Notting Hill Housing Trust

Elmgrove House

Inspection report

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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

We carried out this unannounced inspection on 10 and 11 January 2018. At our last inspection on 20 and 22 October 2015 we rated this service "Good". At this inspection we found the service remained "Good".

Elmgrove House is managed by Notting Hill Housing and provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

People using the service lived in one of 14 bedsits in a purpose-built, three-storey building in Hammersmith. Each floor contained a shared kitchen and lounge which were also used for activities. Not everyone using Elmgrove House receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection there were 14 people using the service including one person who was in hospital, of which eight people received the regulated activity of personal care.

The service had a registered manager who had been in post since April 2017 and registered since August 2017. 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 had care plans which were developed in line with their needs and reviewed regularly. Care plans were used to draw up clear schedules for care workers each day which were checked during handover to ensure people had the right care. There were systems agreed with the local authority to vary people's hours on a weekly basis to meet their changing needs.

There were varied and interesting activity groups and people usually chose to eat together in a communal dining room. People received support to get enough to eat and drink and staff took action when people were at risk of weight loss or malnutrition.

The provider was meeting its responsibilities to obtain consent to care and assess people's capacity to make decisions. Where relatives consented on behalf of people there was evidence that they had the authority to do so. Complaints were addressed by managers who had systems to respond promptly to straightforward concerns. People were positive about the caring and kind nature of staff and we saw examples of people given reassurance and staff tending promptly to concerns.

The provider had risk management plans in place, for example to address falls and promptly sought medical attention when people were unwell. Staff were recruited in line with safer recruitment processes and an interview process that checked that they had the right understanding of their roles. Staff received appropriate training and supervision to carry out their roles. There were processes to safeguard people from abuse, and medicines were safely managed. When things had gone wrong the provider took action, including discussing what had been learned and how problems could be avoided in future.

The provider told us they intended to merge with another provider later in the year. This means that this location will be archived at this time and registered under the new, merged provider. We will aim to return to this service within 12 months of registration.

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 remained good.	**Good**
Is the service effective? The service remained good.	**Good**
Is the service caring? The service remained good.	**Good**
Is the service responsive? The service remained good.	**Good**
Is the service well-led? The service remained good.	**Good**

Elmgrove House

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.

Why we inspected – This was a routine inspection as we had rated the service "Good" 24 months ago. We aim to return to services rated "Good" within two years of the publication of the report.

Since our last inspection the provider had informed us of four allegations of abuse against people who used the service. Two of these did not constitute abuse, and a further allegation concerned abuse by a third party. One allegation concerned abuse carried out by another person who used the service. We looked at how this was addressed by the provider and lessons learned as part of this inspection.

This inspection took place on 10 and 11 January and was unannounced on the first day; the provider knew we would be returning on the second day. The inspection was carried out by an adult social care inspector.

Prior to the inspection we reviewed information we held about the service, this included notifications of serious incidents the provider is required to tell us about. We asked the provider to complete a provider information return (PIR) which is a document for providers to tell us what is going well and how they intend to develop the service. In carrying out this inspection we looked at records of care for three people, medicines management for four people and records of recruitment and supervision for three care workers. We looked at records relating to the management of the service such as allocation sheets, handover documents and checks managers carried out of the service. We spoke with the registered manager, an assistant director, support officer, one care worker, night manager, activities co-ordinator and a care and support compliance manager. We spoke with two people who used the service and four relatives, and carried out observations of activities and a communal meal.

Good

Is the service safe?

Our findings

People were protected from avoidable harm. A person who used the service told us, "Definitely [it's safe], yes", and a relative told us, "They're all very kind, I know they wouldn't do anything that would harm my mum." Care workers had received training in safeguarding adults; a care worker told us "I would talk to my manager, they would definitely take it seriously."

Where allegations were made concerning people who used the service the provider had reported these to the local authority and had worked with them in order to manage risks. Where an incident of abuse against another resident had occurred the provider had worked with the local authority to provide a 24 hour chaperone to prevent further incidents until the person had been rehoused. Incident reports showed that this had been effective and the family concerned confirmed with us they were happy with how the provider managed this. There was evidence that the provider had reflected on how they had managed the situation and whether anything could have been handled differently, this included writing a case study and holding a "lessons learned" meeting.

