Kirklands Healthcare Limited

Meadow's Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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 37 people, some of whom were living with dementia.

People's experience of using this service and what we found
The provider had developed a range of audits following the last inspection but some related to people's care and the management of the service, had not been not fully embedded and were ineffective to drive improvements. There were limited opportunities to seek views about the quality of care provided from people, their relatives, staff and professionals and to influence changes.

Some areas of improvements were found in relation to managing risks to people and plans were in place to review their care needs. However, further improvements were needed to ensure key aspects of people's care were met. Information in people's care plans and the guidance for staff to follow using the handheld devices was inconsistent, limited or not recorded. People's care was not always monitored and there were gaps in daily care records.

People's prescribed medicines were not always administered safely and some medicines processes remained unsafe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, there were no care plans in place to enable staff to support people where restrictions had been placed on their lives. The manager assured us this would be addressed immediately.

Staff recruitment had improved. Most staff had received training for their role such as medicines administration and topics related to managing risks to people, and health and safety. The manager had set dates for staff to complete the required training for their roles to provide effective care. There were enough staff and deployment of staff had improved. However, at busy times of the day people did not always received prompt support from staff.

People told us they felt safe. Staff knew what abuse was and were confident the manager would act on concerns. Safeguarding processes were followed.

Staff followed infection control procedures to keep people and visitors safe from the risk of contagious diseases including COVID-19 transmissions. There was ongoing decorating and refurbishment throughout the service.

Systems were in place to monitor incidents, accidents and falls and these were followed up appropriately. Lessons had been learnt and shared with the staff team when things went wrong and improvements made.

Rating at last inspection and update
The last rating for this service was inadequate (published 28 March 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made and the provider was no longer in breach of some regulations.

This service has been in Special Measures since our last inspection in December 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 6 and 7 December 2021. Four breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve Regulation 13 and Regulation 18. We also served a Warning Notice in relation to Regulation 17 (Good governance).

We undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

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.

This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have identified breaches in relation to people receiving safe care and treatment and governance arrangements.

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.

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 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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always 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 Health and Social Care Act 2008.

This was a focused inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 (Good Governance). We also checked whether the provider had met the requirements in relation to Regulation 12, (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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 two inspectors, a pharmacist inspector 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
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 dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was no registered manager in post. The service had a manager who had started on 7 March 2022. They had begun the process to apply to CQC to be registered.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. This included the provider's action plan which set out their plans how regulations would be met. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with 15 people who used the service about their experience of the quality of care provided. We spoke with 16 members of staff. This included the nominated individual, a director, the operations manager, the manager, senior care workers, care workers, the kitchen assistant, dining room assistant and house-keeping staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. 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 two health care professionals who visited the service.

We reviewed a range of records. This included nine people's care records and 26 people's medicine records. We looked at two staff files in relation to recruitment, and information relating to training, supervisions and meetings. A variety of records relating to the management of the service, including policies and procedures were reviewed.

On 19 April 2022, the Expert by Experience spoke with four people's relatives about their experience of the care provided.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At the last inspection the provider had failed to administer people's medicines safely and risks relating to people's health, safety and wellbeing had not been properly assessed, managed or monitored. This was evidence of a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

Using medicines safely

● Some medicines processes remained unsafe. When people were prescribed a course of medicine such as antibiotics, staff copied the information from the paper medicine administration records (MAR) to the electronic MAR (eMAR) incorrectly. This meant people were at risk of not receiving their medicines as prescribed. There was conflicting information between the paper and the electronic protocols for administering 'when required' medicines such as pain relief. One person's record had conflicting information about whether they could verbalise if they were in pain, which could lead to confusion.

● People's eMARs had additional instructions to support staff to administer time sensitive medicines correctly but these were not followed. For example, where medicines should be given before or after food and prescribed medicines for Parkinson's disease to help with mobility at specific times of the day. This meant those medicines may not be as safe or effective for people. Where people received their medicines via transdermal patches applied directly to the skin, the application site was not rotated as per manufacturer's instruction. This meant people were at risk of receiving unsafe medicines because of thinning skin and developing skin sensitives.

● The electronic devices used for the eMAR system were not locked when staff moved away from them in communal areas. This meant there was a risk that the eMAR could be altered by anyone.

Assessing risk, safety monitoring and management

● Guidance in care plans for staff to follow about how to meet people's care needs had improved, however, further work was needed. Information about people's care needs had been stored electronically but the information available on the handheld devices used by staff was limited. For example, there was no guidance to enable staff to safely how to support a person may become unsettled. Mobility care plans did not provide details of the sling (used to hoist people) or which colour coded loops to be used. This information was found in a separate file. Although a staff member was able to tell us which sling and loops were to be used, the lack of information in the care plans could put people's safety at risk.

