Kirklands Healthcare Limited

Meadow's Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Meadow's Court is purpose built and registered to provide personal care and support for up to 60 adults with physical or age-related care needs. At the time of the inspection the service was supporting 44 people, some of whom were living with dementia.

People's experience of using this service and what we found
People were at risk of serious harm. Medicines storage, administration and management were unsafe. Infection control procedures were not always followed to keep people, staff and visitors safe from the risk of contagious diseases including COVID-19 transmissions.

Risks to people were not always identified, managed or monitored to ensure people were safe and protected from harm. Care plans were not up to date and lacked guidance for staff to provide safe care. Guidance provided by health care professionals was not always clearly recorded or followed by staff. Systems to monitor and review risks to people and their care plans was not effective.

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. Further action was needed to ensure the policies and systems in the service were followed. Systems and processes to protect people from the risk of abuse and improper treatment was not robust.

There were not enough staff to meet people's needs safely. The deployment of staff was not managed. Systems to ensure staff were trained and supported in their roles and were not effective.

The provider did not have robust oversight and audits were ineffective as these failed to identify issues which placed people at risk of harm. Lessons had not always been learnt when things went wrong.

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 rated good (published 6 March 2021). At this inspection the service deteriorated to inadequate.

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The inspection was also prompted in part due to concerns received about risks to people, medicines, infection control, staffing and the management of the service. We decided to inspect and examine those

risks.

This report only covers our findings in relation to the key questions of Safe and Well-Led. 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.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, service users from abuse and improper treatment, staffing and governance and quality monitoring good governance. Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 of the provider's 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Meadow's Court

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.

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
This inspection was carried out by three inspectors on 7 December 2021 and two inspectors and a pharmacist inspector on 8 December 2021.

Service and service type
Meadow's Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and five relatives about their experience of the care provided. We spoke with 15 members of staff including the director, operations manager, a deputy manager, senior care workers, care workers, the chef, house-keeping staff and maintenance staff. We 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.

We spoke with four health and social care professionals who visited the service.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with the GP and the local safeguarding officer.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● Medicines storage, administration and management was unsafe. The medicine room was not always locked when it was not used by staff. Fridge and room temperatures were not monitored to ensure the medicines remained effective when administered. We found liquid medicines, eyes and nasal drops had not been dated when opened, which is important as they only have a short shelf life once opened.

● People did not receive their medicines as prescribed. One person said, "I'm supposed to have one tablet before breakfast but it's always late." The medicine administration records (MAR) was not completed fully or accurately. This meant people's health was put at risk.

● Instructions for time sensitive medicine that needed to be given at specific times of the day and to be taken before food were not followed. Body maps to instruct staff where to apply prescribed topical creams were not in place. Where people received their medicines via transdermal patches applied directly to the skin, there were no charts in place to monitor the application, checks and removal of the patch to reduce the risk of skin sensitivity and irritation. This meant people's health was put at risk.

● Staff did not routinely offer 'when required' medicines to people such as pain relief. The MAR charts had little or no instructions as to how and when medicines were to be administered. There was no evidence to demonstrate the GP had been contacted to clarify the when medicines were to be given.

The provider had not ensured people's medicines were managed and administered safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider has created an action plan outlining the improvements planned. We will assess the impact of this at the next inspection.

● Following the inspection some action was taken to address the urgent risk such as body charts to indicate the site for the application of creams and a rotation chart for transdermal patches. The community nurses took responsibility to administer insulin and injections and the GP was reviewing people's medicines.

Assessing risk, safety monitoring and management

● Risks associated with people's individual care needs and the impact of their health conditions had not been fully assessed. Care plans lacked guidance to enable staff to meet people's needs safely or were out of date.

● People's care was not monitored. People at risk of developing pressure sores needed to be re-positioned every two hours to reduce the risk of skin damage or developing pressure sores. Records showed people were not re-positioned every two hours, for example, there were gaps of more than four hours, which put people's health at risk. People were at risk of poor diabetic support because the care plans did not provide

sufficient guidance for staff to follow. Staff were not aware of the signs or symptoms that would indicate people with diabetes had high or low blood sugar level. There was no information to instruct staff as to the action they should take.

● Care plans were not reviewed in response to changes to people's health or following incidents such as falls. Some care plans had contradictory information about people's eating and drinking. Instructions from the dietitian, about the type of modified food and drink to be provided was not included in the care plan or shared with the kitchen staff. This put people at risk of having unsafe diets.

