

# 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



### Overall summary

We carried out an unannounced focussed inspection of this service on 12 May 2015. Breaches of legal requirements were found. After the focussed 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 12 May 2015 we found that the provider was not meeting the standards of care we expect in relation to ensuring that appropriate arrangements for the management of medicines are in place. We undertook this focused inspection on 3 September 2015 to check that they had followed their plan and to confirm that they now met legal requirements with regard to the management of medicines. At our inspection on the 3 September 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](http://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 36 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

# Summary of findings

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.

# 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 not administered safely.

**Requires improvement**



# Drovers Call

## Detailed findings

### Background to this inspection

We undertook an unannounced focused inspection of Drovers Call on 3 September 2015. This inspection was completed to check that improvements to meet legal requirements with regard to the management of medicines, which were planned by the provider after our focussed inspection on 12 May 2015 had been made. The team

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 inspection team consisted of two inspectors.

During our inspection we observed care and spoke with the manager, the operations manager, the provider and a nurse. We also looked at four care plans in detail and records of audits and medicines. We also spoke with the local authority.

# Is the service safe?

## Our findings

At our previous inspection in May 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 not made the required improvements.

People did not get their medicines as prescribed. We looked at medication administration records (MARs) for people on both units and covered people who used nursing and residential services. Four of the records we looked at showed that people were not getting their medicines as prescribed. For example, we found that one person had been out of stock of one or more of their medicines for up to 11 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 medicines for a period of five days because they were also out of stock. People were at risk of their condition deteriorating because they were not receiving their medicines according to their prescription.

One person required Warfarin and we observed from the records that they had not received the prescribed dosage of Warfarin on two occasions in August 2015. On both occasions records showed that they had received more

than the prescribed dose. Warfarin is a medicine which requires careful monitoring and management in order to keep people safe. The person was at risk of significant harm due to the incorrect dose of medicines being given.

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 four identification sheets in the medicine records did not match information on the MARs. One person had recently been discharged from hospital and their discharge letter included a list of medicines to which they were allergic. Whilst a copy of the discharge letter was kept with the MAR this person remained at risk of being given a medicine that they were allergic to as neither the MAR nor the identification sheet listed all of the medicines that they were allergic to. For the remaining three people the pharmacy had printed the wrong allergy on the MARs and the home's staff had failed to notice this. A recent medicines audit carried out on 2 September 2015 did not identify these issues. People were at risk of receiving medicines which they were allergic to.

We observed the medicine round and saw people were administered their medicines safely and appropriately. People were addressed by their name to ensure that they received the correct medicines and staff observed that they had taken their medicines before completing the MARs.

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].

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	<b>Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.</b>
Treatment of disease, disorder or injury	People who use services and others were not protected against the risks associated with inadequate arrangements for the safe administration and management of medicines. Regulation 13