight to ensure the restrictions were necessary and people were not unlawfully restricted. This placed people at risk of having their liberty deprived without the appropriate legal safeguards in place and an infringement of their human rights.

Systems were either not in place or not robust enough to demonstrate people were deprived of their liberty with the lawful authority required. This placed people at risk of significant harm. This was a breach of Regulation 13(5) (Safeguarding service users from abuse and improper treatment) 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

● Records showed people's needs were not consistently assessed appropriately, directly impacting care delivery. As mentioned in the Safe section, care planning for risk management had been ineffective meaning people were at risk of avoidable harm.

● As detailed above, the registered manager and provider consistently failed to assess people's needs in line with the law. Disproportionate restrictions had been placed on people without effective assessment.

Staff support: induction, training, skills and experience

● Drovers Call had high use of agency staff to meet people's care and treatment needs. The provider failed to ensure agency staff had the necessary skills and training to support people. We found the behaviour management training agency staff had received was not adequate. Agency staff were not trained in the level of restraint they were using for people. This placed people at risk of harm.

● We looked at the training matrix and despite showing staff had received training, systems were either not in place or robust enough to ensure staff were competent to meet the needs of people. Issues identified during this inspection demonstrated staff lacked knowledge in regards of understanding and managing health conditions, behaviour management and medication management leading to people being at risk.

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

● We observed lunch in 2 areas of the home during the inspection and found people were offered a choice. However, the dining experience was not carefully considered to meet people's needs. For example, a person was being supported to eat by staff, however, this was rushed, staff continued to bring food to their mouth when this was already full. Additionally, a person was given their food but placed on a mobile table too far away from them, consequently food was dropped on the floor before the person got it to their mouth.

● We asked people what their thought were regarding the food at Drovers Call. One person told us, "They [Staff] could do with going to cook school. Choices are limited, it's like children's food." Another person said, "I get 2 choices of food, they're not bad. Not sure if I can have snacks other times but you get all the cups of tea you want."

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

● People were at risk of harm as the environment was not always safe. We saw that some communal bathrooms had damaged fixtures and fittings; people had access to these areas of the home that posed a risk. The service accommodates people who may be unable to ensure their own safety,

● We found a bathroom full of equipment, this was accessible, any attempt to use the equipment or access the facilitates could result in a slip, trip or fall potentially causing injury. This placed people at risk of harm.

● People were at risk of deterioration of their emotional wellbeing. The environment was not dementia friendly; The complex care units within the care home, lacked any stimulation, with minimal furniture in areas. Additionally, upper floors lacked access to open spaces and any form of stimulating environment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● We found healthcare professionals involved with the care of people. However, as detailed in Safe, timely action was not always sought to manage health conditions. Additionally, management and staff lacked understanding and knowledge of how to support people with risk behaviours, leading to escalation of distress quickly, posing risks to themselves and other people. Due to intervention from CQC external professional advice was sought and in-depth reviews were taking place.

● People we spoke to gave mixed feedback regarding access to healthcare and raising health concerns when needed. One person told us, "Depends on what nurses are on [shift] they don't take much notice." Another person told us, "I regularly see a nurse practitioner, I also get offered to see an optician and dentist."

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.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

● People did not consistently receive care and support that met their individual care and treatment needs. This was supported by feedback from people and relatives who told us the quality of care was inconsistent. During the inspection we spoke to a person who told us, "I spend 23 hours a day in my room. I can't stay in the main room [Lounge], staring at walls all day."

● A relative told us a person was resistant to taking medicines due to their personal beliefs and they [Staff] have been trying covert medications. They said, "They haven't discussed a medication plan with us and they don't keep us up to date with [Persons] needs. [Person] came in in January and they have deteriorated since. I think that families should be more involved than they are. I would like to be asked my opinion sometimes. why don't I get consulted on their medications and behaviour changes."

● During the inspection, we observed agency staff arrive and express they were unaware of where to be or what to do, they were then asked to support people. We observed no information about people being given to agency staff. This was further collaborated when we spoke to people, for example, a person said, "I have to walk with someone holding both hands. I get a bit panicky with agency as they don't' know how to walk me properly."

Respecting and promoting people's privacy, dignity and independence

● People did not consistently receive privacy and dignity during the delivery of care. One relative told us, "They [Staff] can't find [person's]glasses or braces. I've asked them to find the braces and make sure [Person] wears them because they are needed to hold [Person] trousers up and I do worry about dignity sometimes."

● On a more positive note, one relative told us, "They've [Staff] worked with [Person] as a person rather than as a medical patient and they are not a distressed person now. They have individualised their care. When [Person] had difficulty eating and was losing weight they [Staff] developed a special menu with adaptions including food supplements and they have now put on weight."

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

- Records showed care plans did not always contain the information to ensure people's needs and preferences could be met. For example, a person with complex epilepsy needs did not have a care plan in place, therefore, staff did not have sufficient guidance about how to support them to ensure their safety.
- We reviewed records of Incidents and found people's choice and control had been taken away from them. For example, a person was regularly restrained for personal care task. This was not part of their planned care. Additionally, we observed during the inspection 3 staff approach a person, stand either side of them and one behind and take the person to a room. We reviewed this person's care plans, this was not part of their planned care, staff had not considered this may be intimidating, no choice was given to the person, this was a staff led task.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Records showed the majority of people's communication needs had been assessed and how to meet these needs was detailed in their communication care plan. Care plans clearly set out what was their preferred communication method and the level of support needed and any equipment, for example hearing aids.
- However, we found communication needs for a person when they were in a heightened state of distress was not always detailed in their behavioural care plan. We reviewed several incidents where staff had responded verbally to a person and their behaviour had escalated as a result.
- A person within the service did not speak English, staff told us they used a phone translator at times or gestures to understand what the person was saying. However, whilst a language barrier was identified by the provider, alternative methods of communication was not always explored to communicate. For example, recorded on a capacity assessment, staff had noted the person did not understand them. Staff failed to recognise it may be the person does not understand English.