Where incidents and accidents had occurred, these were suitably recorded with evidence of medical assistance sought and further actions documented. For example, one person was trying to leave the service in a way which may not have been safe, the person had been referred for assistive technology in order to manage this safely, including a bracelet which would alert staff if the person was leaving, which we saw the person wearing

Risk assessments had been carried out and management plans put in place where people may be at risk of harm. This included the use of bed and chair sensors where people were at risk of falling, and information on how people mobilised and were supported to make transfers. There was information included on how people's needs may vary from day to day based on their health and mood. Where staff were concerned about people's skin conditions they had involved other professionals such as occupational therapists and district nurses and care plans included instructions on how to apply creams to prevent damage to skin or the development of pressure sores. The provider told us they did not have an overall plan for recording how they managed risks from skin breakdown, which meant that should people's needs change and their skin integrity risks increase it would not be possible to see and review all the measures in place to address this. The provider told us they would be reviewing their documentation and would consider implementing this.

There were risk assessments completed to manage people's finances safely. This included clear information on who had responsibility for managing the person's finances and whether a cash tin was managed by staff. When money was held this was stored securely and records kept of transactions, two staff had signed for all transactions and monthly checks of the balance and transactions were carried out by the manager.

A facilities officer carried out health and safety checks of the service. This included checks of lighting and fire escapes and checks of the temperatures of communal fridges and freezers. These appeared stable, but there was a lack of clear temperature guidelines for staff. There were weekly checks of fire extinguishers, exits, smoke detectors and floor surfaces, and a weekly fire alarm test which included checking different call

points each time. Disused outlets were flushed by staff on a weekly basis, however this had stopped in October but was resumed when we pointed this out, however night staff were still conducting nightly checks on water outlets. Portable appliance testing was being carried out at the time of our visit and there was an up to date gas safety certificate.

Care workers were able to respond to calls using portable handsets, and there were daily checks of this system and monthly checks of the pull cords in people's flats. There were personal emergency evacuation plans (PEEPs), which assessed people's abilities to evacuate the building, including risks such as smoking, alcohol and drug use, oxygen cylinders and whether people were able to respond appropriately to alarms. Where people were at risk from hoarding, there was a risk assessment process in order to address this, which included reference to an illustrated clutter scale developed by the fire service.

The provider told us that there were two care workers on duty during the day, and we confirmed this with staffing allocation sheets. This was a rounds system, which allocated people's care visits to particular staff roles. Care workers were given their roles at the start of each shift with a written list of visits, including people's allocated times and a list of duties; these were checked at the end of each shift to protect people from the risk of missed visits. Rostering was carried out by an external business support team. At night there was a single member of staff on duty; lone workers carried a mobile device which they could use to summon help in an emergency and would detect if they had fallen or had an accident. There was also a night manager who was based across the provider's west London services who staff could contact if they needed further support and a senior manager was on call at all times to support staff in the event of an urgent or serious concern.

Staff were recruited through safer recruitment measures. This included assessing people's suitability for the role through practical exercises themed around customer service and the understanding of the role. Several new staff were now in place, and a relative told us "There are new staff who are equally caring." Prior to starting work, the provider obtained proof of people's identification, their right to work and a complete work history, including references. Where there was a gap in a care worker's work history this was explored by managers. Prior to starting work the provider carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

Personal Protection Equipment was in place in bathrooms and instructions on the safe disposal of pads in order to protect people from the risk of infection. Staff received three yearly training on infection control. A care worker told us, "The gloves and aprons are all in the assisted bathroom and there's gloves in every flat, so before you go in you get everything you need. There's never any shortage because we always check, and the manager always checks. I think we're good."

Medicines were safely managed by staff who had the skills to do so, and checks of this were carried out by managers. A relative told us "I'm really impressed with medication, they're very strict with how that's documented."

Medicines administration recording (MAR) charts were compiled by a single pharmacy who the provider had regular meetings with. Medicines were signed in by a member of staff and witnessed by another. We reviewed three MAR charts for four people and saw that these were correctly completed. Staff received training in medicines administration every 18 months and were observed three times administering medicines in order to ensure their competency.

