

Littlemoor Care Home Limited

Littlemoor House

Inspection report

70 Littlemoor
Chesterfield
Derbyshire
S41 8QQ

Tel: 01246563150

Date of inspection visit:
12 September 2023

Date of publication:
25 October 2023

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Littlemoor House is a residential care home providing personal care to up to 5 people. The service provides support to older people and people with a learning disability. At the time of our inspection there were 5 people using the service.

The home has a communal lounge, dining room and kitchen. Bedrooms are set over 2 floors.

People's experience of using this service and what we found

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting underpinning principles of "Right Support, Right Care, Right Culture".

Right support: Safe recruitment processes were not established and carried out. Pre-employment checks, to ensure staff had the correct skills, knowledge, and characteristics for working with vulnerable people, were not always carried out properly. The provider had not ensured they had the required information available about each member of staff.

Amendments were needed to people's care plans to demonstrate how people were being enabled to have maximum choice and control over their lives as restrictions had not always been consented to and recorded.

Risks to people from the environment were not always assessed and managed. Mould and damp were found in 2 bedrooms and cleaning schedules had not been effective at removing surface mould. Chemicals were not always stored safely. The environment required redecoration and refurbishment, for example paint was peeling from the walls in 1 bathroom and door threshold strips were loose.

Right care: Medicines were not always managed safely. Protocols were not clear for staff applying creams and there were no records of where the creams had been applied. We recommended the provider undertake a review of their medicines management systems and processes to improve storage and medicines protocols.

People did have a personalised package of care. However, the provider was not able to demonstrate how they were ensuring people's human rights were maintained alongside a number of restrictive practices that were in place.

End of life care information in people's care plans concentrated on people's wishes after they had died and

there was no information on how people wished to be supported before they died.

Right culture: The provider was not aware of the inspection criteria for services supporting people with a learning disability or autistic people. Governance systems were not robust, and audits did not cover all areas of the service. Information from audits was not analysed or used to make improvements to the service. Records were not always maintained. For example, people's money had not been recorded from February 2023 to September 2023. The service had not received any complaints and the registered manager told us minor concerns raised by people who used the service or their relatives were usually dealt with, however these were not recorded. We recommended the provider reviewed the complaints procedure in line with Regulation 16 of the Health and Social Care Act. Consideration had not been given to how the service would meet the underpinning principles of right care right support right culture. However, staff received specific training to support people with a learning disability.

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. The policies and systems in the service did not support this practice.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection:

The last rating for this service was good (published 08 December 2017).

Why we inspected

This inspection was prompted by a review of the information we held about this service.

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.

Enforcement

We have found breaches in relation to consent, maintenance of the premises and governance of the service at this inspection.

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 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 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 safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement 

The service was not always effective.

Details are in our effective findings below

Is the service caring?

Good 

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Details are in our well-led findings below.

Littlemoor House

Detailed findings

Background to this inspection

Inspection team

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

The inspection was carried out by 2 inspectors 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

Littlemoor House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both 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 a registered manager in post.

Notice of inspection

We gave the service 24 hours notice of the inspection. This was because it is a small service and we needed to be sure that a member of staff would be available to support the inspection.

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. 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 used all of this information to plan our inspection.

During the inspection

Inspection activity started on 12 September 2023 and ended on 20 September 2023. We visited the service location on 12 September 2023. We spoke with 3 people who used the service and 1 relative about their experience of the care provided. We spoke with 4 members of staff including the registered manager, deputy manager and care workers.



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 good. At this inspection we have rated this key question 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.

