

Support Direct Limited

# Hanwell Community Centre

## Inspection report

Hanwell Community Centre  
Westcott Crescent  
London  
W7 1PD






Date of inspection visit:  
10 February 2016  
11 February 2016

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Inadequate</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

This inspection took place on 10 and 11 February 2016 and was announced. This was the first inspection of the service since 5 September 2013 when it was registered with the Care Quality Commission (CQC).

Hanwell Community Centre is a home care agency that provides personal care and support to people living with dementia, learning disabilities, autistic spectrum disorder and mental health difficulties as well as older people, people who misuse drugs and alcohol, people with an eating disorders, physical disabilities and sensory impairments. The service is actually named Support Direct Limited but is located at Hanwell Community Centre and the service is registered with CQC as Hanwell Community Centre.

On the day of our inspection, the agency provided approximately 1,200 hours of support on a weekly basis to 61 people. All of the people using the service were receiving personal care.

The agency had the registered manager in post who had been managing the service since it was registered with CQC.

A registered manager is a person who has registered with the CQC 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.

The registered manager did not have a full understanding of all the requirements related to the delivery of regulated activities. The agency did not notify CQC about important events, which occurred within the service as required by the law.

The agency did not have robust records and data management systems in place to audit the service delivery and ensure consistent, high quality of care.

The agency did not always protect people from harm and abuse, because they did not have systems to ensure effective reporting, monitoring, analysis and review of safeguarding concerns.

People did not always receive safe care and treatment, as the agency did not identify risks to their health, safety and welfare.

The agency did not monitor peoples' medicine administration records (MAR), therefore the managers could not assess if people using the service received their medicines as prescribed.

The agency had a complaints policy and procedure in place, however, it was not effective and people using the service and their relatives raised their concerns directly with the local authority.

The agency did not always support people to express their wishes and people were not always actively involved in making decisions about their care, treatment and support.

People's care plans did not always specify their nutrition and dietary needs as well as spiritual and cultural wishes, therefore staff who supported them did not have access to this information.

All staff received medicines training.

The agency had robust recruitment procedures in place to ensure they only appointed suitable staff to work with people who used the service.

The agency had a rota system to ensure all staff members knew who they were assigned to visit that week and that all staff planned absences were covered.

People said the staff usually arrived on time and they called if they were running late.

People told us they felt involved in their care and they trusted that staff would inform the agency if they were ill or needed the attention of another health professional.

The agency was working within the principles of the Mental Capacity Act 2005 (MCA).

The agency asked people using the service to give their consent before offering care and treatment to them.

Family members said they were happy with the care their relatives received from the agency and people using the service told us staff treated them with dignity and respect.

The agency assessed the needs of people using the service prior to agreeing the care package.

The agency had a service users' feedback questionnaire to obtain people's views about the care they received from the agency.

Staff received an induction to their role as care workers.

Staff received regular, formal supervision from the registered manager.

Staff told us they felt supported by management and there was a culture of open and transparent communication.

External professionals gave positive feedback about their work with the agency and said that communication with the agency was prompt and efficient.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Inadequate ●

The service was not safe.

The agency did not always manage medicines safely. Not all medication administration records (MAR) were available in people's files and therefore the agency could not assess if staff always administered medicines as prescribed.

The agency did not assess risks to the health and wellbeing of people using the service.

Not all staff had current safeguarding training and the agency did not have systems to report, analyse and monitor safeguarding concerns.

The agency had robust recruitment procedures to ensure it only appointed suitable staff to work with people who used the service.

### Is the service effective?

Good ●

The service was effective.

Staff reported concerns about people's health and wellbeing to their managers.

The agency worked within the principles of the Mental Capacity Act by enquiring about people's mental capacity and asking for their consent to deliver the care package.

Staff received formal supervision from the registered manager.

### Is the service caring?

Good ●

The service was caring.

People using the service and their relatives told us they were happy with the care and support they received from the agency.

People using the service said staff respected their privacy and dignity when delivering personal care.

### Is the service responsive?

The service was not always responsive.

The agency had a complaints procedure, however, not all people using the service were aware of it or they did not want to make a complaint directly to the agency.

The agency planned people's care, however care plans did not reflect people's personal wishes and preferences.

People had their care needs assessed prior to receiving their care package.

The agency used a service quality questionnaire, therefore people were able to give their feedback about the service they received.

**Requires Improvement** ●

### Is the service well-led?

Some aspects of the service were not well led.

The agency did not notify CQC about important events, which occurred within the service.

The agency did not have records and data management systems in place to audit the service delivery and the quality of care.

Staff said they felt supported by the management team.

External professionals told us the communication with the agency was efficient.

