Lifeways Independent Living Alliance Limited

Independent Living Alliance Liverpool

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an announced inspection on 8 November 2016.

Independent Living Alliance Liverpool is a registered domiciliary care agency that provides personal care and support to people in their own homes. The organisation provides care to people with learning disabilities, physical disabilities, mental health conditions and acquired brain injury. At the time of the inspection 10 people were using the service. As part of the inspection we were invited to meet with two people living in specialised housing which catered for their health needs.

A registered manager was 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.

The people that we spoke with had no concerns about the safety of services and spoke positively about how safe they felt.

The provider had delivered an extensive training programme for staff and managers regarding adult safeguarding. The staff that we spoke with confirmed that they had attended the training and were able to explain the different types of abuse and what action they would take if they were concerned that abuse or neglect were taking place.

The care files that we saw showed clear evidence that risk had been assessed and reviewed regularly. Risk was reviewed by staff with the involvement of the person or their relative and maintained a focus on positive risk taking to support independence.

Staff were safely recruited following a process which included individual interviews and shadow shifts. People using the service were invited to be part of the recruitment process up to and including participation in interviews.

Staff were trained in the administration of medicines, but because the services were community-based, they were not always responsible for storage and administration. Some people who used the service were able to self-administer their medication, others required prompting. Self-administration had been risk assessed to ensure that it was safe.

Staff had been recruited and trained to ensure that they had the rights skills and experience to meet people's needs. Staff were required to complete an induction programme which was aligned to the Care Certificate.

Staff were supported by the organisation through regular supervision and appraisal. We saw evidence of

these processes during the inspection. Staff also had access to 'team and practice development' days where a range of issues were discussed and actions set to generate improvements.

The service operated in accordance with the principles of the Mental Capacity Act 2005. Staff understood their responsibilities in relation to the act.

People were supported to shop for food and prepare meals in accordance with their support plans. Some people were supported with menu planning to improve their nutrition or manage a health condition.

People's day to day health needs were met by the services in collaboration with families and healthcare professionals. Staff supported people at healthcare appointments and used information to update support plans.

The houses that we visited had been built with the needs of the tenants in mind. They made good use of assistive technology to maximise people's independence.

We had limited opportunities to observe staff providing support during the inspection. Where we did observe support we saw that staff demonstrated care, kindness and warmth in their interactions with people. People told us that they very were happy with the care and support provided.

We saw that staff knew the people that they supported well. When we spoke with them they described the person and their needs in detailed, positive terms. Staff told us that they enjoyed providing support to people and were able to explain how they involved people in making decisions about their day-to-day care and support.

We saw from care records that people were given choice over each aspect of their service. This choice included; staff, activities and times of support. The support plans that we saw used person-centred language and provided an appropriate level of detail to inform staff. It was clear that people had been actively involved in developing their care and support plans.

The provider encouraged people and their families to provide feedback through a range of formal and informal mechanisms. They issued annual surveys and sought feedback at each review. Information from surveys was shared with people and their families.

People were given a number of options if they chose to complain about the service. They could speak directly to staff or managers. They could also use the complaints procedure. The complaints procedure was shared with people as part of their introduction to the service.

The service had clearly been developed and was continuing to develop with input from people and their staff. A recent engagement event had identified a number of areas for improvement and associated actions.

The organisation had a clear set of visions and values which were displayed in brochures and other promotional materials. These visions and values were linked to organisational strategy and used as one of the criteria on which quality was assessed. Staff were able to explain the visions and values of the services and applied them in their practice.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. Each of the staff was positive about the support and quality of care offered by the organisation.

The registered manager was clearly aware of the day to day culture and issues within the service. We saw that they knew the people using the service and their staff well. Notifications relating to people who used the service had been submitted to the Commission as required.

The registered manager was knowledgeable about their role and the organisation. They were able to provide evidence to support the inspection process in a timely manner and facilitated meetings with service users, family members and staff.

