Lifeways Community Care Limited

Lifeways Community Care (South London)

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?	Requires Improvement

Summary of findings

Overall summary

This announced inspection took place on 23 and 31 May and 1 June 2018. Lifeways Community Care (South London) provides care and support to people living in their own flats or houses in various supported living settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of this inspection 60 people were using the service, many of whom had complex health and communication needs. The service was being provided across six London boroughs and Kent.

Not everyone using Lifeways Community Care (South London) receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service did not have a registered manager in post, the previous registered manager left in July 2017. 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.

At this inspection we found that improvement was required because some staff described a poor working culture at the service. They told us they did not feel supported by senior managers, were unable to question practice and did not feel they could work in an open and transparent manner. The provider worked in partnership with key organisations such as the local authority but did not consistently update them when changes in management staff occurred which resulted in important information not being always communicated.

The provider had safeguarding adults' policies and procedures in place and staff understood their responsibility to safeguard the people they supported from abuse. Staff were also aware of the provider's whistleblowing policy and procedure. People's finances were managed safely. Risk to people had been assessed and there were appropriate management plans in place to mitigate any identified risks. There were procedures in place to deal with foreseeable emergencies and people had personal emergency evacuation plans in place.

Appropriate recruitment checks took place before staff began working at the service and there were enough staff available to support people's needs. People received adequate support to take their medicines safely. People were protected from the risk of infectious diseases because staff had completed infection control and food hygiene training, and knew of action to take to reduce the spread of infections. Where issues were identified, lessons were learnt to improve the quality of the service.

Before people started using the service they were assessed to ensure their needs would be met. New staff

were supported with an induction to familiarise themselves with the provider's policies and procedures and to shadow experience staff. All staff were provided with mandatory training to ensure they had the knowledge and skills to undertake their roles. Staff were supported through supervision and appraisals to support them to perform their jobs efficiently.

People were supported to maintain good health and had access to a GP and other healthcare services when required. They were supported to cook and eat nutritious food in sufficient amounts for their health and wellbeing. The provider worked in partnership with other health and social care services to provide people with joined-up care. Staff were aware of the importance of seeking consent from people and demonstrated an understanding of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People told us that staff were kind and compassionate towards them. People and their relatives had been consulted about their care and their views were taken into consideration when planning their support needs. People's privacy and dignity were respected, and their independence promoted to maintain life skills.

People received care and support that met their individual needs and preferences. Each person had a support plan in place which provided staff with guidance on how their needs should be met. Staff understood that people's diversity was important and respected their differences and choices. People were supported to partake in various activities of their choice. They were encouraged to maintain relationships with their family and friends. People's communication needs had been identified and appropriate guidance was in place to ensure their needs were met. The provider had a complaints policy in place and people told us they knew how to complain. Where required, people's end of life wishes had been discussed with them and appropriate plans were in place to ensure their wishes would be met.

The provider had systems in place to assess and monitor the quality of the service. There were systems in place to continuously learn and improve on the service delivery. The views of people and their relatives were sought through annual satisfaction surveys and regular tenants' meetings, and this feedback was used to improve the service delivery. The provider understood the requirements of the Health and Social Care Act 2008 and notified the Care Quality Commission (CQC) accordingly.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were systems in place to protect people from abuse and people's finances were being managed safely.

Risks to people had been identified and assessed, and appropriate management plans were in place to mitigate the risks. There were processes in place to deal with foreseeable emergencies.

The provider had safe recruitment processes in place and there were sufficient numbers of staff on each shift to meet people's needs.

People were supported to manage their medicines safely as prescribed by healthcare professionals.

The provider had an infection control policy in place and staff followed safe infection control practices when supporting people.

Where issues were identified, lessons were learnt to improve on the service.

Is the service effective?

Good

The service was effective.

Before people started using the service they were assessed to ensure their needs would be met.

Staff were supported through induction, training, supervision and appraisals to ensure they performed their roles efficiently.

People were supported to eat and drink sufficient nutritious amounts for their health and wellbeing.

The provider worked in partnership with other health and social care professionals to provide an effective care.