**Requires Improvement** ●

# Hanwell Community Centre

## **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 10 and 11 February 2016 and was announced. We gave the provider 48 hours' notice because the location provides a home care service, which could mean that the office would not be staffed if everybody was out providing support. We therefore wanted to make sure someone was available.

This was the first inspection since the service registered with CQC on 5 May 2013.

The inspection team consisted of two inspectors. One of them was a bank inspector.

Before the inspection, we gathered information from a Provider Information Return (PIR). 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 also reviewed other information about the agency such as service satisfaction questionnaires that we sent to people using the service and their relatives prior to our visit.

During the inspection visit, we met the registered manager who was also the director and the owner of the agency, two members of the management team and five care workers. We also carried out phone interviews with ten people using the service and six family members.

We looked at the care records for six people who used the service, the staff recruitment and support records for six members of staff, the provider's record of complaints and compliments, and the provider's records of audits and quality monitoring.

# Is the service safe?

## Our findings

The agency did not always protect people from harm and abuse. The agency did not have robust systems in place to ensure prompt and effective reporting, monitoring, analysis and review of safeguarding concerns.

The provider did not use reporting tools that were identified in their safeguarding policy, for example suspected abuse incident or accident and incident forms. A member of the management team showed us a "personal information section" on the service's online database where the management team could record information related to people using the service. The agency recorded concerns brought by staff members, however, there was no clear explanation how the matter was dealt with and if relevant authorities were informed. Care records for one person stated that they had a bad bed sore, however, there was no evidence to show that this had been reported and that appropriate action had been taken.

Out of the fifty one care workers involved in the delivery of personal care, seven had not yet received training on safeguarding offered by Hanwell Community Centre. The registered manager advised us that three out of the seven care workers brought with them certificates of training on safeguarding undertaken with their previous employers and four were awaiting safeguarding training with the agency. The registered manager advised us that the training was due to take place in April 2016.

Prior to our visit CQC received information from another professional stating the agency did not report a safeguarding concern regarding a vulnerable person that they supported. We spoke about this with the registered manager who informed us that they alerted the local authority, however, we did not see any record of such a referral being made. The agency did not have a central safeguarding log to ensure that all safeguarding concerns were dealt with, analysed and that lessons were learnt to avoid similar situations in the future. In addition, the registered manager did not submit statutory notifications regarding safeguarding concerns to CQC.

The above evidence showed that the provider had not taken all possible steps to identify the possibility of abuse and to prevent abuse from happening.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who received safeguarding training could describe potential signs of abuse. They told us they reported their concerns to their managers.

People did not always receive safe care and treatment because the agency did not always identify risks to their health, safety and welfare. We looked at the care records for six people using the service and we saw that five did not have risk assessments and risk management plans. Records for three people stated they were at risk of losing their balance, however, no falls risk assessments were available. One person had difficulty with swallowing, but no choking risk assessment was in place. We saw a record of a complaint made to the local authority by a family member of a different person using the service. They stated that a

staff member had left a glass of water for their relative to drink. This was dangerous as the person had difficulty with swallowing, was at risk of choking and was only allowed to consume liquids that were coagulated with a food thickener. This incident suggested that the agency did not always deliver care and support in a way that reduced risks to people's safety and welfare.

Some people needed support with food preparation and eating, however, their care plans did not always have detailed information on what support they needed. Consequently, staff did not have access to it. Two people, whose files we looked at, were diagnosed with diabetes but their care plans did not state what food they could or could not eat. A second person was receiving food via percutaneous endoscopic gastrostomy (PEG) tube. In this procedure, a flexible feeding tube is placed through the abdominal wall and into the stomach. We did not see this information recorded in the person's care plans. We also looked at daily care records for this individual and we saw that staff had been supporting them with using the PEG tube. The staff's training records showed they were doing it two weeks prior to receiving formal training required to operate such equipment. This practice could increase the possibility of incorrect use of the tube and could cause harm to person's health and well-being.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medication administration records (MAR) for one person using the service and we saw that they were completed correctly. However, not all MAR sheets were available in people's files. The agency could therefore not assess if staff always administered medicines as prescribed. This was a particularly serious issue in the case of a person who required anticoagulant medicine to prevent blood clots.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people required support to take their medicines and this was part of their care plan. All staff received medicines training. We spoke with six staff members who confirmed that they received the training and were aware of medicine administration procedures. We also saw up-to-date medicines training certificates in staff files.

The agency had robust recruitment procedures in place to ensure they only appointed suitable staff to work with people who used the service. We looked in personnel files for six staff members and saw that all required recruitment paperwork was in place. This paperwork included an application form and references that were requested by the agency. All six staff members had up-to-date Disclosure and Barring Service (DBS) checks.

