Lifeways Community Care Limited

Lifeways Community Care (Halifax)

Inspection report

Rimani House
14-16 Hall Street
Halifax
West Yorkshire
HX1 5BD

Tel: 01422380022
Website: www.lifeways.co.uk

Date of inspection visit:
03 May 2016
04 May 2016
05 May 2016
06 May 2016

Date of publication:
24 May 2016

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

The inspection took place between the 3 and 9 May 2016 and was announced. This meant we gave the provider a short amount of notice (48 hours) that we would be visited the office in order to ensure a manager was present and to seek consent in advance from people who used the service in order to visit their homes.

At the last inspection in May 2015 we found the provider was compliant with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, but identified a number of improvements were needed to ensure people received good health and support outcomes. At this inspection, we checked whether these improvements had been made.

Lifeways Community Care (Halifax) provides support for people with a range of disabilities and complex needs. The service provides supported living services for people living across West and North Yorkshire and East Lancashire. The service aims to enable people to live independent and dignified lives, by the provision of care within their own homes.

A registered manager was in place. 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.

Since the last inspection a new registered manager was in post. We found a number of improvements had been made to the service since the previous inspection. Care plan documentation was more comprehensive and person centred. The service had improved the way it engaged with and involved people who used the service.

People all said they felt safe whilst using the service. Staff understood how to identify and act on allegations of abuse. Where safeguarding incidents had occurred appropriate action had been taken to help keep people safe.

Since the previous inspection, risk assessment documentation had been overhauled and was now more comprehensive and person centred. Staff had a good understanding of how to look after people in a safe way.

There were sufficient quantities of staff deployed to help ensure people were kept safe and in order to support them to achieve good health and support outcomes. Staff were recruited safely to help ensure they were of suitable character to work with vulnerable people.

Overall medicines were managed safely. In most cases people received their medicines as prescribed, although we did identify some concerns at one supported living property. Prompt action was taken by the registered manager to investigate these concerns and put measures in place to prevent a re-occurrence.

Overall, care and support was delivered by staff who had the right skills and knowledge to care for people. Staff received a range of training and support tailored to their role. However some relatives told us that changes to the staff team led to inconsistencies in the level of care and support.

People were supported appropriately to maintain a healthy diet. People were involved as much as possible in the sourcing and preparation of food to help develop life skills.

People's healthcare needs were assessed and detailed plans of care put in place. People had access to a range of health professionals to help support their health.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, best interest processes had been followed to ensure people's rights were protected. The service had worked with local authorities to submit applications to the Court of Protection where they thought people were potentially being deprived of their liberty.

People and relatives told us staff were kind and caring and treated people well. This was confirmed in the observations of care and support that we observed.

People's likes, dislikes and preferences had been obtained through care planning and staff we spoke with were very familiar with the people they were caring for.

People's needs were assessed and thorough and detailed plans of care put in place. This provided staff with person centred information on how people liked to be supported. Staff we spoke with had a good understanding about the plans of care we asked them about.

The service supported people to plan and achieve goals over time relating to areas such as independence and activities.

The service took steps to involve people in all aspects of the service. For example people were involved in the recruitment of staff and the completion of quality audits as well as the review of their care and support packages.

People had access to a range of social opportunities and activities. People were encouraged to participate in activities daily and also socialise with other people who used the service.

People and staff spoke positively about the way the service was managed. They said the management were supportive and they felt able to raise issues with them.

A range of systems and checks were in place to ensure the quality of the service was assessed, monitored and improved. People were encouraged to provide feedback about the service which was used to drive further improvement.

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.

The service managed risk appropriately. Risks to people's health and safety were thoroughly assessed and clear and person centred risk assessments put in place. Staff had a good awareness of how to keep people safe.

There were sufficient numbers of staff deployed to ensure people received safe and attentive care and support. Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people.

Overall we concluded medicines were managed safely and people received their medicines as prescribed, although we identified concerns at one property we visited which were quickly investigated and rectified by the provider.

Is the service effective?

Good

The service was effective.

Staff had appropriate skills and knowledge to care for people and were supported with a range of training.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Restrictions on people had been assessed and the service had worked with local authorities to put in applications to the Court of Protection where appropriate.

People's healthcare needs were assessed and appropriate plans of care put in place. Staff supported people to access healthcare services when required.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind and caring and treated them well. This was confirmed by our observations of care and support.

