Review of compliance

United Response United Response - 198 Powder Mill Lane	
Region:	London
Location address:	198 Powder Mill Lane Whitton Middlesex TW2 6EJ
Type of service:	Care home service without nursing
Date of Publication:	November 2012
Overview of the service:	198 Powder Mill Lane is a care home for up to five adults who have a learning disability. The service is managed by United Response and is registered to provide accommodation for people who require personal care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

United Response - 198 Powder Mill Lane was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 4 October 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

People living at Powder Mill Lane told us about their favourite activities and special events and the things they enjoyed being part of.
They told us about the visits to local facilities and shops and what they enjoyed about these visits. People told us about the friends they had made at the home.

We spoke with relatives of two people living at Powder Mill Lane who complimented the staff and manager on the support and care they provided to people at the home. They told us that they had seen improvements in their family members overall health and wellbeing.

The provider may wish to note that relatives of people living at the home did not always feel that they were involved or that their feedback was gathered about life at the home and commented that communication was difficult at times. They felt that messages were not always passed on to the manager and said that both involvement and communication could be improved at the home.
Relatives of people living at the home felt that on occasions communication presented difficulties and they could not be sure that information was cascaded or passed to the manager according to their wishes.

Relatives of people living at the home also felt that staffing levels were not always sufficient to secure the safety of all the people living or working at the home. They told us that on occasions people living at Powder Mill Lane had few activities to engage them, apart from watching the television and that arranging health related appointments for people could be difficult.

What we found about the standards we reviewed and how well United Response - 198 Powder Mill Lane was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was meeting this standard. People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was not meeting this standard.
People who use the service and others were not fully protected from the risk of harm meaning there were insufficient processes for addressing the risk of injury to people using the service. We judged this to have a moderate impact on people using the service.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider was not meeting this standard. There was not enough qualified, skilled and experienced staff to meet people's changing and diverse needs, meaning that people were at risk of poor care and attention. We judged this to have a moderate impact on the people using the service.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was meeting this standard.
The provider had an effective system to regularly assess and monitor the quality of the service that people receive.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The provider was not meeting this standard. Records were not accurate or fit for purpose and there was insufficient evidence of record keeping procedures, meaning that people were not being fully protected against the risks of unsafe or inappropriate care and treatment arising from a lack of record keeping. We judged this to have moderate impact on people using the service.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with two people who use the service. The people we spoke with told us about how they enjoyed spending their time and their favourite activities. One person said "my favourite trip is to the shops to buy things I like".

We spoke with relatives of two people living at the home who told us that staff were supportive and kind. Some relatives said that although they felt welcomed at the home, they were not always kept as involved as they would like to be.
Relatives of people living at the home felt that on occasions communication was difficult and that messages did not seem to be passed to senior staff according to their wishes and concerns.

Other evidence
During our inspection we saw that staff were aware of people's individual needs and helped them to make choices about decisions like their food, clothes and activities.

We heard staff providing explanations to people and engaging them in aspects of home life including meal times, planning shopping trips and choosing how to spend time with their friends.

We asked staff how they involved people using the service in life at Powder Mill Lane. Staff provided examples of supporting people with swimming, visiting the cinema and participating in exercise. Some people enjoyed listening to music while others enjoyed stories read by the staff.
Staff described a recent trip to Bird World and a trip along the river Thames which we were told people living at the home enjoyed.

The provider may wish to note that we spoke with staff who advised that key workers were not always involved in the care and support provided to people living at Powder Mill Lane, we asked for examples and were told that people's holiday plans were not fully discussed with all key workers and this meant that people living at the home might holiday with staff unfamiliar with people's needs.

Our judgement
The provider was meeting this standard. People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with two people who use the service and two relatives of people living at the home. People living at the home told us that they enjoyed the activities at the home and the visits to special places.
Relatives of two people living at Powder Mill Lane felt that the care and welfare offered by staff was good and that they had noticed overall improvements. The provider may wish to note that a relative of one person living at the home felt that on occasions there seemed to be difficulty in staff arranging and booking appointments with doctors and other health care staff, and that communication about this was not forthcoming.

Other evidence
We looked at care and support plans and although there had been recent reviews of some people's care, the provider may wish to note that risk assessments did not always take into account pre-empting of recurrent situations for some of the people living at the home. This meant that while some learning took place, this did not always take full account of the presenting risks.

We saw staff providing care and support, meeting people's individual medical, physical and social care needs. Throughout the day we spoke with four staff that were familiar with the requirements of each person living at the home and we saw them providing appropriate support.
We saw records indicating that people's medication reviews were taking place.

We were informed that health and social care staff were involved on a regular basis

with helping staff meet the needs of people living at Powder Mill Lane, and that staff working at the home were responsive to the health and social care team's involvement. The home made regular contact with district nurses, speech and language therapists and psychologists for advice and support in helping people stay well. Occupational therapists and dieticians were in regular contact to ensure that people using the service had access to equipment, meaning that peoples' comfort and their independence were considered and promoted.

