Notting Hill Housing Trust

Elgin Close

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 4 and 5 January 2018. At our last inspection on 30 October and 3 November 2015 we found the service was "Good". At this inspection we found that the service remained "Good".

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. 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 36 self-contained flats in a single four-storey building. At the time of our inspection 36 people were receiving personal care. Each flat consisted of a living room, bedroom, kitchen and bathroom. People also had access to shared facilities including bathrooms equipped with lifting baths, dining rooms on each floor and a guest room for overnight guests. The service adjoined Elgin Close resource centre, which provides activities and a catering service for residents.

The service had a registered manager who has been in post since January 2016, and had been registered since August 2016. 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 found that the provider had systems to safeguard people from abuse and manage risks to people who used the service. Staffing levels were suitable to meet people's needs and people's care visits were organised through a rounds system which meant it was clear who needed to be seen and when. This was planned in line with people's care plans and checked at handover to ensure people had received the right care. Care plans clearly documented people's needs but weren't always easy to follow; however we saw examples of accessible communications and the service had developed documents in order to improve this further.

Care workers were recruited in line with safer recruitment measures and practical exercises carried out to ensure that staff had the right values to deliver good care. Staff received the right training and supervision to carry out their roles.

People received the right support to eat and drink well, including assessing people's needs and making sure that people had the right food delivered by the onsite catering service. People's health needs were assessed and people received support to stay healthy, including diabetes plans and support to attend appointments. Health and safety checks were carried out in order to ensure a safe environment, and people were able to call for help using intercoms and pendant alarm systems.

People were protected from medicines errors by correct management and audit of medicines. Where errors had occurred the service had procedures to ensure that lessons were learned and that these were not repeated. Managers had systems in place to make sure people received the right care.

At our previous inspection we made a recommendation about how the provider assessed people's decision-making abilities in line with the Mental Capacity Act. We found the provider had acted on this recommendation and had robust procedures for assessing people's capacity and to demonstrate that they were working in line with people's best interests. This included working with other health professionals to consider advance decisions such as hospital admission in the event of ill health.

There were good systems of communication in place, such as handovers, team meetings and newsletters. People were engaged with the service through tenants meetings and their views were recorded in tenant profiles. The service was in the process of implementing key-working in order to support people to express their views about their care. People knew how to make complaints and who the manager was, and complaints were investigated and suitably resolved.

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?

Good

The service remained good.

Is the service effective?

Good

The service was effective.

Staff received suitable training and supervision to carry out and develop in their roles.

The provider had robust systems for assessing people's capacity and there were examples of good practice in working with others to make advance decisions in people's best interests.

Assessments were carried out of people's needs and there were measures in place to ensure people maintained good health and had sufficient to eat and drink.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Good

The service remained good.

Elgin Close

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. The service had been rated "Good" in January 2016.

Since our last inspection the provider had made us aware of four safeguarding incidents. Two related to financial abuse by family and friends. One was in relation to a single medicines error and one referred to a potentially more serious medicines error. The provider had informed us what action they had taken in order to prevent a recurrence of this error.

This inspection took place on 4 and 5 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 a single inspector.

Prior to carrying out the inspection we reviewed information we held about the service, including information concerning serious incidents the provider is required by law to tell us about. We asked the provider to submit a provider information return (PIR). This is a document for providers to tell us what they are doing well and how they intend to develop the service.

We reviewed records of care and medicines management concerning four people, and looked at records of recruitment and supervision of five staff. We looked at records relating to the management of the service, including rotas, training, team meetings and communications and audits. We carried out observations of lunchtimes and spoke with six people who used the service. We spoke with the registered manager, assistant director, support officer, operations manager, night manager, two care co-ordinators, the care and support compliance manager and three care workers.

Good

Is the service safe?

Our findings

People were protected from avoidable harm by suitable safeguarding processes and risk assessment measures.

People who used the service told us they felt safe living there. Staff we spoke with were aware of their responsibilities to report abuse and were confident that managers would act on their concerns. Comments from staff included "[Safeguarding] is the number one priority. They take it seriously…they always step up and make sure things are going fine", "I'd hand my concerns over at handover…I do think they would take it seriously, I really do." Staff had received training in safeguarding adults, and records showed that where abuse was suspected this had been reported to the local authority. There was information displayed in communal areas on the forms of abuse and who people could speak with if they were concerned.