The agency had a rota system to ensure all staff members knew who they were assigned to visit that week and that all staff planned absences were covered. The agency used an online care monitoring system that allowed line management of daily home visits done by care workers. It had also implemented an additional back-up system in case of sudden staff absence.

Staff confirmed that they were using the system and people told us care workers mostly turned up on time or shortly after they were supposed to. People also told us that the agency informed them if care workers were running late.



# Is the service effective?

## Our findings

The majority of people using the service felt staff had relevant information in order to fulfil the requirements of their role. However, we looked in the care files for six people and we saw this was not always the case.

The registered manager told us and staff confirmed they received an induction prior to starting their role as a care worker. The induction consisted of initial classroom training that the agency considered mandatory. This included medicines administration, moving and handling, infection control, food hygiene and first aid. The agency also asked staff to complete the Common Induction Standards, which are designed to provide a structured start for workers in the first 12 weeks of employment. We looked at the files for six staff members and we saw that not all of them had completed the Common Induction Standards. This meant that not all staff members had safeguarding and Mental Capacity Act 2005 training which was included in the Common Induction Standards but not in the initial classroom training. We spoke about this with the registered manager who informed us that the agency was in the process of implementing new online Care Certificates training package and all staff who did not complete Common Induction Standards were booked to undertake this new training in March 2016. We saw a training matrix that confirmed this information.

The agency asked all new staff to shadow their more experienced colleagues before working unsupervised with people using the service. We saw evidence of this taking place in staff files.

Staff received effective support in the form of regular one to one meetings and spot checks of their work during care visits. We looked at staff files and we saw evidence of both forms of supervision taking place. All six staff members we spoke with told us they could also request additional, informal support any time they felt they needed it. None of the staff had been employed with the agency for more than one year, therefore they have not received an annual appraisal. The registered manager told us that appraisals were due in February 2016.

People said the staff usually arrived on time and they called if they were running late.

People told us they felt involved in their care and they trusted that staff would inform the agency if they were ill or needed the attention of another health professional. We looked in peoples' care plans and care records. We saw evidence that staff recorded health concerns and additional care needs that people they supported had. The registered manager told us and staff confirmed that they would communicate with the office in case of emergency or concerns about people they supported. The registered manager showed us records of such conversations on the agency's online database.

We checked whether the agency was working within the principles of the Mental Capacity Act 2005 (MCA). The 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.

The agency's representative discussed people's mental capacity and ability to make decisions during the initial assessments. Where people were not able to make decisions the assessor enquired if they had a Lasting Power of Attorney (LPA). An LPA is a legally appointed person who has a right to make decisions on behalf of people who cannot make them for themselves. In case a person did not have capacity or a legally appointed representative, the agency would refer them to a social worker for further assessment. Staff understood the principles of the Mental Capacity Act. One staff member told us "if people cannot make decisions for themselves they need to have somebody with legal powers to do it on their behalf".

We looked at people's files and we saw that they signed their needs assessment giving their consent to receive support from the agency. People we spoke with said that staff generally asked people about their consent before they did anything.

Family members told us they were happy with the care received from the agency. They said, "My (relative) is very happy with the care they get. They are very pleased with it."

## Is the service caring?

### Our findings

The majority of people using the service and their relatives told us they were happy with the care and support they received from the agency. One person said, "They treat my (relative) like they would their mother". A second person told us "They are carers, they know how to talk with people and how to help in the right way".

People told us staff treated them with dignity and respect. One person told us, "The (staff member) who washed me was really sweet. You couldn't take offence – she was a real lady." A second person said, "Mine is the very best. I feel lucky. She is excellent". One family member reported, "They treat (relative) with the utmost integrity and respect."

The agency had their own service quality questionnaire in which they asked people who used the service about their experience of the care they received. The management team was in the process of analysing gathered information in order to inform a future improvement plan for the service.

## Is the service responsive?

### Our findings

The agency had a complaints policy and procedure in place, however, it was not effective. We spoke with ten people using the service. Three people said they knew who to call but they did not feel comfortable with doing so. One person said they did not want to become unpopular with the agency. Two people told us they did not know what the complaint process was and who to call. We saw similar comments in the agency's service quality questionnaire.

We asked the registered manager for information on complaints made to the agency. We saw records of four complaints. All of them were made directly to the local authority and not to the agency. This suggested that people using the service might have not felt confident in the agency addressing their concerns. Two of the complaints we looked at did not have outcomes of an investigation recorded and we could not see how the agency had dealt with them. There was no central analysis of complaints to identify themes of concerns. There was no log of complaints to show when these had been received, investigated and responded to. Therefore, there was no evidence of the agency learning from complaints to improve practice.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People's care records were holistic and contained information on people's key care needs such as what assistance with medicines they needed, support with eating and mobility levels. However, care plans consisted of incomplete information on people's cultural and spiritual needs and their personal wishes and preferences. We looked at care plans for six people using the service and we saw that these sections of their care plans were lacking in any details or had not been answered. Two people we spoke with were not aware of their care plans.

