Notting Hill Housing Trust

Conrad Court

Inspection report

1-78 Conrad Court
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London
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Tel: 02038152105

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23 June 2017

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Conrad Court provides personal care for people living in self-contained flats. At the time of the inspection the service was supporting 42 older people, people with mental health needs and people with a learning disability.

At our last inspection in May 2015 the service was rated as 'Good'. At this inspection we found the service remained rated as 'Good'.

The service had a registered manager in post at the time of the inspection. 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 remained safe. Staff continued to protect people from abuse and managed identified risks . There were staff in sufficient numbers to keep people safe and they had been recruited by the provider using robust procedures to ensure they were appropriate to deliver care.

People continued to be supported by trained and supervised staff. People were treated in accordance with the Mental Capacity Act 2005. People were supported to eat healthily and to access the services of health and social care professionals whenever they needed to.

People told us the staff continued to be caring and treated them with respect. People were supported to maintain relationships and their independence. Staff respected people's privacy and provided people with information about the service.

People continued to receive a service that was responsive to their assessed and changing needs. People were supported to remain active and to avoid social isolation. The provider gathered people's views to improve the service and responded promptly and appropriately to people's complaints.

The service continued to be well led. People and staff thought the registered manager was approachable and open. The service had robust quality assurance processes in place and the provider worked collaboratively with others to achieve positive outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good..	**Good**

Conrad Court

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 is 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 20 and 23 June 2017. The provider was given 48 hours' advance notice because the location provides a domiciliary care service within an extra care setting and we needed to ensure the registered manager and staff were available. This meant the provider and staff knew we would be visiting the service before we arrived. The inspection was undertaken by one inspector and one 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.

Prior to the inspection we reviewed the information we held about Conrad Court including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We asked the provider to complete a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information in the planning of the inspection.

During the inspection we spoke with six people, five staff and the registered manager. We reviewed 12 people's care records, risk assessments and medicines administration records. We reviewed seven staff files which included pre-employment checks, training records and supervision notes and the minutes of four team meetings. We reviewed the service's fire safety records including records of fire alarm tests, building evacuation drills and the visual inspection of smoke detectors and fire equipment. We read the provider's quality assurance information, including audits, and looked at complaints and compliments from people and their relatives.

Following the inspection we contacted seven health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

The service continued to be safe. One person told us, "I am very safe here. The staff are what makes me feel safe, they are always available." Another person told us, "I have never felt unsafe or anything like that"

People were protected because staff were trained to prevent and detect abuse. Staff delivering care and support to people received regular training to provide them with the skills to identify abuse and to take action if they suspected it. Staff we spoke with told us they would report any safeguarding concerns to the registered manager immediately. Safeguarding concerns were raised by the provider with the appropriate authorities in a timely manner. The provider cooperated with authorities to ensure investigations were thorough and people remained safe.

People's safety was enhanced because staff understood the provider's whistleblowing policy. Staff told us that whistleblowing was the practice of informing external agencies such as the local authority or the Care Quality Commission (CQC) if they had unaddressed concerns about people's safety or wellbeing. One member of staff told us, "If the manager didn't take action to stop abuse then I would be on the phone to head office or a social worker." Another member of staff said, "I would be following company policy if I reported the company to CQC if there was bad practice going on. I've never seen any and I hope I never will."

People were protected from the risk of avoidable harm. Staff assessed people's risks. Where risks were identified the registered manager ensured that risk management plans were in place to reduce the possibility of people coming to preventable harm. For example, people at risk of pressure ulcers were supported to apply barrier creams to vulnerable areas, maintain their personal hygiene and remain hydrated throughout the day. Where people were at risk of falling, staff had guidance in care records to reduce the possibility. For example, one person's care records stated, "Staff to encourage [person's name] to keep their flat free of clutter to avoid any trips." Another care record stated, "[Person's name] should not attempt to transfer unless they feel well enough or confident to do so." People wore pendant alarms to alert staff in the event of a fall. One person told us, "I have an emergency buzzer around my neck, I have only had to use it once, but the response was so quick, it's very reassuring." When required people received input from health and social care professionals to reduce risks. This input was recorded in care records and risk management plans were jointly reviewed.

