Care Quality Commission

Lifeways Community Care Limited

Lifeways Community Care

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection took place on the 14 and 15 April 2015 and was announced. We gave the provider 48 hours' notice that we would be visiting the service. This was because the service provides domiciliary care and we wanted to be sure that staff would be available.

Lifeways Community Care is registered to provide personal care services to people in their own homes or supported living. People may have a physical disability, an eating disorder, learning disability or autistic spectrum disorder. On the day of the inspection, 69 people were receiving support. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

People told us they felt safe within the service. Care staff knew how to keep people safe from harm.

Summary of findings

People told us there were enough staff to support them safely.

People's medicines administration records were not being used appropriately to show when people medicines were administered consistently.

The provider did not ensure care staff were supported sufficiently through training so they had the skills and knowledge to support people.

People were able to give their consent before any support was given.

The provider had the appropriate procedures in place to ensure the Mental Capacity Act (2005) legislation was being adhered to and people's human rights were not being restricted where people lacked capacity.

People told us that care staff were supportive to them and caring and kind. People's independence, dignity and privacy was being respected.

People were able to make decisions about the support they received and completed a questionnaire as a way of sharing their views on the service that they received.

People's preferences, likes and dislikes were being met how they wanted. Care staff explained how they ensure people's preferences were met.

While people, relatives and staff told us the service was well led, concerns were identified as relatives did not all know who the registered manager was.

We found that the quality audits being carried out were not effective in improving the service quality to people.

Records were not being completed consistently to ensure they reflected enough detail about people's support needs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not always safe.

People told us they felt safe when being supported by staff and there were enough staff to support them safely.

People told us their medicines were administered to them as they wanted. Medicines may not always be given as prescribed.

Is the service effective?

Requires Improvement

Some aspects of the service were not always effective.

Care staff were not receiving consistent and regular support through training to ensure they had sufficient knowledge and skills to support people effectively.

People were able to give consent before any support was given by staff and the provider ensured the Mental Capacity Act legislation was being met to ensure people's human rights were not restricted.

Is the service caring?

Good

The service was caring.

Care staff were caring and kind to people when supporting them.

Care staff were able to explain how they ensured people's independence, privacy and dignity was respected in how they supported them.

People made their own decisions about the care and support they received and they decided whether they were supported or not.

Is the service responsive?

Good

The service was responsive.

People's preferences, likes and dislikes were being met the way they wanted.

There was a complaints process which so people were able to share any concerns they had.

Is the service well-led?

Requires Improvement

The service was not always well led.

While people, relatives and staff felt the service was well led, however not all relatives knew who the registered manager was.

The provider did not ensure audits were consistently carried out to ensure the service was of a high quality to people.

Summary of findings

Records were not being completed consistently to identify people's support needs appropriately.	

Lifeways Community Care

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.

Our inspection took place on 14 and 15 April 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. Due to how small the service is the manager is often out of the office supporting staff or providing care and we needed to be sure that someone would be in.

The inspection was carried out by one inspector.

We asked the provider to complete 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. This information is then used to help us plan our inspection. The form was not received so we were unable to take any information the provider would have given us into account when we planned our inspection. To plan our inspection we reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents, safeguarding alerts which they are required to send us by law.

We visited the provider's main office location. We reviewed the care records of four people that used the service, reviewed the records for three members of staff and records related to the management of the service. We spoke with one person who visited the office on the day of our inspection, three members of staff and the registered manager who were present throughout the inspection. We undertook telephone calls to three relatives of three people who received services from the provider and one further member of staff.

Requires Improvement

Is the service safe?

Our findings

A person we spoke with said, "Yes I do feel safe". All of the relatives we spoke with told us that people were being supported safely. Care staff we spoke with told us they knew how to keep people safe and had received training in how to protect people. They gave examples of a range of situations where people could be put at risk of abuse and the action they would take to keep people safe. We found that the provider had a safeguarding policy in place so care staff would be able to get the appropriate guidance they would need. The staff we spoke with confirmed they knew about the policy.