There were systems to check medicines had been given, which included weekly checking of MAR charts. The

provider had introduced twice daily checking of blister packs in response to a number of incidents where tablets had been going missing; the provider had met with the pharmacist and confirmed that this was due to a faulty batch of blister packs. Where medicines incidents had occurred these were recorded with details of the error and actions taken as a response, these included additional observations of staff members concerned, a lessons learned meeting on medicines errors and apologising to people and their families. A relative told us "Once a staff forgot to give the medication, they told me which I appreciated. They're very honest and transparent."

Good

Is the service effective?

Our findings

The provider carried out thorough assessments of people's support needs, which was informed by the referral information from the local authority and what people and their families told staff. The assessment covered identified support needs, any services people currently received and any difficulties people may have with physical and mental health, mobility and sensory needs, continence, personal hygiene and personal safety.

Staff received suitable training to carry out their roles. There were a number of new care workers in place, who received a local induction around policies including safeguarding, food equipment, medicines procedures and a clear plan for training and development. New care staff undertook a four day induction; this was in line with the Care Certificate and included medicines, moving and handling, person-centred care, health and safety and continence management. We saw evidence that new staff were completing workbooks in order to complete their Care Certificates. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The manager maintained a training calendar and a record of training received in order to ensure that care workers received mandatory refresher training. This included 18 monthly medicines administration, 2 yearly fire awareness, moving and handling and food hygiene and three-yearly personal safety, infection control and safeguarding adults.

Care workers received two monthly supervisions, with records of discussions maintained by the manager. Topics covered included confidentiality, recording, the use of contact sheets and finance policies. In addition to observations of medicines competency, the manager carried out observations of care visits, including checking that care workers had knocked on the door, introduced themselves, read the floor plan in order to understand their duties and had left the person's flat in a suitable condition. Managers had recorded when they had raised issues with practice, such as care workers not checking medicines records correctly.

People and their relatives were positive about the support given to eat and drink well. Comments included, "The food's always on time and they do it well" and "When my relative lost weight they saw to it that [they] got the extra protein drinks, they're very careful about what [my family member] eats."

Menus and meal choice forms were displayed in the hallway, and there was an ordering system for meals from the catering service which was based in a nearby service also run by the provider. People tended to eat their meals together in the main dining room, and we saw that people were served food promptly and politely by staff who encouraged people to eat at their own pace. People were offered drinks and staff knew what drinks people preferred; these were generally fizzy drinks such as ginger ale and colas, which was in line with people's choices.

We saw evidence of support to prevent malnutrition. For example, one person's plan stated that they would often decline meals, and that they should be offered a milky drink and biscuits if that was the case, which we

saw taking place. Two people had been on nutritional support drinks in line with a dietician's recommendation; there was evidence that this had been followed and that people had gained weight as a result. When a person declined their lunch this was kept warm for them and this was discussed with the next shift in handover.

There was evidence of people receiving support to maintain good health, including records kept of appointments attended. This included calling ambulances or seeking medical advice promptly when people were unwell. The provider maintained emergency hospital appointment forms which included essential information for hospital staff, including information on people's communication needs, cognitive impairments and a brief medical history, as well as information on how to contact the service before arranging discharge.

The provider was working in line with the Mental Capacity Act (2005) (MCA). The Act 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. We saw an example of a capacity assessment, this included identifying the specific decision, and considering whether people were able to retain and consider information and to communicate their decisions. People had consented to their plans; where relatives had done so there was evidence that this was because they had the right to do, for example due to holding powers of attorney, copies of which were kept on people's files. There was information displayed in communal areas on lasting powers of attorney.

Good

Is the service caring?

Our findings

People and their relatives all told us that they felt treated with kindness by care workers and managers. Comments included, "Everyone's exceptionally kind, it's gone very well" and "The staff are amazing". Relatives described some of the work the staff did for them. For example, one relative told us, "My relative needed a new chair; they searched for the right one for her/him. I couldn't have done it unless they'd taken the time."

People also praised the consistency of staffing; one relative told us, "You know them by name, there's not a lot of change" and a staff member said, "It's like a family in Elmgrove and I like that." There was a board with photographs and names of staff displayed by the main office. Managers observed care visits and recorded whether people had been treated with dignity, including whether care workers had knocked before entering people's flats. We spoke with a care worker who gave examples of how they supported a person in line with their cultural and religious needs.

