Lifeways Community Care Limited

Lifeways Community Care (New Barnet)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We last carried out a comprehensive inspection of this service in January 2017. Breaches of legal requirements were found. We rated the service as Requires Improvement, and served four enforcement warning notices on the provider because of the potential impact on people using the service. These were in respect of safe care and treatment, person-centred care, staffing, and good governance. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection of 20 and 21 April and 3 May 2017 to check that the provider had followed their plan and to confirm that they now met the legal requirements relating to the warning notices in respect of safe care and treatment and person-centred care. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lifeways Community Care (New Barnet) on our website at www.cqc.org.uk .

The inspection was also prompted in part by notification of an incident suggesting potential concerns relating to the management of fire safety within one of the supported living schemes that this service provides care at. This inspection examined those risks.

The provider is registered for this service to provide homecare and supported living services to anybody in the community. The service specialises in the care and support of people who have a learning disability. At the time of this inspection the agency was providing a regulated care service to 19 people in their own homes. This included some people living in three supported-living schemes located in both Barnet and Buckinghamshire, and some people receiving stand-alone services in their homes.

The service did not have a registered manager at the time of the inspection. 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. We met with the new manager, who had been appointed just before our previous inspection, as part of our visit to the service.

Our findings at this inspection reflect that, although the provider was operating one service for everyone, people still experienced different standards of care depending on their location. Where service manager arrangements had been stable at one scheme, there was the most evidence of good care. This was not the case for the Buckinghamshire scheme where new managers and a team leader had only recently been recruited, albeit the benefits of the new management input were starting to be seen. We therefore found that the provider had addressed some of the concerns relating to safety and responsiveness as outlined in our warning notices, but others remained and we identified some new safety concerns.

There continued to be errors relating to the safe and proper management of people's prescribed medicines.

This was mostly at the Buckinghamshire scheme where we found that people had not been consistently supported to take medicines as prescribed. However, this was also the case for one person in a Barnet scheme, plus some supporting documents for the safe management of medicines were not always kept up-to-date.

At the Buckinghamshire scheme, the people living there, who were dependent on staff support, were still not often accessing the community, contrary to plans made in that respect. This included one person whose physiotherapist recommended daily walks and whose care plans stated that they liked going out. Records showed they received staff support to go out four times in twenty days just before our visit to their scheme. There was better community support of people at the Barnet schemes.

At the Buckinghamshire scheme, there were no documented checks of hoists, slings, wheelchairs and bedrails since October 2016, despite two people using these and procedures generally requiring monthly checks. There remained no evidence of a professional check of the safety of the mobile hoist that had been used there for a number of months. No-one had been supported to have their weight checked since October 2016, despite one person's care plan requiring this monthly. One person there required staff trained in stoma care, but most staff did not have that training. People's risk assessments were not up-to-date, and did not exist in respect of bed-rail use. This all meant that safety risks for these people may not have been identified and minimised.

There remained occasional infection control concerns including bodily fluid stains on one person's bedding and ingrained food stains on another person's wheelchair belt buckle. However, good standards of cleanliness were usually observed during our visits.

Improvements had been made with ensuring staff working with people at risk of choking had had their competency assessed in respect of providing meal support. At the Buckinghamshire scheme, staff had received additional training in that respect, and we saw plans to provide this for other applicable staff. Individualised guidelines on how to support people to eat safely were easily accessible where needed. People received blended food in its constituent parts, which enhanced their meal experience, and some had adapted equipment to enable greater independence.

There have been improvements to the number of staff who have had a medicines competency check within the last year, and there were plans to complete this process. There have been reductions in the amount of agency staff used overall, and the amount of hours worked by each of the small staff team at the Buckinghamshire service.

There was good liaison with healthcare professionals to reduce some people's medicines and improve on quality of life. We also noted little use of sedative PRN (as-needed) medicines that some people had, which indicated good care provision.

There was evidence of ongoing fire safety checks by staff at each scheme. People had up-to-date and individualised fire evacuation plans, and most staff had up-to-date fire safety training. There were ongoing reviews of fire safety at each scheme in light of the recent notification suggesting potential concerns relating to the management of fire safety.