The registered manager and other senior managers had completed a series of quality and safety audits on a regular basis. Important information was captured electronically and used to produce reports. These reports were shared with senior managers throughout the organisation and used at a local level to monitor and drive improvement. The processes were mapped to the Care Quality Commission's inspection methodology and scored services against qualitative and quantitive measures.

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.

Staff were recruited following a robust process which included individual interviews and the completion of pre-employment checks.

The care records that we saw showed clear evidence that risk had been assessed and reviewed regularly.

The staff we spoke with confirmed that they had attended safeguarding training and were able to explain the different types of abuse and what action they would take if they were concerned that abuse or neglect were taking place.

Is the service effective?

Good

The service was effective.

Staff were required to complete a programme of mandatory training which included a range of relevant social care topics such as; safeguarding, medication administration, health and safety and first aid.

People's day to day health needs were met by the services in collaboration with families and healthcare professionals.

The service operated in accordance with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff demonstrated care, kindness and warmth in their interactions with people.

Staff knew people well and told us that they enjoyed providing support to people.

The provider made use of person-centred planning techniques to maximise the involvement of people in the planning process.

Is the service responsive?

Good

The service was responsive.

The service worked with people to produce person-centred plans to a high standard. These plans were regularly reviewed and used to deliver and monitor care and support.

People were given clear choices and their wishes and aspirations were respected by staff.

The service encouraged feedback and responded positively and effectively to complaints. Feedback was analysed and used to generate learning and improvement.

Is the service well-led?

Good

The service was well-led.

The service had a clear vision and values which were reflected in staff attitudes and the delivery of care and support.

The registered manager offered clear leadership, but remained approachable to people using the service, relatives and staff.

The service used extensive audit systems to monitor and improve standards of safety and quality.

Independent Living Alliance Liverpool

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 November 2016 and was unannounced.

The inspection was conducted by an adult social care inspector.

The provider had completed 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 any improvements they plan to make.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all of this information to plan how the inspection should be conducted.

We spoke with two people using the service, two relatives, a team leader, a service manager, two support workers and the registered manager. We visited people in their homes at a specialist service. We also spent time looking at records, including four care records, four staff files, staff training records, complaints and other records relating to the management of the service. We contacted social care professionals who have involvement with the service to ask for their views.

Good

Is the service safe?

Our findings

The people we spoke with had no concerns about the safety of services. One person using the service who had previously been in shared accommodation said, "I like having my own front door. My meds [medicines] are always given on time. They [staff] come in to check on me too." Another person told us, "I get about 40 to 45 hours [of support] a week. I feel safe living here. The staff are here all the time. They help me with hoisting, but I do my meds myself."

The provider had delivered an extensive training programme for staff and managers regarding adult safeguarding. The staff we spoke with confirmed that they had attended the training and were able to explain the different types of abuse and what action they would take if they were concerned that abuse or neglect were taking place. The provider had a range of systems and procedures in place which allowed people using the services, their relatives and staff to raise any concerns. Evidence of these systems was made available during the inspection. A staff member gave a recent example of how they acted to safeguard people by contacting the police, local authority and their own on-call service. Safeguarding incidents and referrals were recorded and analysed by the registered manager.

The care files that we saw showed clear evidence that risk had been assessed and reviewed regularly. Risk was reviewed by staff with the involvement of the person or their relative and maintained a focus on positive risk taking to support independence. We saw that risk had been reviewed following incidents and adjustments to support plans made as a result. Staff were able to explain what action they would take in the event of an incident or emergency. Each care record contained contact details in case of emergency. A member of staff told us, "When a person presents with a risk, we have good plans. If it's a new risk, we have an interim plan." We were provided with a recent example where potentially unsafe practice had been identified. Staff alerted the service manager to the issue which was dealt with in a safe and timely manner.

Incidents and accidents were recorded electronically and subject to a formal review process which included an analysis that was shared with senior managers. The health and safety manager monitored progress in relation to incidents and accidents and figures were shared with the board of directors and the provider's insurers.