People's likes, dislikes and personal preferences were recorded by the service. Staff demonstrated a good understanding of the people they were caring for and how they best liked to be supported.

Is the service responsive?

Good

The service was responsive.

People spoke positively about the care and support they received. People's needs were assessed and person centred plans put in place which were well understood by staff.

People had access to a wide range of activities and social opportunities. People were supported to plan and go on holidays.

Is the service well-led?

Good

The service was well led.

People, relatives and staff spoke positively about the service and said it was well managed.

Overall systems to assess, monitor and improve the service were effective. A number of improvements had been made to the service over the last year such as to care plan documentation and in the way the service engaged with people.

People were involved in the running of the service and their views and feedback used to drive improvement.

Lifeways Community Care (Halifax)

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place between 3 and 6 May 2016 and was announced. This meant we gave the provider a short amount of notice (48 hours) that we would be visiting the office in order to ensure a manager was present and to seek consent in advance from people who used the service in order to visit their homes. The inspection team consisted of one adult social care inspector, a specialist advisor and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for people with learning disabilities.

On 3 May 2016 we visited the provider's branch office to review documentation and records relating to the management of the service. On 3 May 2016 and 4 May 2016 we visited five supported living properties where we spoke to people who used the service and staff. Between 5 May and 9 May 2016 we made phone calls to people and their relatives to ask them about the quality of the service.

In total we spoke with 11 people who used the service, six relatives, 10 support workers, three area managers and the registered manager. We observed some aspects of care and support in the homes we visited.

We looked at eight people's care records, medication records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting relevant local authorities. 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 was completed and returned to us in a prompt manner.

Good

Is the service safe?

Our findings

Prior to the inspection we sent questionnaires to people and their relatives asking them about the various aspects of the service. 29 responses were received. 100% of respondents said they felt the service protected people from abuse and that people felt safe using the service. This was confirmed by comments we received during the inspection. People we spoke with told us they felt safe whilst using the service and did not raise any concerns with us about staff. For example one person told us "I have superb staff. They look after me really well."

Some people receiving support were unable to communicate verbally with us. However during visits to people's homes we observed their body language and concluded they appeared comfortable and relaxed in the company of staff.

Staff told us they had received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. They were confident any concerns reported would be fully investigated and appropriate action taken. A member of staff said, "I would go to whatever lengths were needed to ensure people were protected from abuse".
Where concerns were identified, we saw the provider took appropriate action, reporting these to the local safeguarding authorities and ensuring preventative measures were put in place to reduce the risk of a re-occurrence. Safeguarding was imbedded throughout the organisation and was discussed on interview, induction and regularly through staff support such as supervisions and meetings. A whistleblowing helpline was in place where staff could confidentially raise concerns, the details of which were listed on the reverse of staff ID cards.

The service looked after spending money for some people who used the service. Appropriate records were kept and checks on finances to help reduce the risk of financial abuse. Following theft of some money at one of the supported living properties we found procedures had been refined demonstrating continuous improvement of the service. People and relatives told us their finances and personal possessions were looked after appropriately by the service and that they had no concerns about this aspect of the service.

We concluded there were sufficient staff to ensure appropriate care and support. We saw staffing levels were broadly in line with commissioned support hours and these were reviewed from week to week to monitor staff deployment. Support packages varied, for example some people received periods of 1:1 and 2:1 staff support. We saw arrangements were in place to ensure these were fulfilled. People, relatives and staff all told us there were sufficient staff deployed to ensure people received the agreed level of care and support. For example one relative told us "Staffing levels are very high. There is at least 2 staff on for three people, sometimes more." Agency staff were occasionally used to cover unplanned absences and ensure staffing levels were maintained.

Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people. Staff told us that before commencing work they had gone through a robust recruitment process to ensure they were suitable to work for the service. These checks included seeking references from

previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. We reviewed staff files which confirmed these checks took place. Prospective candidates had to attend an interview and a meet and great with people who used the service. Records showed people receiving support were included in the interview process. This was either through people asking questions as part of the interview panel or their opinions sought through the meet and great. We saw people's comments on candidates were recorded demonstrating they were involved in the recruitment process.