We looked at service users' feedback questionnaires that the agency asked people to complete. Two people stated they did not know what their care plans were. We saw that these individuals did not sign their care plans. This evidence suggested they were not involved in the planning of their care.

Staff did not always feed back to the agency about the changing needs of people they cared for. One person we spoke with said, "The workers come in to wash and dress (my relative) but they (a person using the service) don't need it now. We would rather they stopped coming now."

We looked at people's care notes. One person's records stated that they did not want to receive support from a particular staff member and they asked them to leave. However, we saw that this staff member returned to deliver personal care to the same person for the next three days. We spoke about this with the registered manager. They said they addressed the situation as soon as they knew about this. However, the staff did not convey the information immediately and consequently the person received support from a staff member they did not want.

None of the people whose files we looked at had their culinary and spiritual needs section in their care plans completed.

The above evidence showed that the agency did not always support people to express their wishes and people were not always actively involved in making decisions about their care, treatment and support.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We also saw good evidence of the agency meeting people's needs. One person told us, "They are quick to help – providing me with a grab rail and a raised loo seat". A second person stated in their service quality questionnaire, "The dialogue takes place about meeting needs and tasks to be completed".

People told us the agency assessed their needs prior to agreeing the care package. Relatives told us, "They came round at the start and asked loads of questions and told us about it all (the support)". People's care records all had completed care needs assessments they had signed.

The agency used a service quality questionnaire. The aim of the questionnaire was to obtain people's views about the care they received from the agency. The registered manager provided us with a copy of a draft report following the survey and informed us that the agency was in the process of analysing their findings and producing action plans in order to improve the service delivery and experience of the care by people who use it.

## Is the service well-led?

### Our findings

The agency had a registered manager in post who had been managing the service since it was registered with Care Quality Commission on 5 May 2013.

The registered manager did not know all the requirements related to being a registered provider with the CQC. Consequently, they did not always fulfil their responsibilities with regards to managing a registered service.

The registered provider is required by law to notify the CQC of important events, which occur within the service. During our inspection, we saw evidence of three significant incidents and events taking place, which should have been reported to CQC and to the local authority but had not been.

The agency did not notify CQC about safeguarding concerns regarding people who were receiving support from the agency, a police incident and number of deaths of people using the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We have requested that in future all notifications are sent to CQC in a timely fashion so that, where needed, action can be taken.

The agency did not have robust records and data management systems in place to audit the service delivery and ensure consistent high quality of care. We did not see records of medicines or care plans audits, a central safeguarding register as well as incidents/accidents and complaints logs. The registered manager confirmed they did have not such documents at the time of our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the registered manager about all our findings on the day of our visit. They acknowledged the areas for improvement and said they would put measures in place to rectify all gaps in service delivery.

Staff told us they felt supported by management and there was a culture of open and transparent communication. One staff member told us "sometimes I just come (to the office) to say hello as it is very friendly environment". A second person said, "I can always speak to management and they always support me". This suggested that staff felt comfortable approaching the management team with any issues if needed.

We spoke with external professionals who gave positive feedback and said that communication with the agency was prompt and efficient. One person told us, "I have no concerns. I find the manager and the office staff who we mainly deal with very efficient. They respond to e-mails very quickly and are always ready to help us in emergencies if we need agencies at short notice".

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>The registered manager did not notify the Care Quality Commission without delay of any important events, which occurred within the service.</p> <p>Regulation 18 (2)(b)(f)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The registered person did not ensure that care and treatment were provided in a person centred way.</p> <p>Regulation 9 (3) (b)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered manager did not ensure that care and treatment were provided in a safe way to service users because:</p> <p>They had not assessed the risks to the health and safety of service users</p> <p>Regulation 12 (2) (a)</p> <p>They did not ensure the proper and safe management of medicines.</p>

Regulation 12 (2) (g)

Regulated activity	Regulation
Personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The registered manager did not take all possible steps to identify the possibility of abuse and to prevent abuse from happening.</p> <p>Regulation 13 (2)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints</p> <p>The registered person did not always operate an effective system for identifying, receiving, recording and handling complaints.</p> <p>Regulation 16(2)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered manager did not operate effective systems to:</p> <p>Assess, monitor and improve the quality of the service.</p> <p>Regulation 17(2)(a)</p> <p>Assess, monitor and mitigate the risks relating to health, safety and welfare of service users.</p> <p>Regulation 17(2)(b)</p>