Where money was kept on behalf of people, this was safely stored in an area which people could only access through senior staff. Staff had recorded transactions and maintained records of these, and transactions were countersigned either by the person or another member of staff, with monthly checks carried out by the registered manager.

The provider carried out checks to ensure that the environment was safe, with an onsite facilities officer responsible for health and safety and maintenance. This included daily checks of bins, door entry systems, fire escapes and medicines storage and weekly checks of fire doors, fire equipment and food storage temperatures. The provider had carried out a legionella risk assessment and carried out weekly flushing of disused outlets in line with this. A quarterly inspection was carried out in order to verify and carry out checks of gas and electrical safety, fire safety, portable appliance testing and emergency lighting.

Where there were risks to people's safety such as falls or behaviour which may challenge, the provider had carried out risk assessments, including measures in place to promote people's safety and the equipment provided to address these. There were moving and handling risk assessments which described how people mobilised, the kinds of tasks which would be undertaken by care workers and factors such as weight, comprehension, environmental factors and unsuitable footwear which may increase the risk of falling Risk assessments described the kinds of tasks which people needed support with such as making transfers and the level of support required. These included identifying the support people needed on "good" or "bad" days depending on people's changing health needs. Where people required hoists to make transfers safely there was evidence of suitable servicing and maintenance of these. The provider carried out health and safety checks of people's flats, including fire precautions and checked for hazards such as trailing wires and those relating to smoking. There was an up to date list of people's evacuation needs and the level of support people required to follow fire procedures.

People received support from suitable staff due to a robust recruitment and allocation system. The provider had implemented 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. A care worker told us "We know where we will be at a certain time and the customers will be expecting us at this time. Generally it suits the needs of the customers and it's good." We looked through two weeks of allocation sheets and saw that staffing was as described by the provider. Rotating was carried out by the provider's resource team. The registered manager told us "We have a very stable staff team, in 2016 we used agency as a last resort but since then we've only used bank staff." Care workers told us that staffing levels were usually adequate to meet people's needs and that managers tried to cover staff sickness. One person said "I think the management is very positive and want things to go well for us, they are on our side."

People who used the service told us that they were able to use pendant alarms and intercoms in their flats to summon help if needed. Comments included "You can call someone at any time if you need them, it's better as people are around" and "I call for help and they come, including at night if needed." Care workers carried handsets to answer alarms, these also sounded in the main office. We observed calls being answered promptly throughout the day; the system also generated printed records which showed it was in constant use and that calls were responded to promptly. Staff also carried mobile devices for personal safety which they could use to call for help with a single button and to alert a call centre when they were going into a high-risk environment. There was a night manager on duty every night who moved between the local services and was available for care workers to contact if they needed support and a senior manager was on call at all times to support staff if there was a serious or urgent 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. A manager told us "It's good to see the real person and how they react, we need the right personalities." Prior to starting work, the provider obtained proof of people's identification, their right to work and a complete work history, including references, and 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. DBS checks were repeated every three years; there were clear renewal dates recorded and managers showed us notifications they received of when these were due.

The provider carried out suitable assessment, recording and auditing of people's medicines. Risk assessments were carried out on people's abilities in areas such as ordering medicines, reading labels, opening bottles and taking medicines safely. These identified the level of assistance people required in these areas and actions required, and there was a clear date for the review of these assessments. The provider's policy was that medicines be supplied only in blister packs by a single pharmacist across all their services; there was evidence of six-weekly regular meetings with the pharmacist in order to discuss any issues of concern. The provider had recently reviewed their medicines policy in order to simplify this and introduce clearer processes for care workers.

We reviewed medicines administration recording (MAR) charts for three people who used the service over a three month period. MAR charts were provided by the supplying pharmacy, medicines were signed as received by staff and charts were correctly completed. The provider carried out monthly internal audits, which involved taking a sample of three people's medicines and checking that they were correctly supplied, stored, administered and recorded, and whether unused medicines were disposed of safety and whether people were taking any homely remedies which may present a risk. There was a list maintained of staff who had been trained and assessed as competent to administer medicines.

Where errors had occurred a medicines error report had been completed, which looked at the nature of the error, whether the appropriate people had been informed, what actions had been taken and how it could be prevented in future. A more serious error had occurred where a person had accidentally received a double

dose of medicines for a five day period but there was evidence of learning from this. The provider followed their procedure and established this had been caused by a blister pack being delivered at an unexpected time and stored with the in use medicines. This had been addressed in the regular meeting with the pharmacist and an additional audit of all people's medicines had been carried out, managers had also carried out a lessons learned meeting with the staff team in order to discuss what could be done in order to prevent a repetition.