Following the last inspection in June 2015, risk assessment documentation had been overhauled. We found documentation was now more robust and thoroughly assessed the risks to people's health, safety and welfare. Risk screening took place annually or more frequently if changes to people's circumstances were identified. Risk screening assessed risks in areas such as mental capacity, communication, health, hygiene, medicines, food and security. This risk screening was used to develop detailed risk assessments where required. These provided staff with clear and person centred information on how to minimise risks to people. For example, one person was at risk of malnutrition and feeding was enhanced by a Percutaneous Endoscopic Gastrostomy (PEG). Care plans clearly demonstrated why the PEG was needed and under what circumstances it had to be used. The assessment also included instructions on the safe maintenance of the PEG tube. We also saw risk management procedures being used to help a person to self-medicate. Whilst self-medication had not been achieved, care plans showed how support staff had introduced self-medication in a controlled risk-free way. For example, staff made available a single days supply of medicines to assess competence and compliance with medicine taking. At each time the medicine was required to be taken a prompt was given if necessary. Where risks or non-compliance had been identified staff had reverted to administering medicines. The risk assessment demonstrated a willingness to encourage independence and engage in positive risk management. Where people went out into the community, robust and person centred risk assessments were in place detailing how staff should support them in a safe way. Risk assessments were signed by staff who supported them to demonstrate they had fully read and understood them.

Staff we spoke with were able to confidently describe the risks associated with each person they supported and how to ensure the risks were effectively controlled. This understanding was confirmed during observations of care and support. For example one person had PICA (an appetite for substances that it may be unsafe or unwise to eat). During observations of care and support we saw all staff were highly aware of the need to ensure objects were kept away from them to keep them safe. For another person, staff had identified a risk associated with glass picture frames and had ensured all glass was removed but kept the pictures up to ensure a homely and pleasant environment.

The service supported people to live in a safe environment by completing periodic health and safety checks of people's homes and the equipment within. This included fridge temperature checks, electrical checks, wheelchair checks and environmental assessments. Area managers reviewed these checks on a monthly to ensure they were consistently undertaken.

Procedures were in place to support staff to act appropriately in the event of an emergency. We reviewed one incident where staff had acted quickly and effectively in a medical emergency to ensure a person received prompt urgent and emergency care. We saw the staff had been praised by the ambulance service and received an internal award due to their effective action. A relative we spoke with also told us there had been an emergency situation within the last year that had been well handled by the service.

We looked at how medicines were managed, by reviewing medicines records in the provider's office and also in the supported living premises which we visited. Overall we concluded medicines were appropriately

managed and robust systems were in place to check medicines were given as prescribed and to take prompt action to investigate and learn from any errors.

People were assessed as to their ability to administer their own medicines. People's abilities were graded to ensure people who may not be able to self-medicate could be helped to do so by prompting and over time develop the required skills. Detailed medication profiles were in place which described the medicines people were prescribed and how to support them in a safe way.
All known allergies to medicines were recorded within MAR to ensure staff were aware of these risks.

At one of the properties we visited, we identified some unsafe practices, however we concluded this was an isolated case caused by a lack of diligence by staff based at the property. We concluded medicines were managed in a safe and robust way at the other properties we visited and on reviewing records in the office. For example at one property, we identified that one person had been given an incorrect dose of a medication on two recent occasions. This was immediately investigated by the provider, a safeguarding alert put in and medical advice sought which concluded the person would come to no harm. At this property we also found instances of stock balances not being consistent with the number stated as present in records which indicated there had been occasions when prescribed medicines had not been given despite being signed for as given. These discrepancies were promptly investigated by the provider, and a report of the action taken to prevent a re-occurrence was sent to the commission within 24 hours of us identifying the error.

Stock balance checks at the remaining four supported living premises we visited showed that the number of medicines in stock matched with what records stated should be present showing medicines had been given as prescribed. MAR Charts at these properties were accurately and consistently completed demonstrating people received their medicines at the times they needed them.

Medicines were stored securely and appropriately at all the properties we visited.

Protocols were in place detailing the circumstances when "as required" medicines should be given This helped ensure these medicines were given in a consistent manner by staff.

Where hand written MAR charts were in place we saw in the majority of cases these were checked and signed by two members of staff to ensure the details of the prescription were correct.

Routine medicine checks were undertaken on a weekly basis by staff and also by the area manager on a monthly basis. We saw evidence these were identifying and rectifying any issues. We saw where previous medication errors had occurred appropriate investigations had been undertaken. There was a low instance of medication errors indicating systems and processes around medicine management were mostly effective and being followed.

Good

Is the service effective?