People were supported to access healthcare services when required.

Staff were aware of the importance of seeking consent and demonstrated an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) where people lacked capacity to make decisions for themselves.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

People and their relatives were involved in making decisions about the care and support they, or their loved ones received.

People's privacy and dignity was respected and their independence promoted.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in planning the care and support they, or their loved ones received.

Staff understood the Equality Act and respected people's diversity including their cultural backgrounds.

People were supported to engage in activities that interested them.

People were supported to maintain relationships with people that were important to them.

People's communication needs had been identified and met.

The provider had a complaints policy in formats that met people's needs. Where people had made a complaint, they had been responded to satisfactorily.

People's end of life wishes had been discussed with them, where they wished to do so, and appropriate plans had been put in place to ensure their wishes would be met.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We received mixed views from staff regarding the organisational culture and support they received from their managers.

The provider work in partnership with key organisations such as the local authority but did not consistently update them when changes in management staff occurred which resulted in important information not always being communicated.

There was no registered manager in post. The area manager was responsible for managing the service. They told us they were in the process of making an application to CQC to become the registered manager.

There were systems in place to assess and monitor the quality of the service and make improvements where required.

The views of people and their relatives were sought to develop the service.

There were systems in place to continuously learn and improve on the service.

Lifeways Community Care (South London)

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 checked 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 23 May, 31 May and 1 June 2018 and was announced. We gave the service 5 days' notice of the inspection site visits to enable them gain consent from people for an inspector to visit them in their homes. Inspection site visit activity started on 23 May 2018 and ended on 5 June 2018. On the first day of our inspection, we visited the office location to see the manager and office staff; and to review care records, staff files and other records used in managing the service such as policies and procedures. On 29 May 2018 an expert by experience made calls to people on the telephone whilst they were in their homes. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On 31 May 2018, one inspector visited one supported living scheme and on 1 June 2018 another inspector visited two supported living schemes. During these home visits, we spoke with people to gather their views about the service and observed how they were being cared for. We also spoke with staff and looked at care plans and other records used in managing the service.

Prior to the inspection we reviewed information we held about the service including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information in the planning of the inspection.

We spoke with six people and three relatives. We also spoke with 18 staff including the area manager, a regional quality manager, office staff and care workers. We reviewed eight care files including care plans and risk assessments. We looked at 10 staff files which included recruitment checks, supervisions and appraisals. We also looked at other records used in managing the service including policies and procedures, accidents and incidents, audits and complaints logs.

Following our inspection, we contacted seven local authorities that commission services from the provider and health and social care professionals to obtain their views about the service.

Good

Is the service safe?

Our findings

There were systems in place to protect people from abuse. People told us they felt safe using the service. One person told us, "I feel safe here. I would tell my mum or dad if someone was shouting at me or trying to hurt me." The provider had safeguarding policies and procedures which gave guidance for staff on the processes to follow to protect people from abuse. Staff knew of the types of abuse that could occur as well as the signs to look out for, and said they would report any concerns of abuse to their line manager. The provider had a whistleblowing policy which staff said they would use to escalate any concerns of poor practice to senior managers or external organisations such as the local authority, or CQC. The area manager knew of their responsibility to report any concerns of abuse to the local authority safeguarding team and CQC. At the time of our inspection, one person reported to us an allegation of verbal abuse which we have reported to the local safeguarding team to investigate and therefore cannot comment on the outcome.

Prior to our inspection we received information of concern regarding how people's money was being managed at the service. We raised this issue with management staff and they explained that an appointee system was in place for each person and records we reviewed confirmed this. Staff showed us records they maintained including receipts and daily checks carried out during changeover of shifts to ensure there were no discrepancies and that people's finances were being managed safely. Financial capability and risk assessments had been carried out for people to ensure appropriate support was in place for each person to manage their finances safely.