There was evidence that these measures were effective at reducing the risk of medicines errors; seven errors had occurred in 2017, but five of these had happened in the first half of the year and only two in the second half, with no errors having been noted since September.

The provider also promoted learning from incidents through incident and accident forms; these included details of the incident, action taken in response and any investigation that had been carried out into the root cause and signed off by a manager. We found that the majority of these incidents recorded when people had fallen or felt unwell and had called for help. The provider also sent these to an external compliance manager who could look at patterns and identify if risk assessments required review.

Good

Is the service effective?

Our findings

At our previous inspection in October 2015 we made a recommendation about how the provider assessed people's capacity to make decisions about their care 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 found the provider had acted on our recommendation and had developed some good practice in this area. Where people were able to they had signed their care plans, and where there was concern about people's capacity the provider had carried out a detailed capacity assessment in line with the MCA. This included identifying the specific decision, and considering whether people were able to retain and consider information and to communicate their decisions. Where people lacked capacity the provider had measures in place to demonstrate they were acting in the person's best interests, including considering the person's views and values and those of other relevant persons. The provider had carried out best interests meetings with relatives and other people in their lives.

There was evidence of good practice in considering advanced decisions about care and treatment. For example, for two people it was highlighted that they may develop an infection which could require hospital treatment in future. The provider had worked with people's GPs in order to weigh up the relative benefits of hospital admission or treatment at home in terms of medical, social and emotional impact. A decision had been made about hospital administration considering that hospital treatment may be of limited value medically but would have a severe impact on the person's emotional wellbeing. This meant that people were protected from care and treatment that may not be in their best interests.

There was also evidence of good co-working with other care providers. This included a clear scheme for when external carers were involved in people's care and what tasks to be done with their support. There was evidence that poor practice by other agencies was challenged by the staff team and reported accordingly.

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 support officer told us "I go through people's needs and understanding of what extra care is about. It's partly for us to assess the person and for the person to decide if we're suitable for them." 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 and supervision to carry out their roles. A staff induction was carried out when people joined the service, which included an orientation of the building and a learning and development plan. This was signed off at the end of the person's probationary period. The provider maintained a training system to make sure that care workers received mandatory training which highlighted when training was due for review. Mandatory training included safeguarding, emergency first aid, infection

control and personal care, fire awareness, personal safety, moving and handling, food safety and medicines administration. Care workers were positive about this, comments included, "I get enough training, I can ask my manager for more" and "We get an On Track (review) twice a year, and this includes a section where we're asked what we want to do…We go to other schemes and get exposure to other areas if we want to."

The provider also maintained a "Stepping Stone" programme which was designed to recognise and develop talented staff. One care worker told us "I work in the office on a Friday, [the manager] is very positive about promoting people to develop our skills." There were examples of staff signing up for additional training for roles which could develop their skills, such as running wellbeing sessions or becoming community exercise leaders. Staff also received training in resilience. A senior manager told us "This was in response to a focus group, customers are getting more complex so it's about how they manage challenging situations and how they reflect on that."

Staff received supervision at least four times per year, and an agenda was agreed between the care worker and their supervisor. Topics for discussion included key-working, use of communication books, activities and training. Additionally, care workers received a 6-monthly appraisal, where they were required to assess their performance in certain areas and to reflect on times when they had provided good quality support. We found that managers carried out an extensive set of ratings of people's performance in key areas, although judgments did not routinely contain evidence for the reasons behind the rating.

People received suitable support to eat and drink. Comments from people included "Staff know what I need to eat, if I'm not well they bring my food here" and "The food is nice." Most people using the service received meals from the catering service in the adjoining resource centre. People benefitted from clear systems of communication between the services, with an ordering system which highlighted people's dietary needs as highlighted on their care plans. Care workers told us this worked well "The catering has a list of people who are on diabetic and soft foods, that usually works out well" and "The kitchen works very well." The catering service supplied weekly menus and a member of catering staff routinely attended tenants meetings to discuss the menu contents. Care workers routinely recorded what people had eaten and drunk. We carried out an observation of lunch on the second floor of the building, and we saw that people received their food promptly with suitable and respectful support from care workers.