Our findings

People and relatives told us that overall people received effective care from the service. For example one person told us "They make sure I am well fed. They check food is in date. They weigh me. They take me to the doctors."

Overall we concluded people received care and support from experienced staff who were familiar with people's needs. People and relatives told us that staff had the right skills and knowledge to care for them, although some people said that there had been a number of changes in staff which was not good for consistency and continuity. One person told us "staff have the right skills, like them all." A relative told us "It is wonderful and I have every confidence in the carers." A second relative told us "I am very happy with them (the staff) in general. There are quite a lot of changes at the moment so not sure who people are." A third relative told us "They seem experienced. There can be occasional changes of staff. The ones at the moment are experienced." A fourth relative told us, "The staffs' skills seem to be OK. They seemed to have chopped and changed a lot. Sometimes we go and see a new face. It is better than it was." The registered manager told us that there had been a large recruitment drive over recent months which had led to a number of new faces but this process was now largely complete.

Questionnaire responses showed that 96% of people who used the service said they received support from familiar staff. Staff we spoke with had a good understanding of the people they were caring for confirming they knew people well. Questionnaire responses showed 96% of people told us that care workers had the correct skills and knowledge to care for them.

Team leaders and management told us staff all received periodic training in the core competencies which included health and safety, food hygiene, safeguarding, medicines and fire safety. Support staff we spoke with and records we viewed confirmed this to be the case. Some training such as medicines was underpinned by competency assessments to ensure staff had learnt the required skills and knowledge to support people effectively. Staff told us the training they received was effective in giving them the skills they needed to care for people.

New staff were supported to achieve the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. Staff also received a local induction to their place of work where they met the people they were supporting and went through local procedures such as fire and health and safety.

Specialist training was provided to staff dependant on the needs of the people they were supporting. For example some staff had received positive behaviour support training, epilepsy and autism training to help ensure they met the needs of the people they were supporting. We saw an example of how expertise gained through positive behaviour training had been used to inform care planning and reduce the occurrences of behavioural incidents. One staff member told us how they had received 'intensive interaction training'

which had been very interesting and thought provoking. They told us how it had allowed them to appreciate things from the point of view of the people they were supporting which has in turn lead to improvements to their working practice.
Staff received periodic supervision and appraisal where their performance was discussed and any developmental needs.

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. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to DoLS although the service had assessed the restrictions placed on people and had worked with the relevant local authorities to put in applications to the Court of Protection where they thought deprivation of liberties were taking place. Staff understood the current status of DoLS applications for people who used the service.

The registered manager and support staff had a good understanding in the application of the Mental Capacity Act. This was reflected in the documentation we reviewed. We saw any mental capacity assessments were specific to the reason the assessment needed conducting. For example we saw an assessment had been conducted to allow staff to deliver personal intimate care to meet the person's needs, for medical interventions and for holidays. We saw the outcome of mental capacity assessments were produced in Easy-Read format to aid understanding for the person.

We spoke with staff about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint. They also demonstrated their understanding restraint should only be used in a way which respected dignity and protected human rights. They told us restraint was not a feature of the service and the service focused on positive behaviour support which had been provided through training to some staff.

Care plans identified areas of care where consent should be sought. Support 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. We saw in one care file the consent procedure for choosing which clothes the person would wish to wear. The care plan directed staff to present a number of outfits for the person to choose from. The person was not able to articulate their wishes verbally but the care plan showed staff how to interpret body language and hand-gestures.

People and relatives spoke positively about the food provided by staff. For example one person told us the food was "superb" and another person said "food is very good." Daily records provided evidence of the food people had been supported with. We reviewed these which showed people received a varied diet.

Nutritional risk assessments had been completed which identified if the person was at risk of fluid imbalance or malnutrition and reflected the level of support they required for eating and drinking. For example, one person had a history of poor dietary intake associated with weight loss. We saw care plans evidenced which foods were preferred and how food was to be made appetising to encourage a good intake of food. The care plans recorded the person's weight which indicated the current strategy was effective. Healthy eating was also promoted through the care plan process and healthy weight loss strategies were

put in place where appropriate. Staff we spoke with understood how to protect people from risks surrounding eating and drinking such as choking.

We saw some people had been assessed as to their capability to make their own meals. We saw in such circumstances people had been found to have abilities to prepare food under supervision to protect them from harm from hot surfaces and boiling water. Staff we spoke with explained how they encouraged people to participate in shopping and food preparation in order to develop life skills.