Risks to people had been assessed, and where risks were identified appropriate management plans were in place. Risk assessments were person centred and specific to people's individual needs, covering areas such as medicines, finance, skin integrity, eating and drinking, manual handling, personal care and the environment. For each risk identified, there were appropriate management plans for staff on the action they should take to minimise or prevent the risk occurring. For example, where one person had been identified as being at risk of scalding, we saw guidance for staff included supporting them to cook, monitoring their bedroom radiators, checking water temperatures before a bath and checking their food temperatures to ensure they were safe. Staff who supported this person were aware of the details of their risk assessment; they told us of the action they took and showed us records they maintained to ensure the person was safe from the risk of scalding. We also saw risks to people had been assessed by healthcare professionals where required, including GPs, occupational therapists and speech and language therapists to ensure appropriate risk management guidance was in place for staff covering areas such as moving and handling, equipment use and swallowing. Risk assessments were reviewed regularly to ensure they were reflective of people's current needs.

There were procedures in place to deal with foreseeable emergencies. A fire risk assessment had been completed for people and a personal emergency evacuation plan (PEEP) was in place for each person. This gave guidance to staff and the emergency services on the support people required to evacuate from their homes in the event of an emergency. Staff knew of actions to take in the event of a medical or fire emergency. They told us they would also contact emergency services promptly to ensure people received appropriate support in a timely manner.

The provider had safe recruitment and selection processes in place. Appropriate recruitment checks had been carried out before staff began working at the service. Staff recruitment records contained application forms which included their full employment history, two references, criminal records checks, a health declaration, proof of identity and their right to work in the United Kingdom. New staff we spoke with confirmed these pre-employment checks were undertaken before they could work with people. This showed that staff were vetted to ensure they were suitable to work with people using social care services.

Sufficient staff were available to meet people needs. People and their relatives told us that there were enough staff on each shift to keep people safe. Staffing levels were determined based on an assessment of each person's needs. Service managers were responsible for planning the rotas based on the needs of people in each supported living scheme. Some people lived alone in their own flats and received one-to-one support whilst others lived together and therefore had a team of staff supporting them. However, feedback from staff regarding staffing levels was mixed. One staff member told us, "The staffing levels is okay, it is nice working one-to-one with people." However, another member of staff said, "It is understaffed, everyone works really hard and there is a lot of agency staff use." A management staff told us, "We are short staffed, we are having to use regular agency but recruitment is picking up and we have new staff coming up." We found that the provider used regular agency staff to cover staff vacancies and absences to maintain consistency with people. During our home visits, there were adequate numbers of staff on each shift and the staffing rotas we sampled showed the numbers of staff planned for matched the number of staff available on each shift.

People's medicines were managed safely. Medicines administration records (MAR) were in place where people had been assessed and found to require support to manage their medicines. The MAR included a picture profile of the person, details of any known allergies, their GP contact details and a staff signatory sheet to help reduce the risks associated with medicines administration. The MAR also included a list of medicines people were taking, the reasons for which they were prescribed, the method of administering and any side effects. We reviewed a sample of MARs and found them to be up to date and without any gaps. We checked remaining stock of medicines and this correlated with information in the MARs. This meant people had received their medicines as prescribed.

Where people had been prescribed 'as required' medicines, there were protocols in place which provided staff guidance on when to administer them. Medicines were stored in locked cupboards in people's houses or flats. Staff told us they had received training in medicines administration and were confident in supporting people manage their medicines safely. Records showed that staff had completed medicines training and their competencies had been assessed to ensure they had the knowledge and skills required to support people take their medicines safely. People's medicines were reviewed by healthcare professionals such as their GP or psychiatrist when required.

People were protected from the risk of infection. The provider had an infection control policy which provided guidance for staff on how to prevent the risk of infection. Staff told us they wore gloves and aprons where required and washed their hands regularly. Cleaning equipment such as mobs and buckets were colour coded to prevent cross contamination. Staff had completed food hygiene training and knew of the support to provide people prepare their meals safely. Food stored in the fridge was in date, labelled appropriately to prevent people from consuming food that had expired or contaminated. Records showed that where a person had undergone a surgical procedure, guidance for staff included maintaining safe hygiene levels and staff confirmed procedures they followed such as regular cleaning to prevent skin infection.