● Since our last inspection staff had received some essential training identified by the provider. However,

some staff training had not been updated or completed in topics related to health and safety, record keeping and managing health conditions such as diabetes, continence care and dementia awareness. This meant people were at risk of receiving unsafe and inappropriate care and support.
● People's care was not consistently monitored and care plans were not always followed by staff. Gaps were found in the daily monitoring records. For example, records showed a person at high risk of developing pressure damage had not been repositioned in line with their assessed need. There was limited or no information about how people's health conditions impacted their lives to enable staff to provide effective care. Whilst no one had been harmed these examples demonstrated people were at increased risk of not having their needs met safely.

Medicines administration and management processes were not robust to ensure people received their medicines safely and as prescribed. People's care needs were not effectively managed or monitored which increased the risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely. Senior staff had been re-trained in the administration of medicines and they knew how to monitor for side effects and effectiveness of medicines. The time taken to complete the medicines round had improved. Medicines with a short shelf life such as liquid medicines and eye drops had been dated when opened, to ensure these were effective and safe to use. The eMARs had been completed to confirm people had taken their medicines.
● Action had been taken since the last inspection. People's medicines had been reviewed by the doctor to ensure they were not taking unnecessary medicines. People's care needs and risks had been reviewed.
● Kitchen staff told us and records confirmed they had up to date information about people's dietary requirements. Staff had guidance about how to meet people's care needs, modified diets and the role of staff to support people with eating and drinking.
● Some staff had been trained in managing risks such as pressure area care and choking risks. There were two 'anti-choking devices in the service. Devices such as this are used to remove obstructions in the airways when a person is choking. One device was located in the dining room and accessible in an emergency.
● Information such as individual personal emergency evacuation plans (PEEPS) were held in a central location, so they were accessible in an emergency. PEEPs had been updated and provided a brief overview of the person's health, their ability and the level of assistance required to evacuate in an emergency, and details of any equipment needed.
● There was ongoing refurbishment and decoration of the home. Systems and equipment in the service, were maintained by the maintenance team. These included fire, gas and electrical safety systems, the passenger lift and equipment used for the delivery of care, such as hoists.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. However, there were no DoLS care plans in place to provide staff with information about conditions related to a DoLS authorisation and how these were being met. We raised this with the manager and they agreed to take immediate action.

At the last inspection there were not enough staff, staff training and competence 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

Staffing and recruitment

● People's views about staffing was mixed. Comments included, "There's more new staff and they seem to get on. It's so much better now, thank you," "Staff come when you need them. I still think there are times an extra staff member is needed mainly in the dining room" and "At night-time if I press the buzzer staff don't come in time. There are only two [staff] on at nights there were three."

● Staff deployment had improved but this was not always the case at busy times of the day. People waited in the dining room after breakfast for staff to assist them to move elsewhere. A person's dignity had been compromised as no staff were around to assist them to the toilet. At times there was a lack of person-centred care for instance a staff member supported two people to eat at the same time. This was raised with the manager and they agreed to take immediate action.

● The provider had used a dependency tool to calculate the safe staffing levels, which took account of people's needs and risks. Staff told us and rotas showed there were enough staff on duty. On the inspection day a care worker was absent at short notice and the manager supported staff to meet people's needs as no cover was found.

● Recruitment checks were undertaken on staff prior to starting work. This included references, proof of identity and Disclosure and Barring Service (DBS) checks. DBS checks helps employers make safer recruitment decisions.

● New staff told us they had completed induction training and shadowed experienced staff until they were assessed as competent.

At the last inspection the provider had failed to protect people because infection prevention and control measures were ineffective. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection in relation to infection prevention and control.

Preventing and controlling infection

● The exposed wooden handrails we identified in the lift remained a risk of cross-contamination. The manager took immediate action and sent photographs following inspection visit that showed the handrails had been made safe.

● Staff were not always swift to manage spillages such as drinks and bodily fluids in the dining room. A CQC team member told staff about a spillage, and a wet floor sign was placed on the floor until the area was cleaned. Although no one was harmed, prompt action to manage spillages promoted people's safety.

● The home was clean and equipment used for the delivery of care were clean and stored safely.

● There were PPE stations and foot operated clinical waste bins throughout the service. We observed staff putting on and taking off PPE safely and regularly sanitising hands.

● The provider had made improvements to ensure visitors were prevented from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was re-admitting people returning from hospital safely.

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

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives told us they felt safe visiting their family member.

At the last inspection the provider had failed to protect 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

Systems and processes to safeguard people from the risk of abuse
● People felt safe with staff and the care provided. One person said, "There's more new staff and they seem to get on; no arguments or bickering. We've got lovely staff looking after us." A relative said, "My relative is as safe as they can be because the [staff] there are looking after them."
● The provider had systems in place to safeguard people from abuse including safeguarding and whistleblowing policies and procedures. Staff had received safeguarding training, knew what abuse was, how to report abuse and protect people from further risks of harm and abuse. Safeguarding concerns were reported to the CQC and the local authority and records showed appropriate action was taken to protect people from further risks.