● Risks to people were not monitored. We observed a person coughing whilst eating a piece of toast. A staff member placed a sick bowl in front of the person but did not check whether they experienced any pain or discomfort. The person's care records showed there had been no previous coughing incident. However, no assessment was carried out to check whether this was a new risk. The senior carer told us a referral would be made to a dietitian but we found no evidence that a referral had been made. This put the person at risk of having unsafe food.

● Staff provided a clear account of the actions they would take to support a person following a fall, which included informing the management. However, incidents and accidents were not always recorded by management. There was little evidence that incidents had been reported to external agencies such as Care Quality Commission (CQC) and the local safeguarding authority. This meant people lives were at risk of harm.

The provider failed to ensure care and treatment was always provided in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider has created an action plan outlining the improvements planned. We will assess the impact of this at the next inspection.

Preventing and controlling infection

● Infection prevention and control measures were not always followed by staff in line with the government requirements to manage the COVID-19 pandemic.

● We were not assured the provider was promoting safety through the hygiene practices of the premises. We saw equipment used in the delivery of personal care, light switches and pull-cords were dirty. Soiled laundry and used continence products were left on the carpeted floor in the corridor. Staff wore watches, jewellery with stones and long-sleeved tops which increased the risk of spreading contagious diseases.

● Relatives told us they followed safe visiting arrangements. However, this was not always the case. We observed vaccination status for visitors were not checked on arrival. There was no area designated to enable a visitor to complete a lateral flow test safely. This meant the provider was not always preventing the risk of spreading infections.

● We were not assured staff used personal protective equipment (PPE) correctly, for instance face masks were worn below the nose or under the chin.

The provider had failed to mitigate risk in relation to infection, prevent and control. This placed people at risk of cross infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has created an action plan outlining the improvements planned. We will assess the impact of this at the next inspection.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured that the provider was accessing testing for people using the service and staff.

Systems and processes to safeguard people from the risk of abuse

● People's needs were not always met in a timely and appropriate way. This had been reported in this

section with examples of not managing known and new risks to people, medicines and unsafe infection control practices. This put people at risk of harm.

● People said they did not always feel safe. One person said, "I use the call bell when I need to use the toilet but have to wait; it gets very uncomfortable when you're desperate for the toilet." Another person said, "Somebody keeps taking my stuff out of my room; clothes and things like that, I have informed staff." There was no evidence that the management team had listened to people's concerns and took action to keep them safe.

● Staff told us concerns about unexplained marks and bruising found on people which they had reported to management but no action had been taken. A staff member said, "[Staff name] completes the incident reports and writes whatever [they] want to write."

● CQC had received concerns about poor quality of care, alleged abuse and concerns that management took no action. We were unable to find records of these incidents due to poor record keeping. We were not assured all incidents had been reported to the local safeguarding authority. Following the inspection we made referrals to the local safeguarding authority in relation to the risks to people that we found.

● Staff gave examples whereby people's liberties were unnecessarily deprived without the appropriate authority. Staff told us concerns were raised with the management about a person who had fallen forward from their wheelchair but no action had been taken. Staff said they used the lap belt to prevent this person from having further falls when being moved in the wheelchair. We found no evidence that a mental capacity assessment or best interest decision had been made to deprive people's liberties. Where people had a deprivation of liberty safeguarding (DoLS) authorised these were not monitored or renewed promptly. This meant people were at risk of abuse and undue restrictions had been placed on their lives.

People were at risk of abuse and having their liberty unduly deprived because robust safeguarding procedures were not followed. 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.

Staffing and recruitment

● People told us there were not enough staff to support them when needed. We heard a person shouting "I want a cup of tea, that's all I bloody wanted." People told us, "Carers are rushed off their feet, there's not enough of them" and "I've had to come out of my room as no-one's brought my lunch and I'm hungry."

● Staff told us the service was regularly short-staffed, which meant they were unable to check on people who needed the regular checks. A staff member said, "Carers are run ragged and domestics have to help because there's no carers about."

● Staff were not deployed effectively and were not given specific responsibilities. At times there were no staff visible in the communal areas when people needed assistance and inspectors had to find staff to assist people seated in the lounge. During the medicine round the senior carer was interrupted several times to answer telephone calls. There was no oversight by management to ensure staff were deployed effectively and responded to people's requests for support and to the call bells. This meant people's safety was put at risk.

● CQC had received concerns about staff training and competence which placed people's safety at risk. Records showed staff training was not up to date and there was no evidence that staff practices and their competence had been checked. This meant people were at risk of receiving unsafe care and support from staff.

