Knights Care Limited

Drovers Call

Inspection report

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Date of inspection visit: 17 December 2015
Date of publication: 19/01/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**

Overall summary

We carried out an unannounced focussed inspection of this service on 3 September 2015. A breach of legal requirements was found. The provider was not meeting the standards of care we expect in relation to ensuring that appropriate arrangements for the management of medicines was in place.The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this focused inspection on 17 December 2015 to check that they had followed their plan and to confirm that they had now met legal requirements with regard to the management of medicines. At our inspection on the 17 December 2015 we found the provider had made improvements in the areas we had identified.

This report only covers our findings in relation to those requirements. 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.

Drovers Call provides care for older people who have mental and physical health needs including people living with dementia. It provides accommodation for up to 60 people who require personal and nursing care. Accommodation is provided in two units an upstairs and downstairs unit. At the time of our inspection there were 31 people living at the home.

At the time of our inspection there was not a registered manager in post. The home has had four registered managers in the past year. The current manager was in the process of applying to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. The management and administration of medicines was adequate.

Summary of findings

People received their medicines in a timely manner. We found that people were getting their medicines as prescribed. However we found that records relating to the administration of warfarin were not clear and it was difficult to identify what dosage people had been given.

Summary of findings

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 consistently safe.

Medicines were administered safely. Records of people's allergies were consistently recorded. Some records relating to warfarin were unclear.

Requires improvement

Drovers Call

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Drovers Call on 17 December 2015. This inspection was completed to check that improvements to meet legal requirements with regard to the management of medicines, had been made. The improvements were planned by the provider after our focussed inspection on 12 May 2015.

We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some legal requirements in relation to those sections.

The service was inspected by one inspector. During our inspection we observed care and spoke with the manager, the operations manager and a nurse. We also looked at nine care plans in detail and records of audits and medicines.

Requires improvement

Is the service safe?

Our findings

At our previous inspections in May 2015 and September 2015 we identified that people were not adequately protected against the risks associated with the unsafe use and management of medicine. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After our inspection the provider wrote to us to say what they would do to meet the legal requirements. At this inspection we found the provider had made the required improvements.

At our previous inspection people had received the wrong dosage of warfarin. At this inspection we saw two people required warfarin and we observed that they had received the correct dosage, however the records were not clear about what dosage had been given when. Warfarin is a medicine which requires careful monitoring and management in order to keep people safe. We also noted that where people required warfarin neither a care plan or risk assessment was in place to support staff with the care of people. People were at risk of receiving inappropriate care. We spoke with the manager who told us that they would review the system for recording warfarin.

People got their medicines as prescribed. At the last inspection we had found that people were not consistently receiving their medicines because they were out of stock. At this inspection we looked at medication administration records (MAR) for people on both units and covered people who used nursing and residential services. Records showed that people were getting their medicines as prescribed and there had not been any gaps in administration due to medicines being out of stock. People received their medicines according to their prescription.

People's allergy status was recorded consistently throughout records. For example information about allergies on the identification sheets matched information on the MARs. One person's MARs did not record their allergies but stated, 'refer to care plan'. The person was allergic to five medicines and the information was not readily available to staff administering medicines. The person was at risk of receiving inapproporiate medicines. We spoke to the manager who told us that they had raised this with the pharmacy and would follow this up again.

A medicines audit had been carried out on 15 December 2015. The audit identified two occasions when staff had failed to sign when they administered medicines. During our inspection we found two occasions when a signature had been missed following administration. This was a medicine which required by law additional records to be kept. These records showed that the person had received their medicines. The manager told us that they had made other changes to ensure that medicines were managed safely, for example creams were now recorded on the MARs rather than on a separate sheet. They said that this meant that the MARs were complete and it was easy to see what care people had received.