Learning lessons when things go wrong
● A system was in place to record all accidents, incidents and falls. These were regularly analysed by the manager to identify any trends or patterns so that changes were made to reduce the risk of recurrence. Staff told us and records showed learning from events had been shared with staff.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection the provider's governance and oversight systems failed 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.

At this inspection enough improvement had been made to meet the Warning Notice but further improvements were needed and the provider remained in breach of Regulation 17.

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

- Since the last inspection there were several changes in the management structure. The service did not have a registered manager. A manager had started on 7 March 2022 and was knowledgeable about how to perform their role. They had begun the process to apply to CQC to be registered. We will continue to monitor this.
- People and relatives told us there had been changes in management but not everyone knew who the manager was. Relatives said, "I'm not sure who the manager is, I tend to go to [name] senior carer," and "I've seen the new manager, they seem to be good and helpful."
- Since the last inspection the provider had used external consultants to develop systems and processes to monitor all aspects of the service. The provider told us they no longer used those consultants, but the schedule of audits still referred them conducting some audits.
- The oversight of staffing and deployment was not monitored to ensure people received support without delay. The emergency call logs showed staff had not always responded promptly. We could not be assured if any action had been taken as the audit was completed at the end of the month. This meant people had been at increased risk of harm because the monitoring of emergency call response time was ineffective.
- The provider had developed a range of audits following the last inspection but these were not fully embedded and a lack of scrutiny made some audits ineffective. There were no checks to ensure the care plans accessed via the handheld devices were in place and accurate and monitoring records were not completed fully. For example, fluid charts showed on some days people did not have enough to drink. The lack of oversight increased the risks to people receiving inappropriate and unsafe care. There were extensive medicines audits but lacked effective scrutiny as the issues we found during the inspection had not been identified on these audits. This meant the audits were not a correct reflection that the administration and management of medicines was safe, which put people at risk of harm.

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's care plans were not consistently personalised to enable staff to provide person-centred care. Decisions made about how people wished to be cared for were not always recorded.

● Relatives told us they were not always aware of reviews or kept informed about any changes to their family member's health or concerns. One relative whose family member lives with dementia told us they were not told about a recent fall or medical appointments. This was shared with the manager and they took immediate action.

● Records showed some staff had not completed the essential training identified by the provider. There were no formal meetings planned with all staff whereby the provider could share updates and information about any changes planned in the home. This meant opportunities for staff to influence changes and share ideas were limited.

● There were limited opportunities for people to give feedback on the service and quality of care provided. People told us no residents' meetings had been held. Some people had completed surveys but opportunities to seek views from relatives of people living with dementia or those with communication needs were missed.

The provider's oversight systems and processes had not been fully embedded to effectively monitor and mitigate risks to people's safety and provide a safe service. The lack of management oversight of people's care and record keeping placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The culture within the home had improved. We received positive feedback about the staff and management. Staff understood their responsibility and were committed to caring for people and improved teamwork.

● The manager had oversight of all departments through daily meetings and records confirmed this. Staff felt supported and they said, "Staff morale is much better - before we were rushing around, it's now organised, not so stressful, its calmer" and "[Manager] is lovely, really nice person and wants to hear if there's a problem and will sort it out."

● People told us they were happy and comfortable with staff who treated them with kindness and respect. One person said, "A lot more things happen now which is good, though I'm quite happy watching and knitting, though I do enjoy hand massage and having my nails painted."

● Provider's policies and procedures had been updated and were accessible to staff

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 last inspection report and rating was displayed in the home and on the provider's website.

● The provider had notified CQC about events they were required to do so by law. This is so we can check appropriate action has been taken.

● A system was in place to monitor incidents, accidents, safeguarding concerns and complaints. Records showed historical complaints had been investigated and actions taken were recorded. The manager told us they had not received any complaints and described the actions they would take if a complaint was received. This included a full investigation, and actions would include an apologise to people, if things went wrong. The manager was responsive feedback and took immediate action to promote people's safety.

Working in partnership with others

● Staff continued to work in partnership with health care professionals involved in monitoring and providing

care and treatment to people.

● We received positive feedback from the local authority who monitors people's package of care, about the improvements made to people's safety. A healthcare professional spoke positively about staff knowledge about people's needs and engagement with the multi-disciplinary team.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines administration and management processes needed further improvements to ensure people received their medicines safely and correctly to remain effective. People's individual care needs were not effectively managed or monitored which increased the risk of harm. Regulation 12 (1) (2) (a) (b) (c) (g)

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 had not been fully embedded to effectively monitor and mitigate risks to people's safety and provide a safe service. The lack of management oversight of people's care and record keeping in respect of people's care needs placed people at risk of harm. Regulation 17 (1) (2) (a) (b) (c) (e) (f)