Care plans contained information on people's healthcare needs and any medical conditions and how staff should best support them. People and relatives told us and documentation we viewed confirmed health action plans were in place. A health action plan is a personal plan about what people with learning disabilities need to do to stay healthy. It lists any help they might need in order to stay healthy and makes it clear about what support they might need.

People and relatives told us the service was good at meeting people's healthcare needs. One relative told us "The carers are very good at contacting health services if needed." We saw evidence in written records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community nurses, specialist nurses, physiotherapists, speech and language therapists, dieticians and dentists. People were supported to attend annual health check-ups and other routine appointments. Hospital passports were in place. A hospital passport contains key information about the person's needs to ensure effective care and support should they be admitted to hospital.

Good

Is the service caring?

Our findings

People and relatives all told us that staff cared for people well and treated them kindly with dignity and respect. For example one person told us "Staff are really really lovely where I am." Another person described staff as "very kind and friendly." A third person told us "I have superb staff. They look after me really well and help me do jobs." A relative told us "It is wonderful and I have every confidence in the carers." A second relative told us the care staff "absolutely" treated their relative with dignity and respect. People and relatives said the standard of care was good, for example one relative told us "I would rate Lifeways eight out of 10 for the quality of the care provided." Another relative told us "The care [person] receives is very good, her needs are met and she is treated with dignity and respect." 96% of people who completed questionnaires said they were introduced to care staff before care and support was delivered and 96% said they were happy with the care and support provided and that staff were kind and caring.

During visits to people's homes, we observed care and support. All of the staff interactions with people were friendly, respectful and caring. We saw people and staff had developed positive relationships with each other and staff had a thorough understanding of people's likes and dislikes. Staff knowledge had been enhanced by a thorough record of people's life stories completed as part of care planning. A key worker system was in place to provide people with a named contact for any care and support queries. We saw staff shift patterns had been arranged around people's individual needs so people could engage in activities at a time that suited them, which demonstrated a person centred approach to care and support.

Recruitment of staff focused on ensuring staff had the right attitude to care for people with learning disabilities. Dignity, respect and attitude of staff was also monitored through supervision and checks undertaken by team leaders, service users and area managers.

Staff had a high regard for maintaining people's privacy. People were supported to hold their own bedroom keys and we saw a sign on one person's bedroom door reminding staff that their room was private. Staff told us how one person's privacy was important to them and detailed how they helped the person to keep clean in a way which helped ensure their privacy was maintained.

During observations of care and support we saw people looked clean, tidy and well-presented indicating their personal care needs were being met by the service. This was confirmed by relatives we spoke with, for example one relative told us "She always looks clean and tidy when we pick her up". During visits to supported living premises staff were aware that the premises were people's homes rather than simply a workspace, for example we observed staff asking permission from people who used the service before making the inspectors a drink.

People's views and opinions were listened to by the service. Care plans contained detailed information on how best to communicate with people. Staff we spoke with had a good understanding of people's individual communication techniques. Care plans demonstrated the service had listened to people and recorded their likes, dislikes and what was important to them. We saw people were supported to make choices in all aspects of their care and support. For example we saw all furnishing and decoration had been chosen by

the person receiving support. We saw examples of staff helping people to personalising rooms with items which would reduce their distress and provide comfort. People were also listened to about the food they wanted to eat and the activities they wanted to do. People's views were sought on an informal basis, as well as through monthly care plan reviews and tenant meetings.
Where people lacked capacity and did not have relatives available to be consulted as part of care and support decisions, the service supported people to access IMCA (independent mental capacity advocates) to help ensure their rights were protected.

Relatives we spoke with generally said that communication was good with the service keeping them informed about what people had been doing and any issues that arose. People told us there were no restrictions on them visiting relatives or friends

Care planning focused on helping people to increase their independence. For example goals included targets around people helping with housework, laying the tables and making drinks. Staff had worked with people's landlords to help install equipment and fittings to promote people's independence for example wet rooms in bathrooms to make self-care easier. People were involved in daily life around the home for example supported to wash their own clothes. Relatives confirmed this was the case for example one relative said staff encouraged their relative to do things such as bringing down their dirty laundry and putting cups in the cupboard. We spoke with one person receiving support to gauge their level of independence. They told us staff reminded them when their bed needed changing. They told us they were able to load the washing machine but staff needed to help them with ironing. They told us they were responsible for cleaning their room and keeping it tidy.