There remained two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 out of the two regulations we inspected against. You can see what action we told the provider to take at the back of the full version of the report. There were four other breaches of regulations identified at our last inspection; these will be followed up at our next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service remained inconsistently safe. Many people were supported with managing their medicines. However, medicines were not properly and safely managed at one scheme, or for a few other people. Infection control systems at some schemes were still not fully robust.

At the Buckinghamshire scheme, a number of safety checks had not recently occurred for the equipment used by some people, such as hoists, bed-rails and wheelchairs. There were no bed-rail risk assessments, and people's risk assessments were not up-to-date or easily accessible. There remained no evidence of a professional check of the safety of the mobile hoist that had been used there for a number of months. This all meant that safety risks for these people may not have been identified and minimised.

However, safety check records for some other people were generally up-to-date. This included in respect of fire safety. Improvements had been made with supporting people at risk of choking to eat safely, checking that staff were competent to support people to take medicines, and with the amount of hours staff were working at the Buckinghamshire scheme.

Is the service responsive?

Requires Improvement

The service remained inconsistently responsive. At the Buckinghamshire scheme, the people living there, who were dependent on staff support, were still not often accessing the community, contrary to plans made in that respect. This also prevented effective monitoring of their weight, as community resources were used for that purpose.

However, there was good community support of people at the Barnet schemes, and evidence of individualised support of people across the service. There was less reliance on agency staff than at our previous inspection, which helped promote individualised care. There was also good liaison with healthcare professionals to support some people to have a better quality of life through reductions in prescribed medicines.

Lifeways Community Care (New Barnet)

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 was an unannounced inspection which took place on 20 and 21 April and 3 May 2017. Before the inspection, we looked at the information we held about the service including any notifications they had sent us and information from the local authority.

The inspection team comprised of two inspectors. We visited three of the service's supported living schemes and the service's local office. We looked at eight people's care plans, risk assessments, and care and medicines records, along with various management records such as quality-auditing tools and staff rosters. The manager sent us some further documents on request in-between the inspection visits.

There were 19 people using the service at the time of our visits. During the inspection, we spoke with eight people using the service although only one was able to provide us with their views due to communication challenges. We also spoke with one relative and 19 staff including support workers, team leaders, scheme managers, the manager of the service, a quality manager and the regional director.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found the service not to be consistently safe. This was because choking risks to people needing support to eat at one scheme were not properly mitigated, despite a choking incident there a year earlier. There were also concerns there with ensuring the safety of moving and handling equipment, with ensuring staff there had epilepsy training, and with staff working excessive hours. Medicines were not properly and safely managed at another scheme, and medicines competency checks were not in place for a number of staff. Infection control systems at some schemes were not fully robust. Across the whole service, there was some ongoing reliance on agency staff, which undermined consistently safe care. This meant the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider for this regulatory breach because of the potential impact on people using the service.

At this inspection, we found that the provider had addressed some of the above concerns relating to safety, but others remained and we identified some new safety concerns.

The provider was no longer supplying staff at the scheme where there were previous concerns about medicines management. However, our checks of other people's medicines support during this inspection found instances where people were not supported to receive their medicines as prescribed. At the Buckinghamshire scheme, records showed that one person's regular medicine for constipation had run out for four prescribed administrations before a new supply was acquired. Since then, their as-needed (PRN) medicine guidance for a different constipation medicine was not correctly followed on five occasions. On one occasion, the medicine was administered one day too early. On another occasion, it was administered one day too late, and then despite having no effect, it was then not administered the following day contrary to the PRN guidance. We found that their care plan did not refer to this PRN medicine, guiding staff only to support the person to obtain GP advice if concerned. This was not safe and proper management of the person's medicines in support of providing them with safe care.

Records showed that two other people at this scheme had been supplied with a particular patch medicine, to help prevent excess salivation. Their medicine administration records (MAR) and the labels on the medicine packets stated for administration every three days. However, the MAR showed they were given every five days for almost a month, before the frequency changed to every three days. A staff member explained that senior staff instructed for that frequency but could not provide any records to confirm this. This demonstrated a failure to provide safe medicines care to these two people.