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

- We found activity staff were employed by the provider and observed activities during the inspection.

People appeared to engage and interact with the activities. However, we observed that other than some activities, there was not enough social stimulation for people.

● We spoke with relatives who felt their relatives did not have enough to do. For example, a relative said, "There's no stimulation for people on the weekend, they just sit there." Another said, "I'm happy that [Person] is being safely cared for; it's a bit sad there's no activity for them, but what can you do."

● People we spoke to had mixed feedback regarding activities. One person said they often get taken out and enjoy these trips which include to the seafront. Another person told us when asked if they enjoyed living at Drovers Call, "There is nothing enjoyable about being here, but I need to be here."

Improving care quality in response to complaints or concerns

● The provider had a system in place to record complaints when they were received, and action taken. There were a policy and procedures in place for handling complaints. However, it was demonstrated this was not always effective.

● We received mixed responses from relatives, a relative told us, "I've spoken to [Registered manager] about the agency staff, mixed up laundry and lack of activities on weekends, but nothing's changed." In contrast another relative told us, "If I had any concern I would go straight to [Registered manager] or the deputy...all the office staff are really good; they're very well organised."

● This inconsistent approach to dealing with complaints means improving care quality cannot always be recognised or sustained.

End of life care and support

● We reviewed documents regarding end of life wishes in place for people and found incomplete information. One care plan we reviewed stated, '[Person] is not on any end-of-life care'. Another care plan stated, 'Speak to family once died'. However, there was no further information of what people's wishes were at the end of their lives. A lack of information could lead to confusion and inappropriate care being given at the end of a person's life.

● Some care plans were completed, this meant people's wishes were known and could be met with a dignified death being supported. Systems were not consistent enough to ensure peoples preferences and wishes for end of life could be met.

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.

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

- At this inspection we found indicators of a closed culture within the service, due to unlawful use of restrictive practices and the use of punitive language. The distinct lack of registered manager and provider oversight led to a decline in the safety and quality of care standards delivered to people.
- Management had failed to ensure people's needs could be meet. We consistently found people's care and treatment needs had not been identified or assessed, this meant people were at risk and had their care impacted, due to inadequate support.
- People were exposed to poor outcomes and at significant risk of injury, due to the registered manager and provider's inability to assess and manage behaviour effectively and take timely action to monitor and mitigate health risks to people.

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; Continuous learning and improving care

- The registered manager and provider had failed to be open and honest. We found due to a lack of oversight the registered manager had failed to identify incidents that had placed people at risk of significant harm. Consequently, the registered manager and provider had failed to notify the relevant professional bodies when appropriate and failed to investigate incidents effectively.
- We could not be assured regulatory requires had been met by the provider, during the inspection we found a significant number of incidents that had not been subject to review from the management team, therefore, there was an increased risk we had not been notified regarding several incidents.
- The provider had also failed to monitor the performance of the management and senior team at Drovers Call. This was evidenced by the failings and significant concerns we found at the inspection not having been identified prior to our visit. This failure of organisational oversight and governance resulted in substantial risks to people and created additional risks to the safety and quality of service provision.

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

- Organisational governance and quality monitoring systems had failed in assessing, monitoring and mitigating risks to people's safety, as evidenced by not identifying mismanagement of health conditions, inadequate behaviour management, accident and incident oversight and disproportionate use of restrictive practices. We found inadequate systems in place to monitor the safety and quality of service provision. The failure to have these in place significantly restricted the ability to identify risks and address shortfalls,

exposing people to the risk of avoidable harm and poor-quality care.
● A lack of oversight at the service and provider level meant the quality and safety of the service had declined. We found no effective monitoring in place, which resulted in poor care and people subjected to physical harm.
● Audit documents we reviewed had been ineffective. Medicines audits had failed to identify refusals of medicines, storage and stock issues. Accident and incident audits had also failed to identify multiple additional incidents along with care planning and environmental oversight. Consequently, we found significant concerns in these areas which posed risks to people.

Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at risk of harm. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the areas of concerns within care delivery, governance and leadership with the provider. The provider responded to the concerns identified with an action plan, which gave us assurance the provider was committed to driving improvement in leadership and care delivery in the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Feedback from relatives was mixed. One relative told us they were not always informed of changes to their loved one's care. For example, "I wasn't aware [Person] had stopped feeding themselves, and staff were having to feed [Person]. More recently [Person] had stopped walking and I only found out when I visited and saw a wheelchair in the room." More relatives we spoke to told us, "They [Staff] always tell me about things like falls, but they don't seem to think about telling relatives about changes in conditions, you can find out, but you need to find the right person."
● The registered manager worked with health and social care professionals to ensure people received care which met their needs. However, this was at times when people were in crisis and distressing intervention was required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 provider systematically failed to assess and manage a wide range of risks which placed people at risk of avoidable harm.

The enforcement action we took:

Urgent Notice of Decision to Impose Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were either not in place or not robust enough to demonstrate people were deprived of their liberty with the lawful authority.

The enforcement action we took:

Urgent Notice of Decision to Impose Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to assess and monitor the quality of the service. This placed people at risk of harm.

The enforcement action we took:

Urgent Notice of Decision to Impose Conditions