Care staff we spoke with told us that risk assessments were being used to reduce risks to people. We found that these documents were being used in a range of different areas. For example, manual handling, medicines administration and dysphagia. Dysphagia is where someone has problems swallowing certain foods or liquid. These documents identified where there was a risk and how it should be managed. Where people had a risk or there was a potential risk to how care staff supported them, there was clear guidance through the assessment as to what action or work process care staff should follow. Care staff we spoke with demonstrated an understanding of the risks to people and how they were being managed so people could be supported safely.

One person we spoke with told us they always had enough staff to support them. Relatives we spoke with confirmed this. The registered manager told us that the service they delivered to people was on a one to one basis in a supported living environment in people's home. Care staff worked in small teams which allowed them to cover each other when required. The care staff we spoke with told us they had enough care staff to meet people's needs. One member of the care staff did however tell us that when permanent care staff were on holiday or sick they would struggle on occasions to have enough staff to meet people's needs. We found no direct evidence that there was not enough staff to meet people's needs, but we discussed this with the registered manager who told us that this would be followed up with team leaders who managed the care staff to ensure holiday requests were covered appropriately.

Relatives we spoke with told us they had no concerns with how people's medicines were being administered and stored. Care staff we spoke with told us they were not able to administer medicines until they had received the appropriate training. They also told us their competency was checked and they were observed regularly and knew how to administer people's medicines. The evidence we saw did not confirm that all care staff were being checked consistently.

We checked three Medicines Administration Records (MAR) which care staff completed once they had administered someone's medicines. We found that there were unexplained gaps on two out of the three MAR we looked at, which indicated that either the medicines had not been given or staff had not completed the records appropriately. The registered manager was unable to give a reason as to why there were gaps but told us this would be discussed with team leaders.

We found that the provider had a procedure to provide care staff with the appropriate guidance to administer medicines to people. The procedures identified to care staff how medicines should be stored and at what point they should be ordered and or discarded. Care staff we spoke with were able to explain how this was being done and who was responsible for ordering people's medicines.

We found where people were administered medicines 'as and when required' there were clear protocols in place to give care staff the guidance required to administer these medicines appropriately. Staff we spoke with confirmed this and explained that these medicines had to be prescribed by a doctor before they could administer them.

The care staff we spoke with told us they had completed a Disclosure and Barring Service (DBS) check before being employed. This check was carried out as part of the legal requirements to ensure care staff were able to work with people and any potential risk of harm could be reduced. We found that the provider had a recruitment process in place to ensure care staff had the appropriate skills, knowledge and experience to be recruited. We found from the provider's recruitment process that references were being sought from previous employers to check the character of potential staff.

Requires Improvement

Is the service effective?

Our findings

All the relatives we spoke with told us that people's health needs were being supported appropriately by staff. Where staff supported people round the clock seven days per week they ensured people's health care needs were met. Staff we spoke with confirmed this and explained that they would accompany people to hospital or make arrangements for them to see their doctor when necessary. We found where people were seen by a health care professional, for example a dentist, the appropriate related information was logged to show the support given.

The relatives we spoke with told us that where people needed support with eating and drinking, the appropriate support was given by care staff. The care staff we spoke with were able to tell us where people had specific eating and drinking disorders and what support they provided. The care staff we spoke with told us they were able to access specific training to be able to support people to eat and drink where they had a specific condition like dysphagia.

The care staff we spoke with told us they were able to get support when needed. This support was given by way of regular supervisions. We found from the staff we spoke with that staff meetings did not always take place, but improvements had taken place since the appointment of the new registered manager for staff to attend more regular meetings. The provider had an appraisals system in place but care staff did not all receive an appraisal consistently so that performance and training was monitored.

We found that where staff were successfully recruited they were required to go through an induction program. Care staff confirmed this was the case and that they were also able to shadow more experienced care staff as part of their induction period. The care staff we spoke with told us they were not all able to access appropriate training so they had the skills and knowledge necessary to support people effectively. One relative we spoke with told us that care staff did not always get the training they needed to support their relative. The relative gave an example where a member of staff had not received training to deal with situations where people may have a seizure. The training records we saw confirmed that while training was made available to care staff not all care staff had completed the training expected. We discussed this with the manager who told us they were already aware of this and action was being taken to ensure all staff attended all training.