Accidents and incidents were recorded, managed and monitored regularly to prevent reoccurrence. Staff

understood the importance of reporting and recording any accidents or incidents or near misses. Records showed that where issues were identified an investigation was undertaken and there were lessons learnt to improve the quality of the service. For example, where a medicines error was identified, the staff member was supported through further medicines training and competency checks to prevent future occurrences.

Good

Is the service effective?

Our findings

Before people started using the service, they were assessed to ensure their needs would be met. Initial assessments were undertaken by service managers and a referral and assessment manager in people's homes, hospitals or from other social care services. The assessments included support people required with their physical, mental and social health; personal care, medicines, moving and handling, communication, finance and accessing the local community. People's relatives and other health and social care professionals such as OTs and social workers were involved in determining people's needs. Information from these assessments were used to draw-up individual risk assessments and support plans.

Staff sought consent from people before supporting them and respected their wishes. One member of staff said, "I always ask people what they want; a bath or a shower. I give them choices." Another member of staff said, "You cannot force people, we always ask and if they refuse you wait and try again later." Staff said if they had any concerns with people consenting to their support they would report to their line manager.

The Mental Capacity Act 2005 (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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive people of their liberty in their own homes must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.
Where people lacked capacity to make specific decisions for themselves, for example with medicines or finance, we saw mental capacity assessments had been conducted and best interest decisions made in line with the requirements of the MCA. Records showed that the provider had worked with the local authority and had carried out assessments and made an application to the Court of Protection to deprive some people of their liberty for their own safety. The authorisation document had been reviewed and we saw that the conditions of the authorisations were being followed.

Staff had knowledge and skills to meet people's needs. Staff were supported through induction and training. All new staff had an induction which included familiarising themselves with the provider's policies and procedures, training and shadowing an experienced member of staff. Staff also had an induction workbook that covered the Care Certificate Standards which they had to complete within three months of starting work. New staff were placed on a six months probationary period where their performance was monitored and assessed, and they were only offered permanent posts when found competent for the role. The provider continued to support staff through regular training considered mandatory for all staff in areas such as medicines administration, infection control, safeguarding adults, fire awareness, manual handling, MCA and DoLS. Staff told us there was enough training available to support them perform their roles.

Staff were supported through supervision and annual appraisals. Records showed staff attended

supervision meetings or 'job chats' with their line managers to discuss issues such as staff well-being, work environment, team work, training and development. Where required, staff were also supported with annual appraisals where their performance was discussed and objectives set for the new year. All staff we spoke with confirmed they received regular supervisions from their line managers to perform their roles efficiently.

People were supported to eat and drink adequate amounts for their health and wellbeing. A relative told us, "Staff do [their loved one's] cooking and help with shopping." Staff had assessed people's eating and drinking needs, and had involved healthcare professionals such as a speech and language therapist (SALT) or dietician where required. People's care plans included any support they needed to purchase and/or prepare food and drinks, any food allergens, their specific dietary requirements or preferences, and any support required to eat or drink safely.

People and their relatives were involved in making decisions regarding the types of food they would like to eat and their preferences; for example, one person preferred 'porridge and grapes' for breakfast. There was guidance for staff on how to support people eat and drink safely and healthily for their wellbeing. For example, one person had been advised by healthcare professionals to have a low-fat diet which was reflected in their eating and drinking care plan. Staff we spoke with were aware of the details of the person's care plan and confirmed they provided them with appropriate support in order that they maintained a healthy weight. People were also weighed regularly and records showed staff made prompt referrals to the GP where required, for example when one person was noted to be losing weight rapidly.

People were supported to access healthcare services where required. People told us they were supported to attend health appointments, and records we looked at confirmed this. A relative told us, "Yes, they take him to the doctor, dentist and optician." People's care files included health appointment records detailing appointments with chiropodists, psychologists, GPs, ophthalmologists and dentists. Each person had a health action plan which was used to support them maintain good health.

