Dove Care Homes Limited

Littleport Grange

Inspection report

Grange Lane
Ely Road, Littleport
Ely
Cambridgeshire
CB6 1HW

Tel: 01353861329

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20 July 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good

Summary of findings

Overall summary

Littleport Grange is registered to provide accommodation and non-nursing care for up to 59 people. There were 46 people living in the home at the time of the inspection. The building has three floors, a cinema room and a hairdressing salon and spa room.

We carried out an unannounced inspection on 21 August 2015 and we rated the home as good.. After the inspection we received concerns in relation to people being safe and receiving the care and support they require. As a result we undertook a focused inspection on 20 July 2016 to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Littleport Grange on our website at www.cqc.org.uk"

At the time of the inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations
about how the service is run.

People were receiving their medicines as prescribed. Staff had completed training and assessments in the administration of mediation to ensure that they were competent. Risk assessments had been completed to ensure that, where possible and appropriate, risks to people were minimised. Staff were aware of the procedures to follow if they thought someone had suffered any harm.

The CQC is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was acting in accordance with the requirements of the MCA including the DoLS. The provider could demonstrate how they supported people to make decisions about their care and the principles of the MCA were being followed.

There were enough staff on duty to ensure that people had their needs met in a timely manner. Staff received the support and training that they required to carry out their roles effectively.

People were provided with the food and drink that they chose and enjoyed. Relevant healthcare professionals had been involved to ensure that people received the support they needed with eating and drinking. People's healthcare needs were being met and when required people had been referred to the relevant healthcare professionals.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of the procedures to follow if they suspected someone may have been harmed.

Staff were following the medicines administration procedures. People received their medicines as prescribed.

Action had been taken to assess and minimise risks to people's safety.

Staffing levels were sufficient to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff were acting in accordance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards.

Staff were supported and trained to provide people with care that met their individual needs.

People had access to a range of healthcare services to support them with maintaining their health and wellbeing.

Littleport Grange

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Littleport Grange on 20 July 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out because we had received concerns in relation to people not being safe and not receiving the care and support they required. We inspected the service against two of the five questions we ask about services: is the service safe and is the service effective.

Before our inspection we reviewed the information we held about the service including notifications the provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about. We contacted local authority commissioners and healthcare professionals that had contact with the service to obtain their views about the service.

During our inspection we spoke with four people who lived at Littleport Grange. We also talked with the registered manager, the deputy manager and two senior care assistants. We looked at the care records for three people. We also looked at records that related to health and safety. We looked at medication administration records (MARs). We observed how the staff supported people in the communal areas. Observations are a way of helping us understand the experience of people living in the home.

Good

Is the service safe?

Our findings

We undertook this inspection because we received concerns that people were not always safe. Concerns were raised about the administration of medicines, people being placed at risk of falls and insufficient staffing levels to meet people's needs.

People told us they felt safe in the home. One person told us, "I feel safe here because there are a lot of staff about."

We checked all recorded accidents and injuries for the month of May 2016. We found that staff had recorded accidents and incidents in line with the provider's policy. For example staff had recorded any bruising or wounds people had on specific body charts to show the location and size of the injury. The accidents and injuries were raised with the registered manager so that they could be analysed and any patterns could be identified. We saw that accidents and incidents had been investigated and any action necessary to minimise the risks had been agreed and recorded. This included any learning for staff or adjustments to the care and support people received. This reduced the risk of an incident occurring again.

However we found one chart that the registered manager was not aware of and no explanation had been given as to how the bruising had occurred. Staff were able to tell us how they thought the bruising had occurred (due to equipment that had been used by the person), however this had not been recorded. The registered manager stated that she would ensure that all the reasons for any bruising was recorded in future so that appropriate action could be taken to minimise it from happening again.

