Notting Hill Genesis

Penfold Street

Inspection report

60 Penfold Street
London
NW8 8PJ

Tel: 02038152193
Website: www.nhhgroup.org.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Penfold Street is an extra care service. The service provides support to older people and people with physical disabilities who live in their own flats at this location. At the time of our inspection there were 46 people using the service.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
People told us they liked living at the service and were well respected by staff. Comments from people using the service included "I find this place exceptionally good" and "I love it here."

People were encouraged to be involved in the daily running of the service and participated in a range of activities, including gardening and trips out. Managers engaged with residents through regular meetings and people were confident approaching the registered manager for advice or for a chat.

There were improved systems for detecting and preventing risk. The service understood which residents were at a higher risk from fires or other avoidable harm and had introduced a range of checks to ensure people were safe. The service worked with other agencies including the London Fire Brigade and health teams to improve the way they worked to keep people safe. People were confident raising concerns with managers and the service acted appropriately when abuse was suspected. Staff members had the right skills to keep people safe and this was reviewed through regular training and observation.

Medicines were safely managed and the service understood how to protect people from infections, including COVID-19. There were systems for reviewing when things had gone wrong and making sure lessons were learned as a result. The provider had delivered an action plan to ensure concerns from the previous inspection were addressed and systems were improved as a result.

Staff members reported feeling well supported by managers and working together to deliver a good service for residents. Staff understood their responsibilities to ensure the service was safe and that safety concerns were addressed promptly.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was requires improvement (published 27 May 2021).

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 3 March 2021. Breaches of legal requirements were found in relation to safe care and good governance. After this inspection the provider met with us to tell us how they would improve the service and by when.

We undertook this focused inspection to check if the provider had made improvements and if they were now meeting the legal requirements. This report only covers our findings in relation to the key questions safe and well-led.

At this inspection we found improvements had been made and the provider was now meeting these regulations.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Penfold Street

Detailed findings

Background to this inspection

Inspection team
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service 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. The Care Quality Commission (CQC) does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service. This included information about serious incidents the provider is required by law to tell us about, the provider's action plan from the last inspection and records of meetings we had held with the provider and the local authority where we discussed the provider's action plan.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 18 August and ended on 30 August 2022. We visited the provider's service location on 18 August 2022.
We looked at records of care planning, risk management and medicines management for six people who used the service. We spoke with the registered manager, care co-ordinator and three care workers, and met with three people who used the service. We looked at records of recruitment for three care workers and reviewed records relating to the management of the service, such as handover notes, audits, team meetings and records of staff training.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection we have rated this key question good. This meant people were safe and protected from avoidable harm.

At our last inspection we found the provider had failed to ensure that people were protected from risks to their health and safety. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was now meeting this regulation.

Assessing risk, safety monitoring and management

- The provider had assessed risks to people's safety. This included risks from falling, moving and handling and assessing people's skin integrity risks. People had specialist fire safety risk assessments where appropriate. There were improved processes for identifying when people were at risk from fire, particularly people who were smokers who also used emollient creams, and managers maintained a list of people who were at the highest risk of fire.
- The provider had introduced new processes for ensuring measures to keep people safe were maintained. Care workers now recorded that they had checked people were using important equipment, such as smoking aprons and pendants to call for help, and that they had carried out checks such as ensuring that people's ashtrays were emptied and that fire supressing equipment was being used. The most vital checks had been highlighted for shift leaders to check on handover each day.
- Managers had improved systems for checking people's safety. This included an improved system of checks to carry out when visiting people in their homes, which was carried out more regularly, and maintaining lists which could indicate when people were at higher risks, for example if people had not been supported with laundry for a longer period of time. Where people were identified as being at higher risk of fires the registered manager carried out specialist fire safety spot checks. The registered manager carried out quarterly observations of care workers carrying out moving and handling tasks to ensure that staff had the right skills to do this safely.
- The provider worked jointly with other agencies to reduce risks to people. The provider worked with the London Fire Brigade who gave specialist advice on what measures were needed to keep people safe and ensured that recommended equipment was put in place. The staff team met regularly with colleagues from mental health teams to review when people were at risk of expressing agitation and discuss appropriate strategies and interventions. The registered manager worked with the housing officer to ensure key equipment such as pendants were reviewed and maintained.

Systems and processes to safeguard people from the risk from abuse

- People were safeguarded from abuse. People we spoke with told us they safe using the service and were confident discussing concerns with the registered manager. When people using the service felt they were at risk of abuse the registered manager acted appropriately, including speaking with the person in private to obtain full details and informing relevant parties such as the police and local authority. A person told us

"Occasionally I've had a problem, but they would sort it."

● Care workers were confident in detecting and raising concerns about possible abuse. Staff had up to date training in safeguarding adults and told us they knew how to raise concerns. A care worker told us "I'm very vocal if I see something unsafe, I think [the registered manager] takes it very seriously and on board and raises with the appropriate people."

Staffing and recruitment

● There were enough staff to meet people's needs. People we spoke with told us they could always reach a member of staff when needed. One person told us "They always come when I call." Comments from staff included, "The other staff are always there" and "Definitely we have enough staff, I think it's quite sufficient." Care workers told they had established procedures for managing short notice absence of colleagues. One staff member told us, "My colleagues are independent and mature enough, if a person isn't there we don't even wait, we make sure the work is covered."