The provider worked in partnership with other health and social care professionals including day centres to ensure people's needs were met. Records showed that staff supported people when they had reviews with healthcare professionals such as the psychologists and GPs to ensure people received safe care and treatment. Staff took prompt action to refer people to appropriate healthcare professionals where they had concerns. For example, staff contacted the emergency doctor for a person to be treated promptly when they had an eye infection. Each person also had a hospital passport which included relevant information for the emergency services such as their medical conditions, medicines and any allergies they had. A social care professional told us, "I'm happy with the quality of support provided by Lifeways Community Care. The staff respond well to instructions and information given and are prompt to inform [name of local authority] of any issues or concerns they may have."

Good

Is the service caring?

Our findings

People were cared for by staff that were kind to them. People and their relatives told us staff were kind and compassionate to them or their loved ones. One person told us, "I like living here. The staff are nice to me." Comments from relatives included, "She's very happy there and well cared for, staff are so caring,"; "I can remember we wanted to take [person's name] out for a birthday supper because he must be in for the bedtime routine and staff stayed out for an extra half hour," and "[person's name] is always well cared for, well dressed and seems happy in himself." All staff we spoke with told us they enjoyed working with people. We observed positive interactions between people and staff during our inspection. Staff addressed people by their preferred names and spoke politely with them. Staff knew people well and cared for them in ways that met their needs.

People and their relatives were involved in making decisions regarding their care and support needs. People told us they had been consulted about their support needs. A relative told us, "They ask [their loved one] and they always have plans…they do all they can [for them]." Staff told us that people were involved in making daily decisions about how they spent their day. For example, one person who was a smoker had been supported in drafting their smoking guidance to ensure they were involved in making the decision about how their smoking habit would be managed safely. People had a decision-making profile which outlined the things that were important to them such as their food, clothing and activities. The decision-making profile included information on who should be making what decisions for people and who was responsible for making the final decision regarding each area of people's lives. For example, we saw that although one person would like their relative and other professionals to be consulted about the activities they participated in, they preferred to make the final decision regarding it.

Staff respected people's decisions regarding their support needs. For example, one person's care files stated they liked red clothing. Their care files included instructions for staff to support them purchase and wear red clothes and various photographs we saw of the person showed their preference to wear red clothing was respected and their needs met.

The service held monthly keyworker meetings and tenants' meetings to ensure people were involved in making decisions about the support they received. A member of staff told us, "[Person's name] is very involved and will always ask you to speak to their Mum, if they're not sure." Documents showed that people were involved in discussions about their accommodation, activities that they participated in, food they ate and how they spent their day. Daily care notes and other support documents showed that people's views were taken into consideration when planning and delivering their care.

People's privacy and dignity was respected. People and their relatives told us they felt they or their dignity was respected. People's support plans included guidance for staff to always respect their privacy and treat them with dignity and respect. Staff told us of how they promoted privacy and dignity. For example, one staff member said, "I cover [person's name] with a towel to maintain their dignity whilst I wash their hair." Another staff member said, "I shut the door to give [the person] privacy." A third staff member said, "We must respect their environment; this is their home and therefore we should show them respect always." Staff

also told us that information about people was kept confidential and only shared with people that needed to know.

People's independence was promoted. Staff told us they promoted independence by encouraging people to do things they could do for themselves, for example with personal care, cleaning their own home or cooking. One member of staff told us, "It is about allowing them to do as much as they possibly can, so they don't lose those skills." Care plans included a list of things people could do for themselves as well as identifying things that they needed support with. For example, one person was identified as being able to choose their own clothes, feed themselves and answer their own door. We observed one person with minimum abilities prepare their own hot drink and staff told us they could do so independently because special kitchen equipment was put in place which promoted their ability to prepare hot drinks on their own.

Good

Is the service responsive?

Our findings

People received care and support that met their individual needs and preferences. At the time of this inspection, people and their relatives told us they were happy using the service and did not have anything to complain about. A support plan had been developed for each person based on an assessment of their needs. Support plans covered areas such as choice and control, health and well-being, everyday tasks, living safely and taking risks, family relationships, community life and behaviour. People's communication needs, their likes and dislikes, people and things that were important to them and their preferences were also included in their support plans. Support plans were person centred and included guidance for staff on how to support each person to meet their needs. They were reviewed regularly and kept up to date to ensure people's changing needs were met. A service manager told us they ensured all new staff had read and were familiar with individual support plans before working with people. Staff we spoke with knew people well and the level of support they required. Daily care notes showed people were being supported in line with the care and support that had been planned for them.

