Knights Care Limited

Drovers Call

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 9 and 11 February 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

At the last inspection on 9 and 11 February 2015 we found that the provider was not meeting the standards of care we expect in relation to ensuring people's care was planned and delivered to meet their individual needs, maintaining appropriate standards of cleanliness and hygiene and did not have appropriate arrangements for the management of medicines. We also found that the provider did not ensure staff were appropriately supported with training and supervision and did not have effective systems to asses and monitor the quality of service provided to people. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. At our inspection on the 12 May 2015 we found the provider had not made improvements in some of the areas we had identified.

This report only covers our findings in relation to those requirements. You can see what action we have told the provider to take at the back of the full version of this report. 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

Summary of findings

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 46 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 had been in post since March 2015 and 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 not protected against the risks associated with medicines because the provider had inappropriate arrangements in place to manage medicines. The management and administration of medicines was inadequate. The provider told us what action they would take to make improvements however we found at this inspection that this action had not been completed and medicines were not managed appropriately.

People did not receive their medicines in a timely manner. We found that people weren't getting their medicines as prescribed. We observed that medicines were not given in a safe manner to ensure that people received the appropriate medicines.

People were not always treated with dignity and respect and staff did not always respond in an appropriate manner to people. There were sufficient staff to meet people's needs and staff were kind to people when they were providing support. Staff in the upstairs unit had a good understanding of people's needs.

Systems to assess and monitor the quality of the service to people were not effective. The provider told us what actions they would take to make improvements and we found at this inspection that the improvements had not been sufficient to meet the regulation. Although audits were carried out on a regular basis and action plans put in place to address any concerns and issues they did not always identify issues of concern. For example, the medicine audits did not identify the issues raised at the inspection.

Systems and processes had been put in place to ensure that infection control risks were managed.

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?

Requires improvement 

The service was not consistently safe.

There were insufficient staff to keep people safe.

Medicines were not administered safely.

Infection control arrangements protected people from risk of cross infection.

Is the service caring?

Requires improvement 

The service was not consistently caring.

Care was not always provided in an appropriate and sensitive manner.

Where people had difficulty communicating staff used non-verbal communication.

People were not always treated with dignity.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

A process for quality review was in place however audits did not identify issues raised in the inspection.

Care records had not been consistently reviewed and updated.

Drovers Call

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Drovers Call on 12 May 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 9 and 11 February 2015 had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service caring, is the service well led. This is because the service was not meeting some legal requirements in relation to those sections.

The inspection team consisted of two inspectors and a Medicines Management inspector.

During our inspection we observed care and spoke with the manager, the operations manager, the provider, a nurse, and three members of care staff, three relatives and two people who used the service. We also looked at four care plans in detail and records of audits and medicines.

We used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk to us. We carried out a SOFI in the downstairs unit.

After our inspection we contacted the local authority who pay for the care of some people living at the home to get their view on the quality of care provided by the service.

Requires improvement

Is the service safe?

Our findings

At our previous inspection in February 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 2010.

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 not made the required improvements.

People did not get their medicines as prescribed. We looked at medication administration records (MARs) for 13 of the people on both units and covered nursing and residential service users. Four of the records we looked at showed that people weren't getting their medicines as prescribed. We found that one person had been out of stock of one or more of their medicines for up to 7 days. This included strong painkillers which were prescribed for regular administration. The person was at risk of being in pain. Another person had not received their inhaler and subsequently suffered with a chest infection.

MARs were inaccurate, for example, records did not consistently record people's allergy status and people were at risk of receiving inappropriate medicines and medicines that they were allergic to. Information about allergies on three identification sheets in the medicine records did not match information on the MAR. The manager provided an allergy list which had been forwarded to the medicines provider however this did not match the MAR or the identification sheets either. People were at risk of receiving medicines which they were allergic to.

We observed the medicine round and saw the nurse went to give medicines to a person and then realised that this was the wrong person. Instead of discarding the medicines they returned the medicines to the medicine pot and gave them to the person for whom they were intended. There was a risk that people received the wrong medicines. There was also a risk that the person receiving the medicines received medicines that had been tampered with.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, [Regulation 12 (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

At our inspection in February 2015 we found there were insufficient staff to safeguard the health, safety and welfare of people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan detailing what action they were going to take to address the breach.

At this inspection some people told us there were not enough staff. They told us, "They [staff] always seem to be short. There can be 10 or 15 minutes when there are no carers in the lounge." Another person we spoke with said, "Sometimes I have to make my bed myself as they don't get round to doing it." They said, "Sometimes the water in the room is not changed for two days."

Staff told us that there were still occasions when there were insufficient staff to provide appropriate care to people. The manager told us that they had increased the number of nurses so that there was a nurse available on both units throughout the day time period which ensured staff received supervision and support. We observed that a nurse was available in both units. They said that the staff numbers had been increased so that the structure on both units was similar and provided appropriate support to staff. However when we carried out observations within the units we observed that there were periods of time when staff were not available to support people. We observed a person called for assistance but this was not provided as there was no one available to support them. Another person required encouragement to drink and this was not available which meant when staff came to clear cups away their drink had gone cold and unfinished.

There was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, [previously Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010].

In February 2015 we found there were insufficient arrangements in place to protect people against the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12.

The manager told us that they had contacted the local authority lead for infection control for advice and was intending to carry out a comprehensive infection control

Requires improvement

Is the service safe?

audit. Cleaning procedures and monitoring had been reviewed. Arrangements were in place for regular cleaning and monitoring of bedrooms and we saw that these were being carried out. We saw that cross infection risks such as uncovered light pulls in communal bathroom areas had been addressed. Domestic staff were able to describe the correct method for cleaning bodily fluids and keep people safe from infection. The Infection Control Policy had been revised to include information about how to deal with spillages of body fluids.