People's health needs were identified in their care plans, including those relating to diabetes and mental health needs. There was evidence that people were supported to attend hospital appointments and wellbeing and screening checks, and we saw that staff were able to raise concerns about people's health. One care worker told us "We very often go overtime, I've done a few trips to the hospital, the appointments take ages. We just get paid extra and if someone needs to be taken they need to be taken. You stay there with them to reassure and bring them safely home." Care workers worked with other professionals to compile and implement personal action plans for addressing diabetes, and the provider had prepared hospital admission sheets with key information about people's health and support needs for hospital staff.

Good

Is the service caring?

Our findings

People who used the service told us that staff were caring. Comments included "I get on well with the staff, they help me with everything I need", "They treat me nicely, you can see we have a good relationship", "The staff are nice…we're very happy at Elgin Close."

We observed pleasant interactions and laughter between staff members and people who used the service. Staff we spoke with gave us examples of how they provided a caring service. For example, one staff member told us of a person who had been using the intercom service a lot and said "I realised their [family member] had died last year and we talked about [them]. I said I'm going to cheer [him/her] up as it's been exactly a year, and I told all my colleagues to be fragile with [him/her]." Another care worker told us "When I go to work I feel so happy because they're in a place where they're happy and there's someone there all the time."

We observed that one person was becoming agitated in a corridor, and a senior member of staff came to support them into their flat in order to provide reassurance whilst promoting privacy. Plans included information on people's emotional needs and how people maintained contact with their family members. For example, one person could no longer speak, but the plan gave times when their family member would call, and informed staff they needed to hold the phone to the person so that they could hear their family member speak.

People who used the service told us they felt listened to and treated with respect. Comments included "They do [personal care] with dignity" and "They are real, proper carers and they are very nice." We observed care workers knocking on people's doors and ringing people's doorbells before entering their flats. There were systems in place to support people to speak up, which included tenants meetings and surveys. Plans included information about people's understanding and their ability to communicate, and the way in which communication difficulties may affect people, such as causing them to become frustrated and how staff could alleviate this. We saw that the provider did not currently have a keyworking system in place, however plans to implement this were advanced. People had been allocated key-workers and care worker's timetables for the day had recently been updated to include key-working time; implementation of this had been discussed in team meetings and handovers.

One person told us "They do listen to me." A care worker said "Everyone's individual and they've all got different needs, we try to [meet those] as best we can. The best way to do that is to listen and see what they've got to say." Another care worker said "I look through pictures with people when they can't sleep at night, it's nice." Staff we spoke with had a good understanding of people's cultural needs and gave examples of how they supported people in a way which met them, such as the foods people liked, the types of religious services people wished to attend and how people liked their hair and skin cared for.

The provider had also worked with people to put together tenant profiles. These contained people's views on what they liked and didn't like, their hobbies and interests and how they preferred to be addressed by care workers. Profiles also contained life story information such as where people had previously lived, people and places that were important to them and languages that they spoke.

Good

Is the service responsive?

Our findings

People received a responsive service through care plans which were reviewed regularly.

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.

We found that reports and plans were computer generated with logs of changes which were made, which meant that these were often very hard to understand. Comments from staff included "Some people find that clunky" and "The format of the plans as it currently stands isn't particularly accessible, that's an area which would be good to work on." However, other information was far easier to follow. For example, for a person with a learning disability there were pictorial timetables and an illustrated support agreement. The support officer told us "[The person] can see what dates people were coming in and what they were doing on those days." Staff members showed us other tools they had developed and planned to implement, such as more illustrated plans designed for people with dementia, and co-ordinators had recently received training in implementing these plans.

People also had individual task plans, which contained a clear summary of people's planned visits during the day 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, but did not routinely record whether all of these tasks had been carried out, this meant that it wasn't always clear when a person's pad had been changed or whether the person had been transferred. However, we saw examples of this information being communicated in staff handovers, and night staff routinely recorded all the visits they had made including additional visits in response to calls; and clearly detailed what tasks had been carried out. Records showed that people received their visits as planned, and there was also recording of additional support, for example when people had called for support at night or needed support in order to attend appointments.

The provider continued to arrange activities for people and there was an activity programme people could access at the adjoining resource centre. This included a monthly cocktail party run by an external group called Magic Me. Weekly activities included chair based exercise, a Christian service, bingo and coffee morning, and a weekly group called Standing Together. This was designed to promote social connections for people with mental health needs, and covered memory books, flower arrangements and music; there was a display of recent activities in the lounge. There was also a monthly visit from a local Baptist choir and recent events had included a party for older people's week, a barbecue and gardening. There were also photographs of activities displayed in the lounge including a day out to Brighton and activities for Mother's Day.