Using medicines safely

- Medicines were not always managed safely.
- Protocols were not always clear for staff about administering medicines which were 'as and when required' (PRN). Staff relied on their own knowledge of residents to administer these correctly. For example, protocols did not detail where creams needed to be applied and records did not show where these had been applied.
- Medicine storage was not always secure and organised. For example, medicines including paracetamol and an inhaler were found in the office in an unlocked drawer. We recommended the provider undertakes a review of their medicines management systems and processes to improve storage and medicines protocols.
- However, people were supported to take the medicines they were prescribed. Staff helped people with their medicines at the right time and people said they were able to get pain relief when needed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Environmental risks were not always assessed and managed.
- Two occupied bedrooms were damp and areas of green mould had built up on the walls and ceilings. Prolonged exposure to high levels of indoor dampness can reduce lung function and cause chronic health problems. One person living in this environment had a history of respiratory health conditions, and this meant they were at increased risk of infections.
- We found 3 door threshold strips were loose creating a trip hazard. These had not been identified by the registered managers checks.
- Lessons had not always been learnt and opportunities had been missed to fix maintenance issues. For example, the registered manager told us they were aware of the mould and damp 2 years ago. Repairs to the roof at the time had not resolved the problem and not enough action had since been taken to fix the problem.
- Chemicals were not always stored safely. For example, a bottle of bleach was found in a communal bathroom and the registered manager told us this should have been locked away. This meant hazardous chemicals were accessible to people.□
- The registered manager responded during and after our inspection, securing chemicals, instructing a damp specialist and offered an alternative room to one person whilst works were completed. This meant we were assured environmental were being addressed.
- People's records contained information about identified risks to their safety and wellbeing and what staff should do to manage these risks to keep people safe.

Systems and processes to safeguard people from the risk from abuse

- There were appropriate systems and processes to enable staff to respond to suspected abuse. However, processes to ensure staff were safe to work with people using the service were not in place. Please see next section for details.
- People told us they felt safe at Littlemoor house. Staff knew how to look out for signs of abuse and how to act upon any concerns they might have. Staff told us, they had completed safeguarding training and would know how to report abuse if they saw it. One staff member told us "I would report to the manager".

Staffing and recruitment

- Recruitment was not always safe. Safe recruitment processes were not always followed to ensure staff employed were of suitable character.
- Suitable pre-employment checks had not always been carried out. For example, checks including reviewing gaps in people's employment history and interviews were not always completed.
- The provider had undertaken DBS checks for staff working in the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- There were enough staff to meet people's needs.

Preventing and controlling infection including the cleanliness of premises

- We were not always assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- The schedules in place for cleaning were not always effective as we found some areas of the home required better cleaning.
- We were assured that the provider was preventing visitors 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 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 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.

We have also signposted the provider to resources to develop their approach.

● Visiting in care homes

People were supported to have visitors and maintain contact with their friends and families.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

- The service was not always working within the principles of the MCA.
- Restrictions were placed on people without recorded consent. For example, the kitchen door was locked overnight preventing access to food and drink for people.
- People were restricted from accessing certain items such as e-cigarettes and personal snacks. People were compliant with these practices and the registered manager explained why they had been implemented; however people's consent had not been recorded in their care plans.

Consent was not always recorded for decisions which placed restrictions on people. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

- The environment required redecoration and refurbishment. For example, paint was peeling from the edges of the walls in 1 bathroom
- The registered manager told us decorators had been planned to attend, however, they had not been able to due to the pandemic. The registered manager had not re-arranged for this to happen.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- An assessment of needs was completed before a person moved into the home by the registered manager.
- People's diverse needs were considered during the assessment process. This included support required in relation to their culture and lifestyle choices.
- People told us about their day to day lives, we also found this information recorded in people's care plans which provided guidance for staff to follow to ensure people's needs and choices were met. However,

people's human rights were not always maintained due to a number of restrictive practices that were in place as above.