Care staff we spoke with were able to explain how people's consent was obtained and the need to get people's consent before supporting them. Care staff told us that some people gave consent by the gestures they made and were able to explain who these people were and how they knew people were consenting. Where people were unable to give consent, care staff understood the role relatives played through best interest meetings. Relatives we spoke with told us about their on going involvement with the service in ensuring their relatives were supported appropriately through best interest meetings, and that care staff kept them regularly informed.

We found that the provider had a Mental Capacity Act 2005 (MCA) procedure in place to be used where there were concerns about people's level of capacity. The MCA sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to 'The Court of Protection' for authority to deprive someone of their liberty. We found from someone's care records that a DoLS application had been made. A lap belt was being used in this instance when care staff supported them in a wheel outside of their home, which led to the provider identifying the person was being restricted.

We found from the care staff we spoke with that they understood the principles of the Mental Capacity Act 2005 (MCA). However they had less understanding of the Deprivation of Liberty Safeguards (DoLS). They were unable to explain the purpose and the impact this legislation would have on people's human rights. The care staff we spoke with told us they had received training in the MCA, but could not remember receiving training in DoLS. Records showed that while training was being made available to care staff a significant amount of care staff had not completed the training. We discussed this with the registered manager, who while they had sufficient

Requires Improvement

Is the service effective?

knowledge to ensure people were not restricted inappropriately they acknowledged that a number of staff had not yet completed all their training and action was being taken to rectify this.

Good

Is the service caring?

Our findings

We spoke with someone who said, “Staff are nice, friendly and kind to me”. Relatives we spoke with confirmed that they found care staff to be caring and compassionate towards people. One relative said, “My daughter told me she recently saw [relative’s name] out shopping with care staff and they were wrapped up well for the time of year and were happy and smiling. This made me feel the staff were caring”. The care staff we spoke with were able to explain the approach they had when supporting people. For example, they always greeted people before supporting them and checked how they were. One member of the care staff said, “I always ensure people are relaxed and calm when I support them. We talk and have a laugh”. People had a staff team to support them who they knew well and had built up a relationship with over time. This ensured care staff knew people well to be able to offer them support that was consistent which then should allow for people to be supported in a relaxed calm environment. The care staff we spoke with were also able to give examples of how people’s independence was promoted. One member of staff said, “I am in their home, so however they want to live or whatever they want I will do providing its not putting them at risk”.

One person said, “I decide how my care is delivered not the staff”. Relatives we spoke with told us that care staff were good at keeping them informed about changes to people’s support needs. One relative said, “Staff do listen to what [relative’s name] wants and needs”. The care staff we spoke with told us that people were involved in the support they received. One of the care staff we spoke with said, “People are involved in the support I give them. If they do not want to get up on a morning, that’s up to them, or if they want to go out for a meal. I am here to support them”. Care staff we spoke with were able to explain clearly why it was important that people were involved in the support they were given. Where people were unable to verbalise their views relatives were actively involved in ensuring care staff understood people’s support needs and what certain body gestures or behaviours were illustrating.

One relative said, “Staff definitely respect people’s privacy and dignity”. The care staff we spoke with told us that they never entered anyone’s room without knocking first, or when supporting people with personal care they ensured people were covered appropriately. Some staff said they would leave the room if this was more appropriate. One member of staff said, “On arrival to [person’s name] I always find him and say hello so he knows I am there. It’s his home not mine”. We found that people’s privacy and dignity was being respected in how care staff supported them. Care staff had a good understanding of how people’s privacy and dignity should be considered in how they supported them.

Good

Is the service responsive?

Our findings

One person said, “I am happy with the support I get from staff”. All the relatives we spoke with told us they were involved in the assessment and care planning process in determining their relative’s needs and how they would be met. They confirmed the support that was agreed was being met and a review was carried out. The care staff we spoke with were unable to confirm that people’s support needs were being reviewed and there was no documentation available to support any reviews.

All the relatives we spoke with told us that people preferences, likes and dislikes were being met by care staff. For example, where people wanted to go out on a social event they were able to do so. Care staff we spoke with had a good understanding of the people they supported and their preferences. Care staff spent their time supporting one person and were able to build up a good understanding of the person’s needs. Care staff were able to ensure that whatever people wanted to do they were able to.

