Kirklands Healthcare Limited

Meadow's Court

Inspection report

Old Church Street
Aylestone
Leicester
Leicestershire
LE2 8ND

Tel: 01162248888
Website: www.kirklandscaregroup.co.uk

Date of inspection visit:
26 January 2023
27 January 2023
30 January 2023

Date of publication:
25 April 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Meadow's Court is a purpose built home, 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 home was supporting 45 people, some of whom were living with dementia.

People's experience of using this service and what we found
The provider's governance systems continued to fail to ensure people's care in relation to their medicines, support and documentation was accurate and up to date. Quality assurance systems had failed to ensure people were supported by trained and well supported staff. There were limited opportunities for people and their relatives to provide feedback on the quality of care provided.

There was a lack of consistent leadership at the home. The service did not have a registered manager, though the provider had appointed a manager who had started on 16 January 2023.

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

People did not always have care plans and risk assessments in place which reflected their changing needs and gave staff clear guidance on how to meet these.

People were protected from potential abuse and avoidable harm. 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.

People were supported by safely recruited staff. People were supported by enough staff to meet their needs in a timely way.

People lived in an environment that was clean and hygienic. Staff followed infection prevention control measures to ensure the risk of infection was managed. There was ongoing refurbishment and decoration. The health and safety of the environment, premises and equipment was maintained.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 20 May 2022). 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 the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive

inspections.

Why we inspected
We carried out an unannounced focused inspection of this service on 14 April 2022. Two 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 relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this unannounced focused inspection to check whether the provider had met the requirements for Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection was also prompted in part due to concerns received about management of risks to people, medicines, staffing and the management.

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 remained requires improvement based on the findings of this inspection.

We have found evidence that the provider still needs to make improvements 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.

Enforcement and Recommendations
We have identified continued breaches in relation to safe care and treatment and governance oversight systems at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor the provider's 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?

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 Health and Social Care Act 2008.

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 an inspector, a specialist 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. Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post since 16 January 2023 and had not yet applied to be registered.

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. This included the provider's action plan which set out their plans to meet the regulations. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 17 people who used the service about their experience of the quality of care provided. We spoke with 5 people's relatives and a visitor. We made observations of how staff supported and communicated with people. We spoke with 12 members of staff. This included the nominated individual, a director, the operations manager, the manager, senior care workers, care workers, 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 spoke with one visiting professional who visited the service. We reviewed a range of records. This included 10 people's care records and 16 people's medicine records and medicine care plans. We looked at 4 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.

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 requires improvement. At this inspection the rating has remained the same. 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.

Using medicines safely

At the last inspection the provider had failed to administer people's medicines safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and further action was still needed. Therefore, this was a continued breach of Regulation 12.

● Medicines management remained unsafe. People's controlled medicines, which required additional controls due to their risk of misuse or abuse, were not stored securely. Liquid medicines, eye drops, and topical creams only have a short shelf-life once opened. People's liquid and topical medicines were not dated once opened by staff. This placed people at risk of receiving medicines that were no longer in date and safe to use.
● People's medicines records were not stored safely as the electronic medicine administration record (eMAR) devices were not locked when staff moved away from them in communal areas. This meant people's eMAR could be altered by staff not administering these medicines. This placed people at risk of harm.
● People did not always receive their medicines as prescribed. Staff did not always follow the medicines policy or people's care plans when administering medicines. For example, we saw a staff member had left the medicines for a person to self-administer their medicines. However, this person had not been risk assessed as safe to take their medicines without staff supervision. This meant the person was at risk of not taking their medicines as prescribed.
● Guidance for staff about administering prescribed 'when required' medicines needed additional details. Protocols lacked information about the desired outcome or the signs to look for where a person was unable to express pain verbally. One member of staff described in detail how and when to administer these medicines. However, the lack of guidance for staff increased the risk of people not receiving their medicines when required.
● Medicines were not always administered correctly. For example, we observed a person received their medicines disguised in water without their knowledge (known as covert administration). There was no best interest assessment and this person had full mental capacity. This was raised with the operations manager who told us the person had capacity. They assured us this practice would be investigated and ensure staff administered medicines correctly.
● Where people received medicines via a patch (applied directly to the skin), staff did not consistently document where these had been placed on people's body. We could not be assured staff rotated the

application site as per manufacturer recommendations. This placed people at risk of deterioration in their skin condition.