Staff support, training, skills and experience

- Staff were trained effectively to meet the needs of people in the home. Staff had the skills and knowledge they needed to support people.
- Staff felt supported in their role and completed induction training when they started work at the home. Staff also completed annual refresher training and specific training to support people with a learning disability.
- Staff received regular supervision meetings with the registered manager.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat meals to maintain a balanced diet. People's nutrition and hydration needs were recorded in their care plans. These included their preferences towards meal choices.
- People's food was stored correctly. Staff knew how to properly handle food as they were trained to do so.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's records showed they accessed support from healthcare professionals.
- People attended appointments with GPs, opticians, and other health professionals. For example, one person told us how staff supported them at health appointments.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection we have rated this key question good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported to regularly attend groups and pursue hobbies and interests. However, 1 person told us they wanted to access a religious group they had previously attended prior to the pandemic. There was no evidence to show the person had been supported to do this.
- People and relatives told us staff were kind and caring. One relative said, "Staff are really nice there and [Person] gets along with them." Staff had developed positive relationships with people, and we observed friendly and warm interactions.
- Staff received training in equality and diversity and mostly understood how to apply this training in the support they provided.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to maintain independence with health and care where they could. For example, one person told us how staff supported them to attend health appointments.
- Care plans contained information about people's personal relationships, and the support staff were to provide to ensure people's individual needs were met.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and respect. Staff formed trusted relationships with people and those who were important to them such as relatives.
- People's care plans detailed the importance of ensuring people received support that respected people's privacy and dignity.
- Staff encouraged and supported people's independence. For example, people were involved in planning, shopping and tasks around the home.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People were not always supported to express how they would like to be cared for if they were to approach the end of their life.
- The information in people's care plans concentrated on people's wishes for after they had died, rather than information about how they wished to be supported before they died.
- The registered manager told us they planned to request support from social workers to have conversations with people about care at the end of their lives.
- However, staff knew people well and understood how people wanted to be supported in general day to day care.

Improving care quality in response to complaints or concerns

- There were no recorded complaints. The registered manager explained complaints were usually 'minor' and dealt with but not always recorded.
- The registered manager had a policy for complaints, when we spoke to people and a relative told us they knew how to complain. One relative told us, "I would speak to the manager." And one person told us, "I would speak to one of the staff."

We recommended the provider reviewed the complaints procedure in line with Regulation 16 of the HSCA.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The service was meeting the AIS. Staff communicated with people in a way they understood. Information was provided in formats that met people's individual communication needs.
- People's communication needs were detailed in their care plans and any support required to ensure these were met.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant

- People were supported to participate in their chosen social and leisure interests on a regular basis. For example, people were accessing the community on the day of the inspection visit for shopping and a meal.
- Staff told us friends and relatives could visit the home freely. Relatives also confirmed this.

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 good. At this inspection we have rated this key question 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.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Governance systems and processes were not robust in monitoring the quality of the service. For example, audits had not identified information missing from people's care plans in relation to restrictions.
- The registered manager had not maintained up to date records for people's finances. The last recorded entries were February 2023. The registered manager did not have a running total of money they held for people and records were not audited. This meant people were at risk of financial abuse.
- The provider had not kept adequate records in relation to recruitment, as required by law. We found this information was not always available.
- The provider did not collate any findings from audits to analyse or share them with the staff team. This meant opportunities were being missed to improve the service.
- Lessons had not always been learnt and opportunities had been missed to fix maintenance issues in relation to mould and damp reported in the safe section of this report.
- The provider had not always sought feedback from people, relatives, and staff.
- The last surveys were completed in 2019. This meant the provider could not show where actions had been taken in response to people's feedback.
- The home had a business contingency plan. The service was reliant on the registered manager for cover and specific daily needs such as access to money and cover. There was no contingency plan for the absence of the registered manager.
- The provider was not aware of the existing risks of closed cultures within the service and was not familiar with right support, right care, right culture.

The provider's systems were not robust enough to demonstrate safety was effectively managed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff meetings took place regularly. Staff told us they were kept up to date with regular information and updates relating to the home.
- Staff told us the registered manager was approachable.

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 was aware of their obligations for submitting notifications to CQC, as required by law.
- The provider understood their responsibility to provide honest information and suitable support in line with the duty of candour.
- The provider displayed a ratings poster in the home.

Continuous learning and improving care; Working in partnership with others

- The registered manager worked in partnership with other health and social care professionals including social workers and the local GP.
- The provider was in contact with other managers of similar services to share knowledge. The provider told us during the inspection they intended to invite managers from other homes to undertake some quality audits in the home.

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 11 HSCA RA Regulations 2014 Need for consent Consent was not always obtained and recorded for restrictive practices.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems and processes were not robust.