● The provider operated safer recruitment processes to ensure that people were suitable for their roles. Managers carried out checks on people, including obtaining references, proof of identification and the right to work in the UK. Recruitment processes included assessments of people's knowledge and suitability to carry out and understand important recording. The provided carried out checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Medicines were managed safely. The provider assessed people's medicines needs, including the level of support people required with certain tasks, and ensured they understood what medicines people took, when and why. When people took medicines as needed (PRN medicines), there were suitable protocols for staff to follow to administer these medicines when required.

● The provider ensured that people safely received their medicines. People's medicines support was recorded on appropriation medicines administration recording (MAR) charts which were kept up to date. Care workers had received training in administering medicines and understood how to complete MAR charts correctly. A care worker told us, "If my medicines training has expired they won't allow me to work until it's updated. The core training they take very seriously."

● There were suitable processes for checking medicines continued to be given safely. Managers checked the storage and management of medicines on regular spot checks and completed audits of records relating to medicines including MAR charts. Care workers were encouraged to audit each other's record keeping and participate in regular reviews of records.

Preventing and controlling infection

● People were protected from infection. Care workers wore appropriate personal protective equipment (PPE) including masks when on duty. There was signage for visitors to indicate what steps they should take to safeguard people from infection, including providing hand sanitiser and masks. Care workers had received training in infection control and understood their responsibilities. There were enhanced risk assessments for people who were at a higher risk of becoming seriously ill if they contracted COVID-19.

● Care workers were carrying out rapid tests for COVID-19 in line with the current guidance on infection control. Testing was monitored by managers and staff were required to self-isolate from work if they tested positive.

● There was a suitable policy for ensuring infection control was maintained, with regular audits carried out by the registered manager.

Learning lessons when things go wrong

● The registered manager ensured that lessons were learned when things had gone wrong. Staff followed processes for recording and responding to incidents and accidents. The service held regular meeting for reviewing records of incidents and accidents and identifying trends and had taken additional steps such putting equipment in place or involving other professionals to prevent a recurrence of incidents.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection we have rated this key question good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

At our last inspection we found the provider had failed to monitor the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was now meeting this regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had implemented an action plan based on the findings of the previous inspection. This included identifying people who were at the highest risk of fire and developing an enhanced audit framework for ensuring that fire safety mitigations remained in place. At this inspection we found the provider had met their action plan and was now meeting regulations.
- The provider had reviewed systems for monitoring quality performance and safety. This meant that checks were carried out by different staff at different time, including front line care workers and the registered manager to review and monitor people's safety. Handovers between shifts had been reviewed and were used to ensure staff were aware of possible risks, including when people had left the service and had not yet returned. Shift leaders understood their responsibilities to allocate tasks to people and ensure important safety checks were carried out. make sure these had been carried out. The registered manager told us, "We introduced peer learning, it's good to see staff involved and pointing out errors. It's about introducing a process we can sustain." A staff member told us "As [managers] get information they pass it on to us, it feels like we are learning together."
- Care workers told us they had noticed a significant change in how the provider monitored quality and safety. Comments from staff included "They have made drastic changes in terms of our writing and documentation. There has been a lot of change from the top" and "We have worked hard to improve, I can see they really regularly do spot checks, I would say that aspect has been a priority for the management."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff spoke of feeling well supported by managers. Comments from care workers included, "Whenever I need them, which is very little, they are always there for me" and "They have supported me to develop and given me all the proper training." Staff spoke of a positive, supportive culture. A staff member told us, "We do look out for each other" and "My colleagues are so independent and mature."
- The provider engaged positively with people who used the service. Comments from people included,

"[The registered manager] is lovely, when I was worried about something it made me feel better when we had a talk". People told us they were confident about approaching the registered manager, and we saw examples of people coming to the main office to talk or discuss issues. The registered manager told us, "I have an open-door policy." Residents meetings were held monthly to update people on changes to the service and to get people's views on what they wanted to see happen.

● People were involved in the daily life of the service. A person told us, "This is my garden, and I work here to greet visitors." Flower beds and vegetable patches were maintained by residents with the support of the activities co-ordinator. There was a new programme of activities and involvement which included activities sessions in the building and trips out into the community. The activities co-ordinator told us, "I really like when a few residents get involved, they'll come back and invite other residents who want to join. Word of mouth really helps, and the residents feel like they are in charge."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● The registered manager understood their responsibilities under the duty of candour. Where things had gone wrong, for example where errors had been identified on audit, or an incident had occurred, the registered manager carried out an appropriate investigation and shared their findings and root causes with the relevant parties. There were systems of checks by senior managers to ensure they had been open and honest about their findings.

● The service worked in partnership with others to deliver an improved service for residents. There were established processes for engaging with external bodies such as health and emergency services to report concerns and ensure people received the right support. The registered manager told us, "Working in partnership with the mental health team was a necessity as we are supporting more and more people with mental health needs and dual diagnosis." The service had worked with palliative care teams to ensure they could plan to support people with end of life care. The provider had worked with the local authority to remove barriers to accessing the service, for example by changing requirements for proof of identification for new residents to ensure that people who were homeless were not excluded from the service.