The provider had failed to ensure people's medicines were administered safely. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took immediate action to mitigate risks in relation to medicines. This included ensuring the protocol for 'when required' medicines for one person was put into place, controlled drugs were stored securely and planning a full audit on medicines.

Assessing risk, safety monitoring and management

At the last inspection the provider had failed to assess, manage or mitigate risks to people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and further action was still needed. Therefore, this was a continued breach of Regulation 12.

● Risks to people were not always kept under review and care plans did not provide up to date guidance for staff to follow to mitigate those risks. For example, one person had experienced numerous falls but their risk of falling was not reflective in their records.
● People and relatives were not always involved in discussions or decisions made about how risks would be managed. One person said, "I have never seen my care plan never in 4 years." Another person said, "I know I have [care plan] as they tell me I do, I am diabetic but I have never read my care plan. They control that."
● Guidance for staff around people's care needs was not kept up to date. For example, a staff member told us a person's whose health had deteriorated and was at risk of choking and their eating and drinking was poor. The person's care plan had been reviewed on 16 December 2022 and still made reference to the person eating independently, having a normal diet and preferring to eat 'finger food'. Not having up to date guidance for staff placed people at increased risk of harm of choking.

The provider had failed to protect people from the risk of harm because risks were not effectively managed or monitored. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from some people and relatives about the care and support provided by staff was positive. One person said, "They help me well with my medication, they are kind and helpful." One relative said, "[Name] was given [walking] frame to walk, has a sensor mat placed next to their bed at night and knows how to use the call bell."
● People lived in a safe environment. Personal emergency evacuation plans were in place and up to date. There was ongoing refurbishment of the home. Regular checks were completed in relation to health and safety, fire safety, equipment and water monitoring in relation to the risk of legionella.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of their role and responsibility to protect people from the risk of abuse. A staff member said, "It means protecting people from abuse, sexual, neglect, finance. I have to report it to my senior, make the person safe and write a statement about it." Staff training records showed most staff but not all had

completed safeguarding training. This was raised with the operations manager, and they assured us training was being monitored.
● People's views about feeling safe was mixed. One person said, "I feel safe here, they (pointed at staff member) make me feel safe." However, others did not feel safe. They said, "I am not safe at night, people come into my room, and I do not know them, that is not good" and "I am not safe here, some of the people (pointed at other people) get angry and shout."
● Safeguarding procedures were followed when incidents had occurred. This included reporting to the local authority, police and the Care Quality Commission. Records confirmed investigations were completed and actions taken to mitigate further risks.

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 not fully working within the principles of the MCA and appropriate legal authorisations were in place to deprive a person of their liberty. Where people had conditions related to DoLS authorisations, those were not fully met. For example, staff did not always record incidents and staff responses to comply with one person's DoLS conditions. This was raised with the operations manager and they assured us this would be investigated and addressed. We have written about this further in the well-led section of this report'

Learning lessons when things go wrong
● A system used to record all accidents, incidents and falls had been analysed by the operations manager to identify any trends and to reduce the risk of recurrence. Records showed a reduction in incidents and when required referrals had been made to relevant health care specialist such as dietitian. Staff were unable to tell us if lessons were learnt as staff meetings were not consistent or reliable.

Staffing and recruitment
● There were sufficient staff to meet people's needs. We observed staff responded to people in a timely manner. However, feedback from people and relatives was mixed. A person told us, "There are more staff now, that is good". A relative told us, "The biggest problem is [my relative] having to wait to go to the toilet, there have been times at night when this is more than an hour." We looked at the call bell log and found no evidence staff were not prompt in responding to call bells.
● Staff told us there were enough staff to support people living at the home. Rotas showed staffing was stable and absences were covered by existing staff, or when required, agency staff were used and worked with permanent staff.
● Staff were recruited safely to the service. Recruitment practices were thorough and included pre-employment checks from the Disclosure and Barring Service (DBS) prior to starting at the service. A DBS check provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● The environment, including furnishings and equipment were found to be clean and hygienic.

● We were assured that the provider was preventing visitors from catching and spreading infections. We observed cleaning staff on duty and completing tasks expected of them.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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
● People were supported to receive visits from relatives and others in line with current government guidance with regards to COVID-19.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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

At the last inspection the provider's oversight systems and processes had not been fully embedded to effectively monitor the quality of the service and a lack of management oversight of people's care and record keeping. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and further action was still needed. Therefore, this was a continued breach of Regulation 17.