The provider had a robust approach to whistleblowing which was detailed in the relevant policy. The policy contained details of organisations that could process whistleblowing concerns and advise staff. Staff were able to explain internal mechanisms for reporting concerns and were aware of the external resources available to them if required. Each of the staff that we spoke with expressed confidence in internal and external reporting mechanisms.

Staff were recruited following a process which included individual interviews and shadow shifts. People using the service were invited to be part of the recruitment process up to and including participation in interviews. We were told that their views were used as part of the probation process. Each offer of employment was made subject to the receipt of two satisfactory references and a Disclosure and Barring Service (DBS) check. A DBS check provides evidence that a person is suited to working with vulnerable

adults. Each of the DBS checks that we saw had been completed recently. Staffing levels were assessed according to individual need. None of the people that we spoke with said that staffing levels had ever been a concern. New staff were introduced gradually and assessed as suitable to work with the person. This assessment was completed by asking the person and their relatives about suitability.

The organisation had a robust approach to the monitoring of safety across its services where appropriate. Some safety checks are not a legal requirement for the provider in non-registered homes, for example; supported living services but were completed with the permission of the people using the service, in conjunction with landlords and in accordance with accepted schedules. These included checks on; medicines, fire safety, water temperatures and gas safety.

Prior to the inspection we had received information of concern relating to the safe administration of medicines. We spoke with the registered manager about these concerns and were told that the issue of missed signatures had been identified during audits. We were reassured that appropriate steps had been taken to improve the safety and accountability of the administration of medicines.

Staff were trained in the administration of medicines but because the services were community-based, they were not always responsible for storage and administration. Some people who used the service were able to self-administer their medication, others required prompting. Self-administration had been risk assessed to ensure that it was safe. We saw evidence that plans were in place for the safe administration of topical medicines (creams and lotions) and PRN (as required) medicines. None of the people currently using the service were prescribed controlled drugs (these are drugs which have additional control measures in place because of their potential for misuse), but systems were in place for safe administration as required. Medication Administration Record (MAR) sheets were completed by staff where appropriate. We were not invited to look at people's MAR sheets, but we saw that the provider's audit systems had identified errors and directly led to changes to the administration and recording systems. Staff told us that this change had generated improvements in safety. One member of staff said, "There's so much medication here. [Service manager] introduced a new system. It's much easier to check."

Good

Is the service effective?

Our findings

Staff had been recruited and trained to ensure that they had the rights skills and experience to meet people's needs. Staff were required to complete an induction programme which was aligned to the Care Certificate. The Care Certificate requires staff to complete appropriate training and be observed by a senior colleague before being signed-off as competent. Shadowing provided the opportunity for competence and suitability to be assessed as part of the induction process. One member of staff told us, "Training has improved significantly. We have service-specific and management training. We can request additional training and we usually get it."

Staff were supported by the organisation through regular supervision and appraisal. A member of staff said, "We can access [registered manager] any time and we have regular meetings, supervisions and appraisals." We saw evidence of these processes during the inspection. Staff also had access to 'team and practice development' days where a range of issues were discussed and actions set to generate improvements.

Staff were trained in a range of subjects which were relevant to the needs of the people using the service. Subjects included; safeguarding adults, moving and handling, administration of medication, Mental Capacity Act 2005 and equality and diversity. We looked at records relating to training and saw that the majority of training had been refreshed in accordance with the service's schedule. People using the service and their relatives said that staff had the right skills and knowledge to meet people's needs. Staff also had access to additional training to aid their personal and professional development. For example, dysphagia, drugs awareness and diabetes.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. People's capacity was assessed in conjunction with families and professionals. Staff were aware of the need to seek authorisation from the Court of Protection if people's liberty needed to be restricted to keep them safe.

People were supported to shop for food and prepare meals in accordance with their support plans. A member of staff said, "People choose their own food. Sometimes we need to prepare their food and help them plan their shopping." Some people were supported with menu planning to improve their nutrition or manage a health condition. People were also supported with eating and drinking in community settings in accordance with their support and activity plans.

