Regal Care Trading Ltd

Le Moors

Inspection report

285-289 Whalley Road
Clayton le Moors
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Tel: 01254871442

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

Le Moors is a residential care home which provides accommodation and personal care for up to eight adults. Support is aimed primarily at younger adults with a learning disability or autistic spectrum disorder, but the service also supports people with a physical disability, sensory impairment and people living with dementia. Accommodation is provided over two floors, with a lift providing access to both floors. At the time of the inspection five people were living at the service.

People's experience of using this service and what we found
We found that at the time of the incident (see below for further information), people had not always received safe care and treatment. People's dietary risks and needs had not always been managed safely, staffing levels had not always been appropriate to meet people's needs safely and staff had not always completed the training necessary to keep people safe. There had also been a lack of effective management and oversight at the service.

During this inspection, we found that since the incident, improvements had been made to the management of people's dietary requirements. Care documentation included up to date information about people's dietary risks and needs and the staff we spoke with were familiar with how people should be supported with eating and drinking to keep them safe. People were receiving an appropriate diet, which reduced their risk of choking. Staffing levels were appropriate to meet the needs of people living at the service. Staff had completed the training necessary to keep people safe if they required emergency assistance, including if they were choking. Management arrangements at the service had improved. The provider's representative visited the service regularly and checks and audits were being completed regularly, to ensure appropriate standards of quality and safety were being maintained.

Staff wore appropriate personal protective equipment (PPE) to ensure people were protected as much as possible from the risk of cross infection. Staff had received training on how to put on and take off PPE safely. Enhanced cleaning was being completed throughout the day, to ensure the home remained clean and the risk of cross infection was reduced. There were clear processes in place for visitors to the service. Due to the national lockdown, only essential visitors, such as health professionals, were allowed to enter the home at the time of our inspection. The provider was supporting people to stay in contact with family and friends through regular video calls and telephone calls. The manager was in the process of planning how visits would take place once lockdown restrictions were eased.

Rating at the last inspection
The last rating for this service was Requires improvement (published 28 February 2020).

Why we inspected
CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key

question.

This targeted inspection was prompted in part by notification of an incident following which a person who lived at the service died. The information CQC received about the incident indicated potential concerns about the management of people's dietary needs and risk of choking. Concerns were also indicated about staffing levels, staff training and managements arrangements at the service. This inspection examined those concerns.

During this inspection we found evidence that improvements had been made by the provider since the incident. We found no evidence at the time of the inspection that people were at risk of harm from these concerns.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question as requires improvement. We have not reviewed the rating at this inspection because we have only looked at the parts of the key question that we had specific concerns about.

Le Moors

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 3 February 2021 and was announced. We gave a short period of notice to ensure the manager would be available and to request some information in advance of our visit.

The inspection was prompted in part by notification of an incident, following which a person who lived at the service died. This incident is separately being reviewed and as a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of people's risk of choking. In addition, potential concerns were indicated about staffing levels, staff training and management arrangements at the service. This inspection examined those concerns.

As part of this inspection we also looked at the infection control and prevention measures in place. This was so that we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice that we can share with other services.

Inspection team
This inspection was carried out by one inspector.

Service and service type:
The service 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. However, during this inspection we only looked at information about the potential concerns related to the incident.

The service did not have a manager registered with the Care Quality Commission (CQC). The registered manager had left in December 2020, and a new manager had taken over the day to day running of the home. The new manager planned to apply to become the registered manager of the service. The registered

manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did before the inspection
We reviewed the information we had received about the incident, including the statutory notification received from the registered manager, care documentation, the incident report and police statements.

What we did during the inspection
We reviewed additional documentation, including one person's care plan, risk assessments and dietary assessment, records of people's meals and drinks, and accidents and incidents records. We observed people's lunchtime experience, to ensure they received meals and drinks which reflected their dietary needs and risks. We spoke with the manager, the deputy manager, a manager from one of the provider's other homes who was supporting the manager, and a support worker. We were unable to gain feedback from people living at the service due to their complex needs.

What we did after the inspection
We reviewed additional information received from the provider, including staffing rotas, staff training records and policies and procedures.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question that we had specific concerns about.

At this inspection we reviewed information relating to concerns about a specific incident, following which a person living at the service died. The information we received about the incident raised potential concerns about the management of people's risk of choking. We also reviewed staffing levels, staff training and management arrangements at the service. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

● At the time of the incident, people's dietary requirements were not always managed appropriately. People's eating and drinking care plans did not always include up to date information about their risks and needs, which meant that staff were not always aware of how to support them safely. People were not always provided with a suitable diet. Staffing levels were not always sufficient to meet people's needs. Staff had not always completed the training necessary to keep people safe if they needed emergency support. At that time, management arrangements at the service were not always effective, as they had not identified the issues relating to the management of people's dietary risks, staffing levels and staff training.

● During this inspection we found that improvements had been made to the management of people's dietary risks and needs. People had been assessed by a speech and language therapist (Speech and language therapists provide support for people who have difficulties with communication, eating, drinking and swallowing). Following the assessment, care plans and risk assessments had been updated appropriately to reflect people's existing risks and needs. Staff we spoke with were aware of people's dietary risks and needs and were following the eating and drinking support plan that had been put in place. Records of people's meals showed they were receiving an appropriate diet, which resulted in a reduced risk of them choking. People were provided with appropriate meals during our inspection. Processes were in place to ensure staff were kept up to date with any changes in people's dietary needs and risks.

● Staffing arrangements had improved. Records showed, and staff told us, that there were enough staff on duty each day to meet people's needs safely.

● The provider had made improvements to staff training. Records showed that since the incident, staff had completed online training in first aid, nutrition and dysphagia (swallowing difficulties), and face to face training in first aid was scheduled to take place in March 2021.

● Improvements had been made to management arrangements at the service. The new manager had been in post since December 2020 and was familiar with people's needs, as she had worked at the service for over a year, as a support worker and then deputy manager. A manager of one of the provider's other homes was visiting Le Moors twice a week to support the new manager with becoming familiar with management processes, audits and checks. The provider's representative was also visiting the service monthly to further support the manager and to ensure people were being supported well. Regular audits and checks were

being completed to ensure that appropriate standards of quality and safety were being maintained.

Preventing and controlling infection

- 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 promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.