Where people had diverse needs, they were supported without discrimination. People and their relatives told us that they or their loved ones were supported to practice their faith if they chose to. One relative commented, "[Their loved one] does go to church if they want to and the staff are quite happy to take them." People's care files included information about their religion, ethnicity and any disabilities to ensure their needs were met. A member of staff told us, "We have one person who goes to church and we allow them to choose what they want to do on Sundays."

Documents showed that one person from a diverse cultural background had been matched with staff to ensure they could communicate and received appropriate support to prepare food which reflected their cultural preferences. Their support plans also included specific guidance for staff about their physical and learning disability needs and how this should be met. Staff were familiar with people's diverse needs and supported them in a caring way.

People were supported to follow their interests and partake in activities that were socially relevant to them. One person told us, "I go out a lot but sometimes I like to stay in my room and play games." A relative told us, "I'm pleased at the way [their loved one] has developed; access to the community, friendship groups, having parties, all life changing for [their loved one] in a good way." People were involved in activities such as attending college, day centres, dance, drama and cookery classes and partaking in voluntary work, as well as other recreational activities such as going on holiday, cinema, disco, shopping, bowling and swimming. Staff knew of the things that interested people and the support they needed to attend. For example, staff supported one person to attend a day centre on specific days suitable for people with their support needs and the person told us they preferred and enjoyed that group.

People were encouraged to maintain relationships with people that mattered to them. One person told us, "My mum is involved, staff call her and she comes here." People's family and friends visited them at their home and people also visited their relatives on set days or special occasions where this had been agreed and planned for in advance. Staff told us that where family and friends were not local to them, they

supported people to be in contact through post and/or telephone and video calls.

People's communication needs in relation to their disability or sensory loss had been identified and met. Information on how each person communicated was included in their care files so that staff were aware to provide them with the support they required. The support people needed to communicate varied from person to person and the support plans contained information regarding this. Appropriate guidance was available for staff on the support to provide such as the use of Makaton, pictures, voice or touch. Makaton is a language programme that used signs and symbols to support people with their communication needs. We saw that there was guidance for staff on how to support one person who had sensory impairment communicate by using sound and touch. We also observed one person using Makaton to communicate with staff and another person using picture cards, and noted the staff understood their needs and supported them appropriately.

Complaints were addressed to people's satisfaction. People and their relatives told us they knew how to complain if they were unhappy about the service and would speak to staff or service managers. One person told us, "I will speak with [Service Manager's name]." Another person said, "I am happy here. I would tell the lady, [social worker's name] if someone wasn't being nice." A third person said, "I feel safe here. I would tell my mum or dad if someone was shouting at me or trying to hurt me." A relative told us, "Initially I will speak to staff."

The provider had a complaint policy and procedure which included guidance on how to raise concerns or complaints and the timescale in which people should expect a response. The complaint procedure was available in formats that met people's needs. At the time of our inspection, people and their relatives did not have anything they wished to complain about. Staff said if people were not happy with the service, they would support them to make a complaint and ensure they were satisfied with the response they would receive. Records showed that the provider had acted to address any complaints that had been raised with them. For example, a relative complained about not being regularly updated about their loved one. We saw that this issue had been investigated and resolved and the relative was now happy with the level of communication they received about their loved one. The complaint and comments log also included compliments from relatives and professionals about the standard of care and support staff provided.

People's end of life wishes had been discussed with them where appropriate and plans were in place to ensure their wishes would be met. For example, one person's last wishes included a church service and a floral tribute and another person had a funeral prepayment plan in place to ensure their end of life wishes would be met. Where people had been assessed and found unable to make decisions about their end of life support for themselves, best interest decisions were in place for them.

Requires Improvement

Is the service well-led?