People were supported to stay in touch with family members. For example, one person's plan had detailed instructions on how they needed to be supported to make video calls to a relative, including passwords and operating information for their tablet and how to safely store it when not in use. A relative told us, "They're always ready to help my relative receive a call or Skype."

People's plans also included information on the emotional support people required, such as ways of encouraging a person to engage if they were not in a good mood. These included encouraging people to look at photographs and providing ice cream and hugs. One person's plan stated that they were prone to forgetting why they were at the service and would regularly become agitated; this said that they should be encouraged to read a letter in their bag from their family which explained this, and we saw this taking place during our visit. The office door on the ground floor was kept open, and we saw people approaching the office for help and reassurance throughout our visit. A care worker said, "They give us time for reassurance, there is a time after lunch when some people get confused."

There was information on people's plans about their communication needs, including the support they required with hearing aids, with clear instructions on when batteries should be changed and spare batteries were kept on people's files. We observed one person approach the office as their hearing aid was not working; two staff provided a great deal of reassurance and kept supporting the person until they were confident it was fixed and had verified the person could now hear them and was happy.

People had named keyworkers, together with a backup keyworker if that member of staff was not available. The registered manager explained, "They're the main person responsible for doing a little extra, such as helping with mail and with appointments." Each person also had a one page profile, which contained information on people's life stories, family background and key events. These outlined how best to support people at different times of day, how people preferred to be communicated with and things people did and didn't like. An example of this was a plan which stated "I take great pride in my appearance, and can be quite strong willed about how I like to dress."

Good

Is the service responsive?

Our findings

Relatives we spoke with told us that the service was responsive in how it met people's needs. Comments included, "They respond to every aspect, whether it's [their] hearing aid or health, whatever it is they are ready to listen and to respond immediately" and another person said, "They have a routine which ensures [my family member's] personal hygiene is kept up to the mark."

People's care plans had all been updated within the last year and contained key information on people's preferred names, likes and dislikes, religious needs, employment or activities and a summary of their care needs. Plans were then based on identifying particular needs, with details of the support required in this area and a date for review. This included people's mobility needs, participation in activities and daily living tasks as well as support with hearing aids, dentures and tending to people's hair. People also had individual task plans, which contained a clear summary of people's planned visits during the day and night and the tasks that may need to be done in this time. Staff had signed these and their allocation sheets to show that the visit had been carried out; including the times taken and exact tasks taking place. This included a breakdown of the support required at night with times allocated to this. People's tasks plans were used to design a "floor planner", which showed care workers who they needed to see and what needed to be done during the day. We reviewed these and saw that care was delivered in line with people's plans.

A board in the main office showed when people's plans were last reviewed and when they were next due for review. A relative said, "They think of things, they'll suggest things…they're very proactive."

The service had been working with the local authority in order to pilot a "core-flexi" model of care. This meant that people's care hours could be reviewed on a weekly basis depending on their needs. The provider told us, "There's a lot of monitoring of hours, we have regular contact with commissioning…we keep records of when care was increased and decreased and send it to social services." We saw examples of when extra support was provided, for example to support people to appointments, and when this was reduced such as due to people becoming more independent or requesting less support with their personal care.

There was a programme of activities in the service, which included weekly yoga and visits from a pet therapy scheme which took place every Friday and involved a specially-trained dog visiting the service. The provider told us this was particularly popular with people who had previously had dogs. There was a part time activities co-ordinator who visited one day a week and ran sessions including board games and coffee mornings, and we saw examples of other activities including baking and tea mornings. Events included a summer barbecue and a Christmas party with an entertainer which was funded by the provider. We observed a member of staff playing board games with one person and inviting others to join in and offering to teach people the rules.

Additionally, the support officer was participating in a programme called "Ladder to the Moon." The staff member explained, "You get a box of tricks with different activities, each month has a different theme." Examples of this included a "Make your own Western" session and an "Icons" activity, where people recreated scenes from classic movies. This also included a music playlist to accompany the activity. Some

people were watching a video which people and the staff had made where they had dressed up in order to recreate scenes from "The Sound of Music". Staff explained that some activities were more popular than others, but they tried to encourage people to engage in their own ways. A staff member said, "A lot of it is spontaneous…The first session was kite-making which was a disaster, but what came out of that was the singing." A relative told us, "[Staff member] chats to them and puts music on. She goes over and above."