The registered manager ensured there were enough staff available to keep people safe. People told us that they felt reassured by the number of staff on duty. One person told us, "The staff are always about just in case and I just generally would say that I feel safe here." Another person told us, "There are enough carers on duty most of the time, it can get short but that is very rare and it doesn't feel unsafe if that does ever happen." Staff we spoke with told us that the rota they were given by the registered manager allowed them sufficient time to meet people's needs as stated in their care plans.

People were protected against the risk of unsuitable staff. The provider followed safe recruitment processes. This began with an application and interview to select candidates who had the required skills, knowledge and attitude to deliver care and support. Successful candidates were vetted. This involved confirming the

identities, addresses, work histories and visa status of prospective staff as well as checking their details against criminal records and databases of people barred from working with vulnerable adults. Once employed by the provider, staff completed a six month probationary period during which time the registered manager monitored their performance and confirmed they were suitable to deliver care to people. This meant the provider's recruitment processes were safe.

People continued to receive their medicines safely. One person told us, "Staff have never made any errors or missed a medicine time or anything like that." The registered manager maintained a record of staff who were trained to administered medicines to people. These staff had completed their competency assessments for the handling of medicines and subsequent medicines refresher training. Staff signed medicine administration record (MAR) charts to confirm that people had taken their medicines as prescribed. The registered manager checked MAR charts regularly. Where people did not require the support of staff to take their medicines this was reflected in care records. For example, one person's care records noted that a person used their inhaler independently and appropriately when required.

People were supported within a safe environment. The registered manager and staff undertook daily, weekly and monthly health and safety checks. These included checks of people's flats, the door entry system, emergency lighting and fire escape routes. Contractors undertook lift maintenance checks and tested electrical wiring. Staff maintained a readiness to keep people safe in the event of an emergency by carrying out fire drills which involved evacuating the building.

People who smoked were supported with risk assessments to reduce the risk of fires in their flats.
Each day staff updated the occupancy list for the service. This meant that emergency services could be immediately informed if any person was unaccounted for following an evacuation.

People were protected from the risk of infection. People told us the service was clean. One person said, "It is a very clean environment here. They have domestics come by every day and they are very nice people too, just like a hotel but with carers." Another person said, "It's very clean here, spotless actually." Staff supporting people with their personal care wore personal protective equipment (PPE). PPE included gloves, aprons and shoe covers. These were plastic items which staff used once and disposed of, to prevent the risk of cross contamination.

Good

Is the service effective?

Our findings

People continued to be supported by skilled and knowledgeable staff. One person told us, "I would say the staff here know what they are doing. They seem to be very on the ball in terms of assisting with people's physical health and all of that. They are very competent." Another person told us, "Staff seem to have a good training regime and seem to work as a team." The registered manager tracked the training staff undertook to ensure that refresher training was completed. This meant staff skills were up to date. New staff received two weeks induction training after which they shadowed experienced colleagues as they provided support to people. This ensured that new staff had the skills and confidence to deliver care independently."

People received care and support from supervised and appraised staff. The registered manager used supervision sessions to discuss people's changing needs with staff and set tasks and targets for staff. For example, staff were set the task of updating individual people's records. Whilst Staff used supervision sessions to state the support they required. For example, one member of staff identified training they required. Additionally, the registered manager carried out group supervision meetings for staff. Group supervisions placed an emphasis on learning and practice. Records were retained of group supervision for staff who could not attend to read later. Group supervision meetings were used to guide staff practice. For example, discussion included the importance of keeping accurate care records and a discussion about the symptoms of and support for Parkinson's disease. The registered manager arranged awareness weeks for staff at which time articles, posters and a folder were made available to staff to improve their knowledge in subjects including falls prevention and dementia. Staff received two appraisals each year. Appraisal meetings were used to evaluate staff performance and agree on a staff development plan.

