Emerald Care Ltd

Amber House - Coventry

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 15 January 2015. Since that inspection we received a concern in relation to how the risks associated with people's care were managed. As a result we undertook a focused inspection on 25 January 2016, to check whether people were safe.

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

Amber House is a small residential care home which provides care and support to a total of 15 people who live with dementia. At the time of our visit, 13 people were living at the home.

The service has a registered manager. 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.

A relative and staff told us people were safe living at the service.

Staff were trained in safeguarding adults and understood how to protect people from abuse.

Risks associated with the care provided to people who lived at Amber House at the time of our visit, had been assessed and action taken to minimise the risk.

Incidents and accidents had been documented in detail, and the provider had taken action to reduce the risks of identified incidents re-occurring in the future.

There were sufficient numbers of staff on duty both day and night to meet people's needs.

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 is safe.

There were sufficient staff to meet people's needs. Staff had a good understanding of people's care needs and how to keep people safe. The provider learned from accidents and incidents and took steps to reduce the risks of incidences re-occurring.

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Detailed findings

Background to this inspection

We undertook an unannounced 'focused' inspection of Amber House on 25 January 2016. This inspection was undertaken in response to a concern received, about how the risks associated with people's care, were managed.

The team inspected the service against one of the five questions we ask about services: is the service safe? The team consisted of an inspector and an inspection manager.

Prior to our visit to the service, we spoke with the local authority commissioners (people who fund the care of people who use services), the police and safeguarding social workers. We looked at information received from the provider. We also reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

During our visit, we spoke with one relative, two care staff, and the care manager. We looked at three care records, incident and accident records, complaint records, and we observed care provided to people.

Good

Is the service safe?

Our findings

This inspection was undertaken in response to a concern received about how the risks associated with people's care were managed.

Relatives of people who used the service told us people were safe. One relative told us the service was "definitely" safe. They went on to tell us, "I am very happy with the care and attention [person is getting]."

There were sufficient numbers of staff on duty to keep people safe. There were three care staff on duty from, 7.30am to 9pm; and two care staff on duty from 9pm to 7.30am with a member of the management team on-call to support if required. The registered manager or care manager, cook and domestic staff were also on duty during the day. Staff told us there were enough of them to meet people's needs. A member of staff told us if they needed additional support they could call on any member of staff to help them because all had received training considered essential to meet people's health and safety needs (for example, moving people and infection control training).

The manager told us that although there were enough staff available to meet people's needs, they were reviewing the number of staff on duty during the evening. This was because staff had identified a particularly busy period between 9pm and 10pm and arrangements were underway to provide an additional staff member during this time. This was to ensure there were sufficient numbers of staff available to monitor people and keep them safe, when other staff were providing personal care.

Staff understood their responsibilities to keep people safe. Staff told us they had received training in protecting adults from abuse and knew how to raise concerns. They understood the different types of abuse and how to recognise them. Staff told us what action they would take if any form of abuse was suspected. For example, a member of staff said, "If I saw a member of staff shouting, I would intervene, and inform the manager, it is not acceptable." The registered manager was aware of their responsibilities to report concerns to the local authority safeguarding team, and had notified any safeguarding concerns to us at the CQC.

The registered manager learned from accidents and incidents that occurred in the home. We were aware a serious incident had recently occurred at Amber House. We saw there had been 'lessons learned' from this incident, and parts of the premises made safer as a consequence. We also saw documentation in relation to safety checks undertaken by the staff team had changed to reflect additional safety checks which were now in place. Staff we spoke with had a good understanding of this.

At the time of our visit, people who lived at the home were protected from risks associated with their care. We looked at a sample of people's risk assessments and spoke with staff about how they minimised risk. Risk assessments clearly identified the risks people had associated with their care and how staff should minimise these risks. For example, one person was at risk of falling and their care record gave staff detailed information about how this risk could be minimised.

Staff had a good knowledge of risks relating to people's care. For example, we asked staff how they would

reduce the risks of a person's skin being damaged if they were cared for in bed. Staff told us they would regularly re-position the person to take pressure off the person's skin. They told us if they found any reddened areas of the skin, they would call the district nurse for further advice.

A small number of people were cared for in bed and regular checks were undertaken on these people. Staff completed records to confirm these checks had taken place. These included checks that brakes were on the hospital style beds once staff had completed care tasks, so there was no risk of the bed moving and putting people at risk. And, for people at risk of falling out of bed, the record also asked staff to confirm that the bed had been lowered and 'crash mats' put in place for people at risk.

The provider demonstrated for us, a new electronic monitoring system which identified the name of the member of staff entering a person's bedroom, and the time they entered and left the room. They expected this, alongside the written records would provide highly accurate accounts of the care provided to people.

We looked at the risk assessment of the premises. This gave detailed information about what any risks were, and the precautions to take to reduce risk. Whilst this covered most of what we could see were potential risks, we noted that there was a fire door on the first floor of the building which opened out to external stairs as a means of escape. The provider had taken practical steps to minimise risks by having an alarm on the door to alert staff if it was opened by a person who lived at the home, and by painting the external stair case yellow, to aid people's descent of the stairs. However, this had not been included in the premises risk assessment. Once we had identified this omission to the manager, it was quickly rectified and a risk assessment put in place.