The provider may wish to note, we spoke with several staff members who explained that agency staff may not necessarily receive information on the shift plan for the day, or daily schedules like cleaning which was felt to be a disadvantage for them.

Our judgement
The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is non-compliant with Outcome 07: Safeguarding people who use services from abuse. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We haven't been able to speak directly with people using the service about this outcome because the people using the service had complex needs which meant they were not able to tell us about all of their experiences.

We did speak with relatives of two people living at the home however, who told us that staff were supportive, thoughtful and kind. One person spoke with us and told us that on occasions there was not enough staff to keep all people at the home safe from potential harm.

Other evidence
Prior to our inspection we received information of concern about staff having been injured at the home. We asked to see records and although we saw past and recent information relating to previous and the most recent incident with actions, it was unclear whether pre-empting strategies had been employed in relation to keeping all people safe at the home because the incident had a re-occurring theme. We saw that the home had a physical restraint policy indicating how people should be restrained safely and with minimum force.

Staff at the home had received training relating to safeguarding of vulnerable adults, deprivation of liberty and physical restraint techniques and challenging behaviour. We were informed however, that the certificates for some of this training had not been received from the external training provider. Staff were also well informed of the

procedures for reporting incidents of safeguarding to the local authority. We observed the care of people at Powder Mill Lane and staff were attentive to people living at the home and spoke confidently of the changing needs of people they were supporting. We spoke with staff about Mental Capacity and the Mental Capacity Act and staff were clear about their responsibilities to the people at the home.

When we arrived at the home in the morning there was only two staff members working at the home, two further staff were off site and we could not be sure that everyone's safety was being fully met at all times.

We looked at records which reflected that care relating to safeguarding of people had been partially reviewed. However, we discussed the risks to people living and working at the home and asked how these risks were being mitigated for all those working and using the service. It was unclear how risks to all people at the home were being managed.
We saw that while two home reviews by staff had been conducted these did not fully take into account the risks to all people at the home and some potential risks for people using the service had not been fully reviewed and updated for several years.

We read a risk protocol statement and records indicating that staff would receive risk assessment training and regular supervision, however, we found that staff records did not fully reflect this was happening.

We looked at the reporting of incidents at the home and noted that there had been six incidents reported in the last six months. We spoke with staff about updates and handovers between shifts and while some staff gave details about how information is verbally conveyed not all staff were aware of a recent incident occurring at the home. Staff told us that on occasions they rely on verbal handovers between shift changes but not all information about peoples' care is covered.

We asked about Deprivation of Liberty used at the home and were informed that these were updated every six months.

Our judgement
The provider was not meeting this standard.
People who use the service and others were not fully protected from the risk of harm meaning there were insufficient processes for addressing the risk of injury to people using the service. We judged this to have a moderate impact on people using the service.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is non-compliant with Outcome 13: Staffing. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with people using the service but their responses did not relate to this part of the inspection.

We spoke with relatives of two people living at the home who told us that they had concerns regarding the staffing levels at the home. Relatives spoke about the needs of the people living at the home and commented that some people needed two to one and on occasions three to one personal support and these comments had been previously raised with senior staff. One person spoke with us and described that at times, when there were not enough staff, the people living at the home spent much of their time sitting in the lounge watching television with little involvement, stimulation or engagement in activities.

Relatives spoke about their concerns regarding the lack of presence of the registered manager, indicating that it was difficult to contact the manager. Relatives of people living at the home felt that on occasion's communication presented difficulties and they could not be sure that information was cascaded or passed to the manager according to their wishes.

Other evidence
When we arrived at Powder Mill Lane we found two staff members were working directly in the home supporting four people, some of who had diverse and unpredictable needs. One of these staff was from an agency but had worked at the home on several occasions. One other staff member was off site supporting someone living in the

community. The manager was attending a meeting elsewhere but returned after being contacted by a staff member.

We looked at records and spoke with staff to ascertain that ten staff were employed at the home, five full time and one part time staff member, three were regular bank staff and all had relevant experience. We asked about where agency staff were employed from and were informed that the home uses one particular agency, familiar with the needs of the home.
During the course of the day - we spoke with four people working at the home and asked questions relating to staffing levels and while staff felt that levels were effective, concerns were expressed regarding gaps during rotas when staff were either not present, or carrying out responsibilities elsewhere, meaning that the home was under-resourced to meet people's challenging needs.

It was unclear on the day of our visit what arrangements had been made to cover staff absence from the home and how the remaining two staff would manage in an emergency. We learned later that day of additional staff who had been contacted with only an hour notice at lunch time to cover the afternoon shift.

We asked about the needs of the people living at Powder Mill Lane and at least one person required one to one and often two to one support. We asked staff how they would respond to emergencies or sudden changes in the home with these staffing numbers. Staff were unsure how they would have managed a challenging situation.