At the time of our inspection nobody was receiving end of life care, however we saw records of co-working with local GPs, palliative nurses and social services in order to prepare for end of life discussions. This

included advanced best interests decision making around hospital appointments and in some cases people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders on the front of their files. The provider had a register of people who may be close to receiving end of life care, which was discussed regularly with managers and health colleagues. One care worker told us "I feel like in the future we will have more and more people staying with us; we'll need better training for end of life care. It's being discussed and I think it will be addressed."

The provider had a complaints policy with a clear handling process. Complaints were logged with a timescale for investigation and response. We saw that this was followed effectively, with complaints investigated and the complainant liaised with, either through meetings or emails. Solutions included compensation, for example when staff had inadvertently damaged a person's property, the provider agreed to replace the item, and when a person's possessions had gone missing, had provided a lockable cupboard for storing valuables. People told us that they were confident speaking to managers and staff if they were not happy about something, but most people told us they had not had cause to complain.

Good

Is the service well-led?

Our findings

People who used the service knew who the manager was and felt that the service was well-led. Comments included "She's lovely", "They all work together" and "They check up on us." Comments from care workers included "We get on with each other and have a laugh, they're supportive and friendly", "I find it's one of the best schemes, we all support each other" and "Where I've got more experience I can teach them what I know."

There were thorough systems of audits and checks taking place. We found that spot checks were carried out by senior care workers and managers, which included looking at the person's condition, medicines, files, condition of their flat and any actions which needed to be taken. The registered manager told us that they aimed to carry these out three monthly. Senior managers from the organisation carried out night inspections. A senior manager told us "It's about checking, and letting them see the senior managers and letting them know they are appreciated." The night inspection checklist included checking the access to the building, staffing levels and health and safety checks, and highlighted any issues of concern. For example, a recent spot check had highlighted that the remote intercom system had been switched off, although night staff were still monitoring this from the office. This was investigated, and managers concluded that this had been an accident, and had labelled the relevant plug clearly so that this could not happen again.

There was clear guidance displayed for staff in the main office on how to respond to certain issues, such as what to do in the event of a person going missing or dying. There was also information displayed on acceptable dress and nail length, and this was checked during spot checks of care workers. 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, but had developed a plan for improving the person-centred nature of support plans.

There were also good communication systems between care workers. For example, a handover was carried out between each shift, and a form was completed to verify that people had had their meal, their care and received their medicines. We found that minutes were not taken of handovers, but we observed one handover session. This lasted over half an hour and was used to discuss each person in turn, including whether people had refused care and if there were any issues of concern, and staff had a detailed discussion about what may be causing the issue and strategies that the next shift should try in order to alleviate this. Care workers told us "Handover is like a staff meeting; an awful lot of information is passed on and we have the opportunity to discuss it so as to build a bigger picture" and "[Handover] is very useful, we get to hear how our customer is…and what to look out for."

In addition to these three daily discussions, there was a team meeting every month where issues such as staff training and customer needs were discussed. As part of this the team had carried out exercises designed to encourage reflective practice, such as situations involving professional boundaries and potential conflicts of interest. The registered manager told us they had recently carried out an exercise called "Knowing our customers", where staff shared knowledge on people's health conditions, care needs

and what they liked and disliked. The registered manager said "It gave staff the option to talk a bit more about what they knew, it was good for me to see staff take the time to get to know people."

The provider engaged people who used the service with regular newsletters including upcoming events, and quarterly tenants meetings. These were used to discuss issues relating to staff changes, health and safety and safeguarding issues and a member of the catering team attended to discuss food. There was also a satisfaction survey carried out late last year, which included checking whether people were happy with the quality of care, approachability of care workers and how complaints were handled. This showed a high level of satisfaction, with 93% of respondents happy overall, but where people had highlighted areas of dissatisfaction managers had put together an action plan to address these, and had produced information for people in a "You said/We did" format, for example to show how concerns about the menus were highlighted.

Managers worked with other professionals to improve health outcomes for people. The service had participated in a pilot scheme to discuss Integrated Care Pathways in order to address falls and provide more co-ordinated care, and although this had not continued it had resulted in an End of Life Scheme in order to prepare for improved end of life care. The registered manager said "The End of Life Scheme is really impressive with a buy in from health professionals." The scheme had also worked with a local school for younger children to come in and link up with people using the service.