People told us that they always received their medicines as prescribed. Staff told us, and records confirmed, that they had completed an administration of medicines training course and had also completed a competency assessment before they could administer medicines unsupervised. The registered manager stated that staff completed either refresher administration of medication training or a competency assessment each year. We observed part of a medication round and saw that the correct procedures were followed. The staff member asked each person if they would like their medicines and explained what they were for. People's care plans recorded how they preferred to take their medicines and this was followed. Guidance for staff to follow when people were prescribed medicines on an "as required" basis was available. We checked that the stock levels of medicines tallied with the medication administration chart for six people. We found one anomaly, however the deputy manager said this was thought to be a recording issue.

People were supported by a staff group that knew how to recognise when people were at risk of harm. Staff told us, and records we saw, confirmed that staff had received training in safeguarding and protecting people from harm. Staff were knowledgeable in recognising signs of potential harm. They were able to tell us what they would do if they suspected anyone had suffered any kind of harm. Staff told us where they could find the contact numbers if they needed to report any incidents to the appropriate agencies about any safeguarding concerns.

Risks to people had been assessed, and action had been taken, to reduce risks whilst still minimising the

restrictions placed on each person. For example, one person had fallen several times when they had become distressed that they would not get to the toilet in time. They had tried to walk there without the required assistance from staff to keep them safe. Staff had recognised this and had assisted the person to sit in an area where they could see the toilet and this had helped them to relax and reduce their anxiety and therefore reduced the number of falls they experienced. We also saw that when concerns had been identified by staff about people at risk of developing pressure ulcers, action had been taken to minimise this from happening.

We saw that there were enough staff to keep people safe. One person told us, "There's always enough staff around. The longest I have to wait is five minutes to have my call bell answered." We observed that staff had time to sit and talk to people. The registered manager stated that staffing levels were based on the needs of the people who lived at Littleport Grange and that when needed staffing was increased. Staff and people confirmed this. During times of staff absence the hours were covered by other members of the staff team, or if needed, agency staff. The registered manager checked the training and qualifications of agency staff before they commenced working in the home. This meant that there were sufficient numbers of staff working with the knowledge, skills and support they required to provide care to people accommodated at the home.

Good

Is the service effective?

Our findings

We undertook this inspection because we received concerns that people were having their liberty restricted without the correct procedures being followed and that people's health needs were not always met.

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 Act 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that where applicable capacity assessments had been completed. When best interest decisions had been made these had been recorded. When needed DoLS applications had been submitted to the relevant authority. This meant that people were only having decisions made on their behalf, or there liberty restricted, after staff had followed the correct procedures.

People received support from staff who had received training which enabled them to understand the specific needs of the people they were supporting. New staff and existing staff were expected to complete the Care Certificate (a nationally recognised qualification). The registered manager stated that staff were required to complete the provider's mandatory training, which included safeguarding, health and safety and first aid. Staff told us that the training programme equipped them for their roles. The training record showed that all staff were either up to date with their mandatory training, or this training was scheduled to take place. Staff were being encouraged to work set objectives as teams for them to accomplish which would improve the service. The registered manager stated that this had helped staff reflect on their own work and make suggestions for areas of growth.

People were supported to maintain a healthy diet. One person said, "The food is nice. You can ask for more and you're given it." We saw that people were supported to eat their meals when necessary. If needed, people had been referred for eating and drinking assessments to see what support they required with their food and drink. When people were at risk of malnutrition we saw evidence that they were being monitored regularly and had been referred to a dietician. For those people that needed it, their food was fortified to provide extra calories. We observed lunchtime and found that people were offered choices of food and drink. When people were not eating the meal they were provided, they were offered an alternative. We saw that feedback was given to the registered manager from the cook when people had not eaten their meal. This meant people could have their dietary needs monitored and minimise the risk of malnutrition.

Records showed people had regular access to healthcare professionals and had attended regular appointments about their health needs. Discussion with staff showed that when they had any concerns about a person's health this was responded to quickly and the appropriate healthcare professional was contacted. During the inspection one person stated that they didn't feel well. Staff monitored the person's blood sugar level and contacted the GP for advice. Records showed that district nurses visited the home regularly to provide people with nursing care such as dressing any wounds.