Good

Is the service responsive?

Our findings

People spoke positively about the care and support they received. One person told us, "I have everything I need and never want to leave here." Relatives told us that staff had listened to them when they had provided important information on people's care needs. Relatives told us they had been involved in the initial care plan process. Another person told us "They help us go on holidays and look for new jobs and opportunities."

Following the last inspection, care records had been overhauled and were now more comprehensive. Staff had worked with people to develop support plans which were person centred. Care plans were both in standard written form and an easy-read format to promote understanding. Care plans contained information such as "How best to support me," "What's important to me" and people's preferred "circle of support" so staff understood people's personal preferences. Support plans were in place which covered areas such as health, eating and drinking and social activity and behaviour. Care plans contained specific information regarding the level of support people needed. We saw care plans reflected potential harm which may come to people without the right care. For example we saw one person had a habit of biting their fingers when they were agitated or anxious. We saw clear instructions for staff to follow to divert their attention to protect the person from harm and injury, this included playing favourite music and putting on favourite television programmes. Each care plan contained agreed goals to help ensure the plan of care helped improved people's health and support outcomes. Staff we spoke with said they found care plans were much improved and the new format presented information in a clear way.

Detailed daily records were maintained for people. These demonstrated the care and support people had been assisted with. These suggested the care plans were being effectively interpreted and actioned.

Some people's routines were very important to them We saw examples of staff catering for these people's needs. For example in one property we visited, wall calendars had been created displaying the activities and events people were due to attend. This helped provide a structured care routine and alleviate the people's anxieties.

Each person had goals in place which had been created in conjunction with the person. As well as goals around each care and support plan, specific goals around independence and activities were in place. We saw evidence these were reviewed on a monthly basis and staff we spoke with demonstrated a good understanding of goals and how they were supporting people to achieve these. The service was midway through introducing new goals documentation which would provide a more robust audit trail of people's goals and their regular evaluation. Where this had been introduced staff were linking daily record entries to specific goals and plans of care which allowed robust daily evaluation of people's goals and achievements. The registered manager told us this would be rolled out to other people's homes within the next few months.

People were encouraged to follow their own interests and activities to enhance their life-skills and means of enjoyment. People and relatives told us they were involved in a range of activities and that staff supported

them to plan and go on holiday. For example one person told us "I am going on holiday soon. My carer goes with me to look after me." A relative told us "[person] goes out into the community every day and he knows all the pubs in town. He also knows all the main supermarkets and enjoys talking to the check-out ladies. He loves going to Skegness Butlins and he even went to a London theatre to see ABBA. I never imagined he could manage that." One relative mentioned that because of a lack of car drivers at times it meant their relative couldn't go on trips further afield as much as they would like."

Care plans contained sections on social activities and community life. These included planning and meeting spiritual needs such as going to church on a Sunday. We spoke with one person who had identified they wanted to go on holiday to America. They told us about how their plans had been facilitated with the help from staff. The holiday was planned and the person was happily looking forward to it. Most people had busy social calendars and were encouraged to go out into the community. People were supported to attend events such as the circus, the theatre, swimming and trips to the seaside.

The service held events and competitions to engage with people who used the service. For example a" Great Halifax Paint off" had been held, with people asked to submit paintings. A number of prizes had been given out and paintings were displayed around the providers' office. People were encouraged to visit other supported living properties to socialise with other people who used the service.

People were involved in the service. An' inclusive recruitment 'YouTube video' had been created by people who used the service. In this people explained how they were involved in recruitment of staff and why it was important. This was being used as a promotional video throughout the provider to encourage other branches to involve people in the recruitment of staff. We saw evidence people's questions had been put to job applicants and their views on the candidates recorded as part of the recruitment decision. Care and support plans provided evidence people had been involved in the creation of support plans. Periodic family forums had been held for relatives to attend and air their views regarding the quality of care and support.

Monthly reviews took place of people's care and support and goals. 96% of questionnaire responses showed people felt involved in decision making about their care and support. We saw evidence that people and their relatives had been involved in regular care plan reviews. Some relatives confirmed this although others said they had not been involved in recent care plan review.

Complaints were brought to the attention of people who use the service through the service user guide. 92% of questionnaire responses stated that the service responded appropriately to any complaints or concerns raised. We saw a low number of complaints had been received, with only one formal complaint received within the last year. We looked at how this had been managed and saw it had been responded to promptly within the timescales stated in the policy. Management had offered to meet the complainant to discuss the issues in more detail. People and relatives we spoke with were generally very satisfied with the service. They knew how to complain and that any previous complaints had been resolved appropriately by the service.