The registered manager told us the provider was actively involving people in how care staff were being recruited. An inclusive recruitment champion was being used to support people to actively take part in the recruitment process used to recruit care staff. People were being given the opportunity to be part of the recruitment process in determining the skills and knowledge most appropriate for the role of a member of the care team.

Relatives we spoke with told us they knew how to make a complaint and who to speak with. We found that the provider had a complaints process in place and all complaints received were logged and all actions monitored with a clear deadline for action to have been taken. One relative confirmed a complaint they had made previously was actioned and handled appropriately. We found that the provider was able to monitor trends as a way of improving the service people received and the complaints procedures was available in other formats.

Care staff we spoke with told us they were able to get support from managers out of hours where there was an emergency. Relatives we spoke with confirmed they knew how to contact the manager of the service when the office was closed. Records we saw confirmed this information was made available to people and relatives.

Requires Improvement

Is the service well-led?

Our findings

The relatives we spoke with did not all feel the service was well led. One relative said, "I do not know who the registered manager is". They felt the provider did not keep them sufficiently informed when the registered manager changed. One person we spoke with said, "I do feel the service is well led". Staff we spoke with felt the service was well led, but told us that this was due to the recently appointed registered manager's actions since taking up their role. The registered manager had taken a number of positive steps to better support staff and visiting service users.

We found that there was a culture of openness. People and their relatives were encouraged to visit the office if they wanted. On the day of the inspection a person visited the office and had a discussion with us. We found that people were being supported to make links within the community they lived and care staff supported people to do so. For example where people owned their own transport care staff were able to drive people to socialise.

We found that a whistleblowing policy was in place to enable staff to raise concerns anonymously. Staff we spoke with were aware of the policy and in what situation they would use it.

We found that there was a registered manager in post as is required to meet legislation. They had been in post six months. The care staff we spoke with spoke very complimentary of the registered manager who we found to have a good understanding of the service they were managing and actions were already being taken to improve some areas of the service. For example, care staff we spoke with told us that regular spot checks were not always carried out to ensure they were supporting people appropriately. The registered manager acknowledged that spot checks were an area of improvement that they had already taken action on.

We found that the provider had a system in place to audit the quality of the service people received. However this was not sufficiently effective. For example, we found gaps on the medicines administration record that had not been picked up or actioned appropriately having already been audited.

We found that there was a system in place to check on the competence of care staff in administering people's medicines. We found that care staff were not being checked consistently. Approximately two thirds of the care staff who should have had their competency checked was showing as incomplete/not checked, and more than half the care staff had not had their practice observed as per the provider's procedures.

While staff knew the appropriate support people needed this was not always recorded in their records. We found that records were not all being used or completed consistently. For example, care records we saw did not all identify how people should be supported, whether reviews were taking place and how people's equality and diversity was being met. People's preferences were not recorded and training records did not clearly evidence whether care staff were all receiving the appropriate training. The registered manager acknowledged this and told us that the provider was currently implementing new care planning documentation and processes which would rectify some of the inconsistency in paperwork. The registered manager also confirmed that all staff would be trained in the new documentation and how they should be used to record people's support needs.

All the relatives we spoke with told us that they were able to complete a questionnaire to share their views on the service. We found that the provider had a system in place to gather the views of people and relatives on the service they received. Any information gathered was then analysed by the provider and where there were improvements to be made an action plan would be used to identify the work to be carried out and who by with timelines for the work. Care staff told us they did not get a questionnaire, which the manager confirmed. The registered manager told us they would discuss this with the provider as to how staff could be included in the process.

We found that an accident and incident procedure was in place so care staff had the appropriate guidance they would need to deal with these events. Staff we spoke with were able to explain how they would handle accidents/ incidents and the documentation they would need to complete. Records showed that accidents and incidents were being recorded and trends monitored as part of reducing accidents and improving the service to people.

We found that regular spot checks by the provider were not in place to ensure the quality of support people received.

Requires Improvement

Is the service well-led?

We found that the provider did not return their completed Provider Information Return (PIR) as we had requested. The registered manager informed us that the form was completed but there were technical online difficulties in returning the form between our systems and theirs. The provider confirmed the PIR was eventually sent but we had no record of receiving it. The provider offered to supply us with a copy of the completed PIR.