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 and hospitals 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 people were supported in line with legislation. People were supported with assessments of their mental capacity when required. Where people lacked capacity they were supported with best interests meetings. For example, one person was supported with a best interests meeting to discuss and agree a medical procedure. Where people were no longer able to manage their finances, the service supported them with a referral to the court of protection. The court of protection makes decisions about people's finances and welfare where they lack capacity. No people at the service were subject to DoLS.

People were supported to eat healthily. The support people required to eat was stated in care records. For example, one person's care records said, "I want the carer to remind me to go to lunch because sometimes I forget or don't realise it's lunchtime." Where people did not require support to eat this was reflected in care records. For example, one person's care records stated, "I do not need any supervision to eat my lunch."

People had regular and timely access to healthcare services. One person told us, "I am able to go to the G.P.I can go whenever I want when I have an appointment. The staff help out with that." Another person told us, "I have a lot of hospital appointments, the staff support me in making travel arrangements and ensuring that I attend by reminding me, as sometimes the appointments can slip my mind." Details of people's health appointments were retained in their care records. For example, health checks for people with diabetes included dates and outcomes from diabetic eye screening, foot care and blood tests. This meant records reflected the support people received to staff healthy.

Good

Is the service caring?

Our findings

Conrad Court continued to be a caring service. One person told us, "The staff are very caring"
Another person said, "I really get on with most of them… I am very happy with the staff here and I am happy to be here."

People were supported to maintain the relationships that mattered most to them. People were supported to maintain contact with relatives by phone and in person. People told us that guests were made to feel welcome. People at the service had developed friendships. Friends visited each other's flats and attended social activities together in communal areas.

People were encouraged to be independent. People's care records noted the support people required to maintain their independence. For example, some people required support to dress whilst others could do so independently. Care records noted that one person had been supported by staff and healthcare professionals to become independent in checking their blood sugar level. The provider also promoted self-organisation among people. For example, people were supported to arrange movie nights at the service. These took place in a large seated area in front of a large TV. Staff supported the event with refreshments and posters to advertise it but the film selection, planning and screening was organised successfully by people independently.

People were provided with information. The provider gave people service user guides. These contained useful information including an explanation of extra care, the process of moving in and settling into Conrad Court, how support is planned and people's rights. There were several notice boards in the service which informed people about activities, staff and to whom concerns can be relayed.

People's privacy was respected. People told us that staff respected their privacy. One person told us, "[Staff] always knock on the door instead of just walking in and are very patient people." Another person told us, "They treat me with respect." Care records promoted people's wishes regarding their privacy. For example, one person's records stated, "I do not like any supervision at night unless I am on antibiotics. Another person's care records stated, "I like to know in advance if there are any planned visits from staff." People gave staff signed permission to enter their flats in the event of an emergency. This agreement to beach people's privacy was in order to keep people safe if staff had concerns about people's safety or wellbeing. The permission form was retained in care records.

Good

Is the service responsive?

Our findings

The service people received remained responsive to their individual needs. People continued to have their needs assessed and staff continued to have guidance in care records as to how people preferred to have their needs met. People received their care and support at agreed times in line with their assessed needs and care plans. This included times for medicines, personal care, meal preparation, cleaning and laundry.

People's changing needs continued to be identified, monitored and met by the service. Where people's needs changed staff took action. For example, one person was reported to experience breathlessness when using their walking stick. Staff responded by making a referral to a healthcare professional who assessed the person's mobility needs. Following the assessment and acting on its recommendations, staff supported the person to use a wheeled walking frame that contained a fold down seat for the person to sit on and rest as they required.

Care records provided staff with information about people's preferences for how their care and support should be provided. Care records noted when people were 'early risers'. Staff had guidance in care records on the support that people required when they woke early in the morning. For example, one person's records noted, "I wake up early each day. I like to get up as early as 4am in the morning. I like staff to make me a cup of tea before personal care." Where relatives met aspects of people's care this was stated in care records. For example, one person's care records noted that a relative prepared their meals. Another person's care records confirmed that a relative supported their financial matters.