Good

Is the service well-led?

Our findings

A registered manager was in place. We found the provider had submitted all required notifications to the Commission. This helped us to monitor events within the service.

People and their relatives all said that overall they were happy with the service and it provided good quality care. One relative told us [person] has done so well since he's been with Lifeways. It's all down to staff and I couldn't find better." Another relative told us "I am happy with everything" and a third relative said "I am very pleased with the whole situation. We visit regularly."

We found a number of positive changes had been made to the service since the last inspection. People using the service and support staff we spoke with told us, they had confidence in the management of the locations we visited. Staff told us, "Since {name} joined us as area manager and there had been a change of other leaders the service was much better." We asked how the service was better to be told, "We know where we are as support staff and what is expected of us." The staff also told us, "There is more of a focus on improving the service." Staff told us morale was good and that they had periodic visits from the management team. A well-defined structure of support was in place which included team leaders, area managers and the registered manager. We saw this had allowed policies and new systems to be disseminated effectively throughout the supported living premises despite the large geographic area covered.

Systems to monitor, assess and improve the service were in place. We saw significant improvement had been made to care plan and risk assessment documentation since the last inspection demonstrating the provider's improvement plan had been effective. More engagement had also taken place with people who use the service and their relatives. The service was committed to continuous improvement, for example there were various further improvements planned such as improving the way goals were documented.

A quality team was in place which was responsible for managing systems to assess and monitor the quality of the service. The quality team also undertook overarching audits of each supported living premises looking at a comprehensive range of areas under the five domains used by the Commission. These also provided a rating for each supported living property from very poor to excellent. We looked at a sample of these which showed the ratings awarded were either "good" or "very good." Where issues were identified, an action plan was produced for the service manager to work through.

Audits and checks were completed by a range of staff, for example team leaders, area managers and the registered manager. Each audit was required to be submitted up the chain of command to provide assurance that the service was working effectively and to an acceptable standard.

Service managers were required to complete a monthly audit and submit to the registered manager, the results of which were discussed in a monthly face to face meeting. These looked at areas such as complaints, safeguarding, finances, staff supervision, medication, care records, and risk assessments. They checked specifics such as whether people had an updated health action plan in place and whether DoLS

applications had been considered. They checked whether team leaders had been completing their required audits and checks such as finances, medication and health and safety checks. We found these audits were largely effective although at one property the checks by the team leaders had failed to identify issues we found with medication management during the inspection.
People who used the service were involved in assessing the quality of the service. Four "quality checkers" had been appointed, these were people who used the service, who undertook audits of supported living premises. This empowered them to be involved in making positive changes to the service. These audits focused on questioning staff, people who used the service and looking at the environment around the houses. We reviewed a number of these and saw people's views had been clearly recorded. This initiative was in its early stages, but the registered manager told us these findings would be inputted into an action plan so that it could be clearly evidenced what improvements had been made as a result of people's input. The quality checkers had been to the providers head office in London to explain the important work they were undertaking and the registered manager told us they would be supported to return to London to report on their findings. We spoke with one quality assessor who was proud of their role and said they really enjoyed it.

Questionnaire responses showed that 84% of people said the service had asked them what they think about the service. We saw that where feasible, staff supported people to hold tenants meetings. These allowed people to comment on their care and support arrangements and helped involve them in decisions in relation to how the service was delivered. People were involved in the planning of future events for example planning days were held annually led by service users, for the annual summer party and Christmas venue where they chose the venue and the nature of the event.

People's views were also sought through annual satisfaction surveys asking people about the quality of the service. We saw these had recently been completed for 2016. We looked at the responses which were mostly very positive and matched the positive feedback we received about the service in our own questionnaires. Where negative comments were received around changes of staff the registered manager provided assurance these had been addressed where possible with the person who used the service.

Staff meetings were held at each supported living premises. These were an opportunity for any quality issues to be discussed with staff and support staffing and any developmental needs.

Systems were in place to record, investigate and learn from any incidents that occurred. Incidents and accidents were logged centrally and were reviewed by the area manager and quality team. We reviewed incident forms which demonstrated that actions were put in place following incidents and that the service was committed to learning from mistakes as part of ensuring continuous improvement of the service.