We saw that there were sufficient facilities for hand hygiene. For example hand gel and soap dispensers were available throughout the home and were filled. Hand gel is important for staff to use in order to reduce the risk of cross infection. Staff wore protective clothing to carry out personal care tasks and when serving meals. We observed that staff removed gloves and aprons appropriately. Arrangements were in place to protect people against the risk of infection.

Requires improvement

Is the service caring?

Our findings

At our previous inspection in February 2015 we found that people did not receive care that was appropriate to their needs. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found that appropriate care was provided however it was not always provided in a caring manner and sensitive manner. We saw that people's views and choices were not always respected.

Although staff in the upstairs unit interacted in a positive manner and understood people's communication needs, in the downstairs unit we observed how a person was ignored by staff when requesting support. They were left to attend to themselves which they achieved with some difficulty as they were unsteady and would have benefited from assistance to keep them safe from falling when mobilising.

Staff did not respect people who lived at the service as individuals, referring to people in a general way and making choices on their behalf. For example we a member of staff referred to people as 'they' and did not ask people what they preferred but responded on their behalf. Later in the day we observed that the television was on whilst a game of bingo was taking place. One person complained that they could not hear however this was ignored. On another occasion people were asked what music they would like to listen to however the staff member did not wait for a response or pursue the choice but instead put on music which they said 'they liked'.

Staff did not understand or support people's lifestyle choices for example, one person told us, "The carers can see me sitting in my chair reading from 5:30 in the morning, but I can't get a cup of tea, and I would really like one by about 7am." People and relatives were concerned that staff did not know or understand people's needs, a relative said, "There is not enough familiarity between the carers and those that live here." People told us and we observed that staff knocked on bedroom doors. We saw that staff addressed people by their preferred name and that this was recorded in the person's care record. We observed two people asked for their drinks in a mug and we saw that staff obliged. However, one member of staff told us that they did not give people a choice because they knew what their preferences were. This meant that if the person changed their mind, they wouldn't have the opportunity to make their preference known.

People were not treated with dignity and respect all the time. There was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to access drinks throughout the day as dispensers were available with a choice of juices. One person was asleep when the tea trolley was brought round and we observed a member of staff spend time with them to encourage them to have a drink and ensure that they had what they wanted.

When staff supported people to move they did so at their own pace and safely. We observed that they explained to people what they wanted them to do to assist them and providing encouragement whilst supporting people.

Requires improvement

Is the service well-led?

Our findings

At our inspection on 9 and 11 February 2015 we found systems to assess and monitor the quality of the service to people were not effective. They did not identify or resolve the issues that were identified by people. There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We also found there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were at risk of receiving inappropriate care because accurate records were not maintained

The provider sent us an action plan in which they told us that they would address the issues raised in the inspection carried out in February 2015. However when we carried out this inspection we found that the majority of the issues had not been resolved. The provider had not acted on feedback provided by us following our inspection or carried out audits to ensure that improvements had been made. The manager told us that they had introduced a programme of audits, particularly focussing on the areas of concern. We saw that audits had been carried out on areas such as medicines and infection control and action plans were in place. However, these checks did not always identify the issues we found during our inspection. For example, the medicine audit carried out in April 2015 did not identify issues and gaps regarding reordering of medicines. Additionally we saw where issues had been identified such as the lack of clarification about allergies, action had not been taken to address the gaps.

The manager told us that they were revising the format of care plans. However the provider did not have a process in place to ensure that care plans had been reviewed and rewritten to reflect people's care needs. Two of the care plans we reviewed were for people who had recently come to live at the service and we saw that care plans had not been completed at all. The provider did not have a system in place to check that care plans were in place. People were at risk of receiving inappropriate care as their care needs were not recorded for staff to follow.

There was a breach of Regulation 17 (1) (2) (c) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 [previously regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010].

The home had had four registered managers over the past year, the current manager had commenced in post in March 2015. The manager told us that they felt supported in their role and had access to appropriate resources and support when required.

During our inspection the operational manager and provider were visiting and they told us that

they felt the recent changes in manager had made improvements to the service. They said that they felt the manager was developing systems and processes to address this, for example they had started to have staff meetings again as they had not previously had these on a regular basis. The manager told us that they were attending handovers and making unannounced visits at weekends and out of hours in order to monitor the quality of care.

People we spoke with told us that they would be happy to raise any concerns they had. They said that they would go to the staff and the manager. One person said, "I would speak to the girls." We saw a relatives' meeting had been held on 29 April 2015. As a result of the meeting relatives had requested a meeting with the provider and this had been arranged for 20 May 2015. The manager also held a drop in session on a weekly basis to facilitate access for people to raise concerns and issues. They said they had discussed the recent inspection report with relatives and they were aware of what actions were being taken. One relative told us that they were aware of the report.

The manager told us that they had rearranged the staffing arrangements to ensure that there were sufficient senior staff available to staff for support and advice. Staff said that they were aware of their roles and felt supported in their roles. However although additional staff had been employed we still found evidence of concerns about staffing numbers.

The provider had some systems and processes in place, for example the service had a whistleblowing policy and contact numbers to report issues were displayed in communal areas. Staff told us they knew how to raise concerns about any poor practices witnessed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a breach of Regulation 17(2) c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of receiving inappropriate records because accurate records were not maintained. Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Treatment of disease, disorder or injury	There was a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems to assess and monitor the quality of the service people were not effective to ensure that people received safe care. Regulation 17
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient staff available to provide safe care to people. Regulation 18.

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
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People who use services and others were not protected against the risks associated with inadequate arrangements for the safe administration of medicines. Regulation 13