People's day to day health needs were met by the services in collaboration with families and healthcare professionals. Staff supported people at healthcare appointments and used information to update support plans. We saw evidence in care records that staff supported people to engage with community and specialist healthcare organisations to support their wellbeing. The majority of care records we saw included

a healthcare action plan which provided clear information on the person's healthcare needs.

The houses that we visited had been built with the needs of the tenants in mind. They made good use of assistive technology to maximise people's independence. For example, people had a buzzer system to call for assistance from the office if required. Doors could be opened and closed electronically by switches placed at an appropriate height. The layout of each building accommodated the safe use of wheelchairs and hoisting equipment because floors were level and doorways had been widened.

Good

Is the service caring?

Our findings

We had limited opportunities to observe staff providing support during the inspection. Where we did observe support we saw that staff demonstrated care, kindness and warmth in their interactions with people. People told us that they very were happy with the care and support provided. One person using the service told us, "All the staff are brilliant. They are all friendly and can't do enough for you." Another person said, "They [staff] are all very pleasant. They recognise [respect] that I'm there when they're talking."

People were supported by the same staff on a regular basis. When new staff were being introduced they were required to work alongside a more experienced colleague on 'shadow-shifts'. This gave people the opportunity to assess whether they wanted the new staff member to be part of their support team. The people we spoke with confirmed that they had a choice regarding who provided care. The registered manager was knowledgeable about each of the people that used the service and each member of staff. People had regular contact with the registered manager and were able to refer to them by name. A contact number for the registered manager was available to people using the service and their families.

We saw that staff knew the people that they supported well. When we spoke with them they described the person and their needs in detailed, positive terms. Staff told us that they enjoyed providing support to people and were able to explain how they involved people in making decisions about their day-to-day care and support. Comments indicated that the people using the service felt valued and involved in the development and delivery of support. One person using the service told us, "They [staff] discuss my care every time." While another person said, "[Staff member] came in to talk to me about a change to my support." We saw that staff were respectful of people and provided care and support in a flexible manner.

The staff we spoke with described the service as promoting choice, independence and control for the individual. We saw evidence that some people had used independent advocates to advise them regarding important decisions about their future. Another person had recently been referred to an advocacy service. Other people were able to speak for themselves or had family members to represent them.

We asked people about the need to respect privacy and dignity. One person using the service said, "Staff always ring the bell and wait for me to answer the door." Staff were clear about their roles in relation to privacy and dignity. A member of staff said, "People have single tenancies, but we still close doors and think about privacy and dignity [when providing personal care]." As part of the inspection people were asked if they wanted to speak with us. It was clear that staff did not exert any influence over the decision and respected people's decision when they declined. We were subsequently escorted to people's homes and introduced. Both of the people that we spoke with had a relative visiting them at the time. They told us that there were no restrictions on when they visited.

Good

Is the service responsive?

Our findings

We saw from care records that people were given choice over each aspect of their service. This choice included; staff, activities and times of support. The support plans that we saw used person-centred language and provided an appropriate level of detail to inform staff. It was clear that people had been actively involved in developing their care and support plans. One relative told us, "The pre-assessment work was excellent." Each of the plans had been regularly reviewed. We saw that changes had been made following reviews and incidents. Staff told us that they were involved in reviews of care and support and shared examples of changes made as a result of their input.

We were given examples where staff had helped people to establish goals that had resulted in greater independence. In one case a person had been supported to complete a programme of training in manual handling. They had successfully hoisted their own staff as part of the programme to develop a better understanding of the process and reduce risk. People's homes and the models of support had been specifically developed to maximise people's independence. This was referenced in support plans. Some people had been supported to lease their own vehicles and designated drivers had been identified within their support teams to provide better community access. People had also been supported to improve their skills and confidence in accessing public transport in case a driver was not available.