We found that there were not enough staff and their training, competence and skills to deliver safe care was not kept up to date. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff recruitment procedures had improved and records confirmed pre-employment and identity checks were carried out. This included a check with the Disclosure and Barring Service which helped to support safer recruitment decisions.

Learning lessons when things go wrong

● The incident and accident reporting system was not robust. These events were not always documented and reported to the local authority and CQC. There was little evidence of investigations to establish the root cause of incidents. People and staff to us further incidents such as falls had occurred but were not always reported to management.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service was not managed effectively. The service had a registered manager. However, the deputy manager and the new operations manager facilitated this inspection. A culture had developed whereby there was a lack of accountability, responsibility and scrutiny at all levels which impacted on people's safety and quality of service.
- Systems and processes to assess, monitor and mitigate risks were ineffective. A range of audits we looked at had failed to identify the issues we found in relation to risks to people, care plans and the guidance for staff to follow. There was a lack of monitoring to prevent further risks to people's health such as developing skin damage. Personal emergency evacuation plans (PEEPs), were not kept up to date, for example, a person's PEEP stated they walked independently despite being cared for in bed and required a hoist to be moved. The medicines audits needed further improvements to ensure checks were carried out on storage, stocks and the administration records to identify gaps or errors. Records were not up to date or stored correctly. For example, completed body maps were found in a folder without an incident report or investigation. There was no oversight or monitoring of safety aspects relating to premises, equipment and fire safety.
- Staff were focused on achieving tasks rather than providing person centred care. Staff deployment was not monitored. We saw staff took breaks when they wanted to with little regard to impact on people. For example, a staff member was not able to clear some spillage on the dining room floor as they were due a break. Medicines rounds took longer because the senior carer administering medicines was expected to answer telephone calls and respond to concerns from staff. There was no management oversight to ensure staff worked effectively.
- The provider did not have a robust system to record and provide assurances that the staff they employed within the service met vaccination requirements as a condition of deployment.
- The system to monitor staff training, their competency and supervision was not effective. Staff induction and training information was not up to date. Staff told us they had not received feedback on their performance. Staff responsible for administering medicines said their competency had been checked. However, we found no evidence to demonstrate staff competence and practice had been monitored and checked. Further awareness training to support people with conditions such as dementia would enable staff to be confident and provide effective support to people.
- There was no system in place to ensure staff supported. Staff morale was low and staff were afraid to speak up. Staff had lost confidence in the management team as no action was taken when safety concerns were reported. Staff told us there were no meetings which meant opportunities to share concerns or to

provide feedback were missed.
● There was no oversight or analysis of incidents, accidents and complaints. Records showed investigations into safeguarding concerns, incidents and accidents were either incomplete or not investigated.
● There was a shift in the culture of the service whereby people were no longer at the heart of the service. There was no formal process to seek people's views about the service. Relatives were happy with the care their family member received. Relatives knew how to make a complaint. One relative said, "We wouldn't wait to report concerns my [relative] would be all over it."

The provider's governance and oversight systems were not robust enough to demonstrate all aspects of the care and the service was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection visit the provider immediately employed an external consultant to help make the required improvements. The provider sent samples of the new audits tools introduced and systems being put in place to improve the quality of care people receive and to enable staff to provide safe care and support. We will continue to monitor this to assess the impact on people at the next inspection of the service.

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 registered manager did not fully understood their responsibility under the duty of candour to be open and honest when things went wrong. Investigations were not always completed. Where an investigation had been completed the correspondence from the registered manager lacked remorse and an apology.
● The registered manager had not always notified CQC about significant events which they are legally required to do so. The newly appointed operations manager assured us they would monitor the quality of notifications to ensure these were sufficiently detailed.
● The previous inspection rating and report was displayed within the service and the provider's website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives said care staff were kind, caring and treated them with respect.

Working in partnership with others
● The service worked in partnership with other professionals such as the GP who conducted weekly visits and community nurses.
● Visiting professionals who visited the service regularly told us the experienced senior carers knew people well and provided information when required. They believed referrals were made appropriately when required and no concerns had been raised about people's medicines or changes in health needs.

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure robust safeguards were in place to protect people from abuse, and the undue deprivation of people's legal and human rights. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not enough staff to meet people's needs. Staff were not deployed effectively around the service. Staff training was not kept up to date, their practice was not checked. Regulation 18 (1)(2)

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	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's oversight, systems and processes to monitor the quality of care and safety were ineffective. Regulation 17 (1)(2)

The enforcement action we took:

We issued a Warning Notice.