People's mental health needs were supported. Staff had guidance in care records to identify if people's mental health needs were increasing. Guidance included the behaviours which staff should be alert to. For example, refusal to take medicines and reduced attention to personal hygiene. Where people may experience anxiety, staff had guidance in care records identifying triggers. Triggers are situations or events which can cause people to become anxious. Knowledge of people's triggers enables staff to support people's anxiety. For example, one person became anxious when meeting strangers. Staff supported the person's anxiety by being present when they met others, such as health and social care professionals, for the first time. The Mental Health Foundation organised weekly meetings for people at the service entitled 'Standing together'. These forums gave people the opportunity to share their experiences and feelings.

The provider took action to reduce people's risk of social isolation. An activities coordinator post was recruited to during our inspection to support people with structured group activities and individual person centred activities. People's hobbies and interests were noted in care records. For example, one person's care plan noted their interests in knitting and reading. Another person's care plan stated, "I enjoy swimming." We found people were supported with a range of activities. These included arts and crafts, movie nights, reminiscence sessions and dancing. The service had a therapy room where people could receive massages. Yoga sessions took place in the same room. Additionally activities took place outside of the service. For example, one person was supported to go to a coffee house whilst another person visited a Japanese art exhibition. People were supported to explore information technology. Staff supported people to access community based resources which provided people with IT skills. This resulted in people joining online

communities including Facebook where they interacted with others.

The provider continued to gather people's views about the service they received. People were supported to attend monthly tenants meetings. These meetings were also attended by the registered manager and a housing manager and were used by people to share their views about support, housing issues and to plan activities. Examples of issues discussed at tenants meetings included, plants and lighting in communal areas, the intercom system, karaoke, menus and a memorial evening for a person who had lived at the service. Additionally, the provider undertook quarterly surveys of people's views to establish their levels of satisfaction with the care and support being provided. These surveys were compared to enable the provider to measure changes in levels of people's satisfaction and identify actions to improve the service people received. The provider maintained a file containing the compliments of people and their relatives. This information was shared with staff to highlight and encourage good practice.

The provider continued to address people's complaints appropriately. Where people raised complaints the registered manager sent a written letter of acknowledgement to the complainant. We found that complaints were responded to in writing and people were given the outcome of the investigation in a timely manner.

Good

Is the service well-led?

Our findings

The service continued to be well-led. One person told us, "The manager is very active, busy and a very positive person. You can go and ask her for advice or for anything and she will help you in anything that she can. She is visible." Another person told us, "The manager is very nice. She is very helpful."

The registered manager continued to be open and approachable. Staff had opportunities to share their views about improving the service and to discuss people's changing needs. A member of staff told us, "Communication is good. We meet three times a day in handovers so we always know how people are and if there have been any changes." The provider undertook surveys of staff satisfaction. Records showed that almost half of the service's staff responded to the most recent survey for which statistics were available. 88% of staff said their appraisal accurately reflected their performances and 80% of staff thought the provider "Acted on the feedback received from [people living in the service]." The registered manager used team meetings to obtain staff views and to share information. For example, records of team meetings showed discussions about the Mental Capacity Act 2005 and deprivation of liberty safeguards.

The quality of care people received continued to be checked robustly. The registered manager carried out regular audits. These included, checks of medicines, care records and health and safety throughout the service. The registered manager ensured that spot checks were regularly undertaken. Spot checks included confirmation that people's homes were clean, staff were on time and wore their ID badges and people were supported in line with their care plans. Senior managers undertook bi-monthly visits to the service during the night to undertake quality checks. Additionally, senior managers from the provider organisation undertook detailed audits of the service every six months. These identified areas for improvement and confirmed that actions from previous audits had been carried out.

The service worked collaboratively with others to ensure best outcomes for people. The service undertook joint activities with Age UK, befriending and volunteering schemes and the Mental Health Foundation which held weekly meetings for people who lived in the service to promote people's wellbeing. The service was represented at the local authority's provider's forum where information was shared and good practice promoted. For example, providers at one forum received information about best practice in infection control. The registered manager understood the legal responsibilities of their registration with CQC and the requirement to keep us informed of important events through notifications when required.