People were supported to follow their interests by staff. One person said, "They [staff] take me shopping, to the pictures and to my local church." Leisure activities were included as part of people's plans. A member of staff shared an example where a person with poor motivation had been supported to develop a routine which included regular visits to a relative.

People could choose their staff and were able to express a preference for males or females. We were told how one person's staff' shift pattern had been changed to ensure that they had access to female staff for personal care.

Before the service started the provider collected information from health and social care professionals and completed their own detailed assessment of care and support needs. The provider made use of person-centred planning techniques to maximise the involvement of people in the planning process.

People were given a number of options if they chose to complain about the service. They could speak directly to staff or managers. They could also use the complaints procedure. The complaints procedure was shared with people as part of their introduction to the service. We saw there were a small number of formal complaints received by the provider. Each complaint had been recorded, processed in a timely manner and a written response produced for the complainant. This was in accordance with the provider's complaints policy. Each of the people that we spoke with said that they would have no hesitation in complaining about the service and would initially approach staff, the team leader or the service manager.

Good

Is the service well-led?

Our findings

A registered manager was in place.

The service had clearly been developed and was continuing to develop with input from people and their staff. A recent engagement event had identified a number of areas for improvement and associated actions. For example, access to information, inclusive recruitment and health promotion. Each action had been delegated to a member of the management team and a deadline set for completion. Where this deadline had passed, we saw that changes had been implemented. The service also made use of a regular newsletter to share important information and promote best-practice approaches.

Open communication was encouraged at all levels. Information was shared at team meetings, supervisions and informally through telephone calls or face to face meetings. A member of staff said, "Information is managed well. New policies are shared via memos. We have 'get it off your chest' meetings too." Another member of staff told us, "I've no problem in speaking out or whistle-blowing. If there was poor practice, definitely." Were also told that managers were approachable and that staff responded well to their guidance and input.

The provider encouraged people and their families to provide feedback through a range of formal and informal mechanisms. They issued annual surveys and sought feedback at each review. Information from surveys was shared with people and their families. The information was available in a range of formats on request. People and their relatives told us that they fed-back to the registered manager, team leader and other staff on a day-to-day basis. The annual service user' survey was managed by an external contractor. Information generated by the surveys was fed-back to senior managers and action was taken in response to the comments. For example, people had asked to be more involved in the recruitment process. A working group had been established, a process agreed and information shared with people using the service.

The organisation had a clear set of visions and values which were displayed in brochures and other promotional materials. These visions and values were linked to organisational strategy and used as one of the criteria on which quality was assessed. Staff were able to explain the visions and values of the services and applied them in their practice.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. Each of the staff was positive about the support and quality of care offered by the organisation. A member of staff told us, "I feel a bit exhausted sometimes, but what gets me here is my belief in the service. This service makes a real difference."

The registered manager was clearly aware of the day to day culture and issues within the service. We saw that they knew the people using the service and their staff well. They said, "I'm proud of so many things. I've got a fantastic team. There have been challenges in recent years, but people have remained loyal and supportive." The registered manager understood their responsibilities in relation to their registration.

Notifications relating to people who used the service had been submitted to the Commission as required.

The registered manager had sufficient systems and resources available to them to monitor quality and drive improvement. The provider had an extensive set of policies and procedures to guide staff conduct and help measure performance. The registered manager was knowledgeable about their role and the organisation. They were able to provide evidence to support the inspection process in a timely manner and facilitated meetings with service users, family members and staff. They spoke with enthusiasm about working for the organisation. They said that they were well supported by senior managers. They told us, "I get well-supported. There's a huge network from other departments and peer support." They understood their role in relation to the assessment and monitoring of quality and coordinated the collection and collation of data in relation to quality and safety audits.

The registered manager and other senior managers had completed a series of quality and safety audits on a regular basis. Important information was captured electronically and used to produce reports. These reports were shared with senior managers throughout the organisation and used at a local level to monitor and drive improvement. The processes were mapped to the Care Quality Commission's inspection methodology and scored services against qualitative and quantitive measures.