We spoke with four staff who gave clear accounts of the training they received to support them in their roles. The staff we spoke with described their experience and knowledge of having supported people at Powder Mill Lane. They spoke with confidence about their individual roles commenting about the quality of the training they received.

We asked the manager about staffing levels and were informed that a proposal had been drafted and discussed to consider current and future staffing levels at the home. We were advised that this proposal had been submitted to the local authority very recently but that nothing had yet been decided.

The home had recently recruited a new staff member and was waiting to fill one outstanding vacancy at the time of our inspection. Although the home made use of a number of relief staff, those staff we spoke with worked regularly at Powder Mill Lane and were familiar with the needs of people using the service.

We looked at staffing records and found that staff were regularly attending training to support them in their roles, however one staff member was not up to date with several training needs and there was no matrix or method of easily checking which staff were overdue with specific training other than by working through each staff member's electronic training records individually.

Supervision records and records about appraisals were not being appropriately recorded. We spoke with staff about support and while one person had received recent supervision, others had not, having had supervision sessions cancelled.

Our judgement

The provider was not meeting this standard. There was not enough qualified, skilled and experienced staff to meet people's changing and diverse needs, meaning that people were at risk of poor care and attention. We judged this to have a moderate impact on the people using the service.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We spoke with people using the service but their feedback did not relate to the areas covered in this outcome. Some of the people using the service had complex needs and were not able to tell us about this outcome in relation to their experiences.

One relative told us that they felt confident to raise questions or issues if they had any concerns although the provider may wish to note that relatives we spoke with had not been invited to give feedback on how the home was functioning or given the opportunity to attend relatives meetings or meet other relatives at events taking place at the home.

Other evidence
We looked at medication audits and saw that checklists were up to date and that the home was making use of internal quarterly audit processes. The home was receiving quality monitoring visits from external resources and other United Response staff.

Medication stocks had been regularly checked and we saw monitoring reports of health and safety at the home. We saw evidence of audits referring to incident reporting figures although there was no qualitative details only statistical data. There were regular audits of first aid supplies available at the home.

We saw documents referring to weekly checks made on the homes transport vehicle and the water temperature at the home and general maintenance and servicing records. We also saw records indicating that audits relating to fire evacuation and staff and people using the service understood these procedures.

Monthly hazard inspections were conducted by the manager and we read about the annual gas boiler and electrical testing audits for these appliances.

Our judgement
The provider was meeting this standard.
The provider had an effective system to regularly assess and monitor the quality of the service that people receive.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We did not speak directly to people using the service because people using the service had complex needs and were not able to tell us about this outcome in relation to their experiences.

Other evidence
We looked at records of five people using the service. We found that three people's care plan and risk assessments had not been reviewed or only partly reviewed. Comments in reviews referred to 'No change' from the previous year and some care plans had not been reviewed since original plans dated in 2007 and 2008.

We were made aware of several changes for some people living at the home and were told how these changes were affecting the home yet the impact of these changes on other people in the home had not been reflected in their records.

We looked at six staff records and found that while some staff had received supervision sessions and appraisals this was not consistent for all staff, with many staff having not received supervision for many months. Several documents were either missing dates, and or signatures. There were inconsistencies across several staff records relating to dates, signatures and content.
We found some staff supervision notes written on loose paper with little reference to whom they were about or when they had taken place or actions for follow up. One

record had no reference to which staff member the record was about, or the date. Some supervision notes were sparse and the most recent entry on one record was dated January 2012.

It was unclear from many of the records we looked at and how these records were organised, to determine whether information discussed at supervisions had been followed up or actions had been taken. We spoke with several staff and were informed that supervision sessions were sometimes cancelled.

We asked to see minutes from staff meetings and found notes and an agenda from a meeting on the 20/08/12 and a copy of an agenda from 15/03/12. We read the subjects covered in a previous staff meeting although it was unclear from some of the records how often staff meetings were actually taking place.

Our judgement
The provider was not meeting this standard. Records were not accurate or fit for purpose and there was insufficient evidence of record keeping procedures, meaning that people were not being fully protected against the risks of unsafe or inappropriate care and treatment arising from a lack of record keeping. We judged this to have moderate impact on people using the service.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: The provider was not meeting this regulation. People who use the service and others were not fully protected from the risk of harm, because there were insufficient processes to assess and address the risk of injury to all people using the service.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: the provider was not meeting this regulation. There was not enough qualified, skilled and experienced staff to meet people's changing and diverse needs, meaning that people were at risk of poor care and attention.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider was not meeting this regulation. Records were not accurate or fit for purpose and there was insufficient evidence of record	

	keeping procedures, meaning that people were not being fully protected against the risks of unsafe or inappropriate care and treatment, arising from a lack of record keeping.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA