Ashamber Homes Limited

Amber House - Didcot

Inspection report

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31 January 2017

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Ratings

Overall rating for this service	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Amber House on 31 January 2017. The inspection was unannounced.

Amber House is a care home for up to six people who have been discharged from hospital and who require care, support and accommodation for mental health issues. At the time of our inspection four people were using the service.

There was a registered manager in post. 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.

We carried out an unannounced comprehensive inspection of this service on 23 August 2016 and found breaches to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations (2014).
After the last inspection on 23 August 2016, we took enforcement action and issued a warning notice. We asked the provider to take action to make improvements in relation to the management of incidents and accidents and in relation to notifying the commission about important events.
This inspection in January 2016 was to check they had met the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to good governance.

We also checked they had met the legal requirements of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations (2014), which relates to notifying the care quality commission of notifiable events.

Since August 2016 the provider had improved their practices in relation to maintaining a complete and accurate record of accidents and incidents within the home. Incident and accident forms were accurate and enabled the service to monitor the ongoing quality and safety of the care being delivered.

Since August 2016 the provider had also improved their practices in relation to notifying the Care Quality Commission of notifiable events that occurred within the service.

Staff and the registered manager shared the visions and values of the service and these were embedded within service delivery. The service had systems to assess the quality of the service provided. Learning from audits took place which promoted people's safety and quality of life. Staff spoke positively about the registered manager.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Good

The service was well led. Records relating to incidents were accurate and complete.

The registered manager of the service had informed the Care Quality Commission of reportable events.

The registered manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

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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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 January 2017and was unannounced. The inspection was carried out by one inspector.

We spoke with two people, two care staff and the registered manager. We reviewed records relating to the management of the home. Prior to the inspections we spoke to commissioners of the home to get their views on the service is run.

Before the inspection we reviewed previous inspection reports, the action plan that was sent to us following the last inspection and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Good

Is the service well-led?

Our findings

At our inspection on 23 August 2016 we found further concerns in relation to record keeping. We noted that incident forms did not always contain information on what steps had been taken by the service following incidents. Without accurate records the provider could not assure themselves of the quality and safety of the care being delivered. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.We took enforcement action advising the provider they must make improvements to meet the legal requirements by 9 January 2017.

At this inspection on 31 January 2017 we found that the service had made significant improvements to address this. Accidents and incidents records were accurate and complete. For example, the incident report form used by the service included completed sections which the service captured important information on whether the incident was 'investigated by the home's manager' and 'what remedial action has been taken to remove the hazard or prevent recurrence'. Learning from incidents also took place. For example, following an incident with a person's medication the registered manager put in place medication refresher training for staff.

The service had introduced 'reflective practice' sessions. This enabled staff to share their thoughts, feelings and any learning from incidents in order to improve the service. For example, during a reflective practice session a staff member had raised concerns relating to what actions they could have taken if the incident had of resulted in harm to the person involved. This in turn made staff question there competencies in relation to dealing with this in the unlikely event that harm occurred. Therefore the registered manager revisited staff competencies in relation to first aid training and arranged for further training to take place.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. At our previous inspection on 23 August 2016 we found that the service was falling to report safeguarding incidents to the Care Quality Commission. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations (2014).

Since our last inspection we found the service had made significant improvements to address this and had notified the CQC of reportable events. For example, the service had raised a safeguarding concern with the CQC and the local safeguarding team. This was in line with our published guidance. This confirmed that the registered manager had recognised their duty under the regulations to report serious incidents to the CQC.

Services are required to display their most recent ratings on their website and at the provider's principle place of business. Ratings of the July 2015 inspection were displayed at the location of the service. However, we noted at our inspection on 23 August 2016 that the most recent ratings were not displayed on the service's website. Both the manager and area manager gave their reassurances that this would be addressed within 21 days of the August inspection. During our inspection planning for this inspection we noted that the rating was displayed on the website.

Staff spoke positively about the registered manager. One member of staff told us "He keeps us motivated".

Another said "I have learnt so much from him".

There was a positive and open culture in the home and the manager was available and approachable. People knew who the manager was and we saw people and staff approach and talk with them in an open and trusting manner.

The manager told us that their visions and values had not changed since our last inspection and for the home to continue, "To support a positive culture and promote the wellbeing of the service users. To respect their wishes and the choices they make. It's also about ensuring people are treated with the dignity and respect they deserve". Throughout our visit we observed staff displaying these values.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One staff member we spoke with told us "(People) are the most important thing in all of this and if I felt they were at risk then I would have no problem in reporting it, and saying it as it is".

Regular audits were conducted to monitor the quality of service. These were carried out by the registered manager and the provider. Audits covered all aspects of care including, care plans, risk assessments, finance, infection control and the day to day management of the service. Learning from these audits was used to make improvements. For example, following a recent finance audit the service highlighted that it needed to carryout regular reviews on people's property to ensure that the service had a full inventory of what belonged to people.

The service worked in partnership with visiting agencies and had links with GPs, the pharmacist and mental health professionals. For example, we noted that following a concern that the service had about a person they arranged a meeting for all professional involved in this person care to attend and discuss further plans that needed to be put in place to support this person's welfare.