The provider had a suitable system for addressing complaints. This included responding to people and investigating complaints, and apologising where necessary. Additionally the provider had a "Quick fix" system in order to address complaints that could be more simply resolved as a single thing needed to happen. Staff documented that they had addressed issues under this system and documented the fix was now in place and that the person who had complained was happy with this.

Good

Is the service well-led?

Our findings

People we spoke with were positive about the managers of the service. Comments included, "She's caring, she makes time for everyone, she's built for the job" and "I'd speak to the manager if I had any concerns." A staff member told us, "Everything's professional with [the manager], if there's an issue you go to her".

The provider operated effective systems for delivering care. For example, there was a clear index on files for what was required and rotas in place for domestic tasks such as shopping and laundry, and communication books for recording upcoming appointments, tasks to be seen to and recording issues of concern. People's care tasks were used to compile "floor plans", which planned out each care worker's duties for the day, and sheets were completed at handover in order to make sure people had had their care, food, medicines and domestic tasks completed. This included records of who was on duty and confirmation that phones and keys were handed over. A care worker told us, "The paperwork is so useful, if I didn't have a guide I'd be lost."

Handover was verbally carried out in a quiet room between shifts. This was used to discuss who had had care, who had not yet had medicines or their meals and to discuss individual people's wellbeing and issues of concern. For example, staff compared their observations on a person's recent coughing episodes and agreed that they would contact the GP. In another case staff observed that a person was not sleeping and discussed possible strategies for early intervention and looking at possible causes for the behaviour. A separate handover checklist was maintained for medicines so that it was clear what had been done on each shift. A care worker told us, "The handovers are very detailed with us, there's no bits that are hidden, we don't get confused and we know everything that's happening. There's transparency."

Managers also carried out checks of each person's care, in practice this took place around every eight weeks and involved checking that people were receiving personal care, looking at people's engagement in activities and the support they received with finances, and whether there were any health and safety issues in people's flats. Where issues had been detected there was a clear outcome and follow up recorded.

The provider also had a care and support compliance manager who was external to the service and carried out twice yearly checks in line with CQC's key lines of enquiry, with an action plan for development. A senior manager told us, "She's like a critical friend." The most recent external audit had not identified any major concerns. The provider had also had an external cyber security audit carried out across the organisation and had provided security training for staff on how to protect people's confidential information. The provider was developing clear plans for the transition to a new, merged provider, including identifying required changes to registration and what policies and procedures needed to be in place on the first day of the new organisation. Managers worked with organisations in the local community, for example following a recent falls prevention pilot they were now able to make referrals directly to falls prevention and wheelchair services.

Team meetings were carried out in addition to daily handover, in practice there had been two regular meetings in six months, which were used to outline the manager's expectation of the staff team, recent changes to documentation and contact sheets and to discuss infection control and responsibilities on

safeguarding. Staff were informed of the importance of signing in visitors and notifying whether a fire alarm test was scheduled that day, which we observed on both days of our visits. The team had carried out exercises designed to encourage reflective practice, such as situations involving professional boundaries and potential conflicts of interest. There were quizzes completed on mental health awareness, mental capacity and a quiz on safeguarding adults, which including staff responsibilities and identifying examples of possible abuse. In addition, the team carried out additional meetings in order to discuss lessons learned, for example with regards to a recent safeguarding incident and one relating to difficulties in medicines management.

There were also systems to engage people who used the service, such as a schedule for tenants meetings. These took place every two to three months and when these hadn't taken place, for example due to people not attending, there were attempts to rearrange these. Areas discussed included fire safety, activities and staff arrangements. Minutes of the meetings, along with feedback from a recent survey were displayed in communal areas, this included a "you said…we did format". Examples of these included exploring installing Wifi in the building, giving instructions to staff about not bulk buying products when shopping, purchasing a laundry rack in response to concerns about clothes shrinking and arranging pest control visits when people had spotted mice.

The provider displayed the ratings of their previous inspection in the service along with information on how to contact the Care Quality Commission (CQC). This was also displayed on the provider's website. The registered manager was meeting their responsibilities to inform us of significant events such as serious injuries and allegations of abuse.