● People and their relatives did not know who the manager was. One person said, "The manager has changed so much, you can ask but I am not sure the staff know what's going on."
● There was a continued lack of effective leadership. The service did not have a registered manager. Care staff relied on the senior staff and the deputy manager. The operations manager provided remote support and visited the service though were not part of the staff rota. The provider had appointed another manager who had started on 16 January 2023. However, they were not fully aware of the day to day management of the home.
● The provider failed to effectively monitor the quality and safety of the service. The provider audits identified some shortfalls but not the issues we found during our inspection. For example, medicines audits were not robust because they failed to identify medicines were not stored safely, opening dates for medicines with short shelf-life were not recorded and there were discrepancies in the medicines stock. Staff told us they did not always check whether topical creams had been applied to people by care staff but had documented on the audits they had done so. This placed people at risk of harm.
●There was a lack of oversight of people's care. For example, staff were aware of new risks to people, but the risk assessments and care plans had not been updated. This meant were people were at risk of receiving inconsistent and unsafe care.
● There was a lack of scrutiny in relation to records and record keeping. The management audit failed to identify missing information and poor record keeping. For example, the eMAR and paper protocols for 'when required' medicine for one person was missing. The management audit had failed to identify staff had stopped recording incidents since 5 November 2022 to comply with the DoLS conditions, which required staff to maintain a record of the incident and staff response. This placed people at risk of harm.
● Management oversight and support for staff was not effective. For example, daily 'flash meetings with

heads of departments and manager walkabouts' did not take place as the service had no manager for some time. Records showed staff training was overdue but there was no evidence of actions taken to address this. Staff told us and records showed staff meetings and supervisions also did not take place. This meant systems to support staff was not robust.
● The system for learning lessons was not always reliable. The provider's action plan set out their plans to how they would improve the medicines management and risks to people and how that would be monitored. The provider recruited new staff who worked with the existing staff but the issues we found at this inspection were found at the previous inspections. This meant the provider had not followed their action plan and did not have an accurate overview of what was happening in the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff did not always respect people and promote their wellbeing. For example, staff did not address people by their preferred names but instead called them, "sweetheart" and "darling."
● People were not always aware of their care plans nor had been involved in the review of their care. Care records viewed confirmed this. This placed people at risk of not receiving personalised care and support that reflected their preferences and diversity.
● The provider had failed to ensure residents' meetings took place regularly. One person said, "I have been to the meetings, but nothing changed, I can't notice any difference." This meant people were not at the heart of the service as there was no evidence they could influence how the service provided.

The provider's oversight systems and processes required further improvements to effectively monitor and mitigate risks to people's safety. The lack of leadership and management oversight of people's care placed increased the risk of harm. There were limited opportunities for people and staff to give feedback on the service. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Policies and procedures had been reviewed and kept up to date. The provider's business continuity plan detailed how people's needs were to be met in the event of an emergency.
● Systems were in place to monitor the health and safety within the home, incidents, accidents, safeguarding concerns and complaints. Records showed these were investigated and actions taken when required.

Working in partnership with others
● The visiting professional feedback was mixed. They expressed concerns around the lack of consistent leadership and not all staff were familiar with the needs of people and support they required. They found the care plans reflected people's preferences and needs.
● Records showed and staff told us they worked with the local authority and health care professionals when people's needs changed to ensure their continued needs were met.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People shared some of their positive experiences. People told us they took part in daily activities and games, which they enjoyed. One person said, "I was involved in the interview of staff, they listened to me and that made me feel valued." People told us they enjoyed the choice and quality of meals including culturally appropriate meals. One person told us they were able to speak with some staff in their preferred language which was not English.
● New staff told us they were completing their induction training but had not received any supervision or

their practices checked. This was raised with the operations manager. They said new staff were not supervised during their probation, however, they assured us meetings to review staff progress would be developed to reduce risks to people.

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

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people were protected from risk of harm because medicines management and administration was not safe and risks were not effectively managed or monitored. Regulation 12(1) (2) (a), (b), (g)

The enforcement action we took:

We issued a Warning Notice.

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 required further improvements to effectively monitor and mitigate risks to people's safety. The lack of leadership and management oversight of people's care placed increased the risk of harm. There were limited opportunities for people and staff to give feedback on the service. Regulation 17 (1) (2) (a), (b) (c) (e) (f)

The enforcement action we took:

We issued a Warning Notice.