Our findings

All staff we spoke with told us they enjoyed working with people. A staff member told us, "I am happy working here." All support workers and their team leaders were happy about the support they received from their service managers. However, we had mixed views from staff including service managers, team leaders and some care staff about the support they received from senior management staff. Positive comments from staff included, "Lifeways has improved, [manager's name] is fully supportive, responds to you and it doesn't feel like being on your own…if [manager's name] had not started I would have left." However other staff told us they were unhappy about the culture of the service and felt unsupported in their role. Staff said they could not question practice and could not speak in an open and transparent manner and not all staff would recommend 'Lifeways' as an employer because not all staff felt supported in their role and there were other matters relating to work load, annual leave and staff pay. We raised this issue with the area manager who told us, senior human resources (HR) directors were in the process of organising a team building meeting where any concerns could be discussed. This area required improvement and we will follow up on it at our next inspection.

The provider work in partnership with key organisations such as the local authority but did not consistently update them when changes in management staff occurred which resulted in important information not always being communicated. One local authority service commissioner told us that the provider worked well and proactively with social workers and local health teams to provide good quality care and support for the people. Another local authority told us the provider worked well with them to make improvement to services when this was required. However, one local authority identified that key information sometimes got lost because there had been regular management staff changes at the service. They said when such changes occurred and key staff were no longer in post the provider did not always inform them in a timely fashion and this had resulted in important information not being communicated and for example staff not being paid in line with an agreement the local authority had with the provider. The provider told us they were in the process of rectifying this issue and we will follow up on it our next inspection.

There was no registered manager in post. The previous registered manager left in 2017 and the area manager was responsible for managing the service. They told us they were in the process of registering with CQC to become a registered manager. The area manager was supported by a team of regional managers and directors and was experienced in managing this type of service. The management team knew of their legal responsibilities under the Health and Social Care Act 2008 and had sent CQC statutory notifications where required. The area manager attended managers meetings to share and discuss issues that were relevant to the running of the service. Minutes of managers meeting showed that topics discussed included new starters, audits, recruitment and staffing.

There were systems in place to assess and monitor the quality of the service. The provider had an internal quality monitoring team that carried out regular audits across the service. The audits covered areas such as care files, medicines, moving and handling, health and safety and staff files. Where issues were identified, action plans were developed to ensure appropriate actions were taken to improve the quality of the service delivered. Service managers also completed their own in-house audits of the supported living schemes they

managed to ensure that appropriate systems and processes were in place before the quality monitoring team audit any of their locations. Action plans were monitored to ensure that improvements were made. Where the provider was in the process of addressing an identified issue, they showed us evidence including email correspondence to demonstrate the actions they were taking. Feedback we received from one of the provider's commissioner stated the provider was proactive in identifying and addressing issues promptly.

There were systems in place to continuously learn and improve on the service delivery. Prior to our inspection visit, the area manager informed us that they had identified that staff were administering insulin to one person without following the provider's medicines policy. They told us that staff members had been trained by a healthcare professional on how to administer insulin and therefore had the knowledge and skills to support the person safely; however, there was no documentation to demonstrate they had received insulin training in line with the provider's medicines training requirements. At the time of our inspection all staff responsible for supporting the person had completed insulin training and their competencies assessed in line with the providers policies and procedures.

The views of people and their relatives were sought to develop the service. The provider used annual surveys and regular tenants' meetings to gather feedback from people and their relatives to improve on the service delivered. Monthly tenants' meetings were held at the various supported living schemes to discuss things that were important to people daily such as their living environment, the activities they participated in or the food they ate. Following these meetings staff acted, for example to organise activities or events such as the celebration of St Patrick's Day to support people's interests. Relatives' views were gathered through annual satisfaction surveys and recent survey results showed that relatives felt the service had been improving. For example, relative's views about how people were supported to stay healthy had increased from 76% to 97%, their involvement in planning the care increased from 53% to 90%, and the support people received to feel safe increased from 77% to 97%. The result of the recent survey had been analysed and action plans had been developed to improve on people and their relative's views about the service. For example, 6% of relatives said they did not know who the manager of their loved one's service was. The action plan included service managers should send their contact details to relatives and/or friends of people they supported to improve on the communication and service delivery.