At a scheme in Barnet, one person was prescribed and supported to take twice-daily eye drops. The number of remaining capsules of this medicine was in excess of the number of capsules that should have been available according to the MAR. This raised concerns that the person had not been supported to take the medicine as prescribed.

At the same scheme, another person did not have a comprehensive record of medicines received and medicines returned to the pharmacy. Forms for these purposes had not been completed in almost three

months and hence for three medicines deliveries. The medicines received form had not been used for people at the Buckinghamshire scheme for a considerably longer time. MAR at both schemes did not consistently record quantities of medicines received and on what date, nor how much stock was carried forward when each new MAR was used. There was therefore no robust system for recording people's medicines stock and usage, by which to properly audit and account for people's medicines support.

At one Barnet scheme, one person was prescribed a medicine for use as needed. Whilst the medicine was for the management of constipation, the individual guidelines in place did not stipulate this, and only guided staff to offer the medicine to the person in relation to sleep management. The guidelines did not clearly support staff to provide the person with the medicine as prescribed.

Some people's medicines were not safely stored. At the Buckinghamshire scheme, sachets and bottles of medicines were stored on top of medicines cabinets in people's rooms as the cabinets were full. At a Barnet scheme we found the key in the lock of one person's medicines cupboard. This was contrary to guidance in the person's care plan which required for staff to lock the cabinet securely.

At one Barnet scheme, we found that household chemicals including bleach were in an unlocked cupboard in one person's flat. Their care plan stated that they could confuse chemicals for drinks and so the chemicals needed to be locked away. This demonstrated a failure to take all appropriate steps in relation to an identified risk.

At the Buckinghamshire scheme, one person's care plan informed us that staff needed to have stoma bag training from a stoma nurse to safely support them. Although a staff member told us of being trained on this, training records for the service did not have information on any staff having had stoma training. The provider's audit of the scheme in October 2016 had also identified this training need. This demonstrated a failure to ensure that suitably skilled and competent staff provided care and treatment to this person.

We saw occasional infection control concerns in respect of people's care, as at the last inspection. At the Buckinghamshire scheme, one person's belt buckle on the wheelchair that they used all the time had ingrained food stains at the start of our visit. At a Barnet scheme, one person's duvet cover and bedding had bodily fluid stains at around midday, despite staff supporting them to get up earlier in the day. Their care plan included for bed linen to be checked daily and changed if needed. There were now separate mops for use in either the kitchenette or the communal bathroom and toilet at this scheme. But there was no obvious means of identifying which mop was for which area, given they were both stored in the same cupboard. We also found no paper towels for drying hands in the communal toilet. These matters showed insufficient attention was paid to ensuring the control of infection at these schemes.

At the Buckinghamshire scheme, staff told us of one person recently having an accident that resulted in a nose bleed and GP advice. Care delivery records confirmed this. However, there was no accident record available at the scheme or in the office. This was contrary to the provider's incident and accident reporting policy. This meant the provider could not assess the health and safety risks relating to this accident and take actions to prevent reoccurrence where practicable.

At the Buckinghamshire scheme, there were no risk assessments available for two of the three people living there by which staff could be guided on how to address safety hazards. There was therefore a risk that staff may have provided care to these people that was not safe, as they could not be informed by the relevant risk assessments.

At the office, we found that risk assessments had been written for these two people in respect of most

aspects of their care. However, they were both dated from 2015 and so were not up-to-date in respect of current care needs. This was not in line with the provider's risk assessment policy which required at least annual review of risk assessments. The risk assessment for one of these people had not been completed in full, in terms of the seriousness of each risk, and in identifying control measures for some identified risks.

There were no bed-rail risk assessments available at the Buckinghamshire scheme or in the office. This was despite us seeing that the two people above had bed-rails in place, and that the provider's October 2016 audit identified this concern. This demonstrated failures to assess, and take reasonable actions to mitigate against, risks of entrapment as part of the care provided to these two people.

Both people required hoisting support, but the risk assessments did not consider which slings and hoists were being used. The provider's audit of the service in October 2016 had identified these matters. Updating the risk assessment was particularly important for one person as staff told us they had had to be supported from a mobile hoist until recently due to their overhead hoist malfunctioning. We asked to see professional documentation that the mobile hoist was safe to use, ordinarily a process that occurred on a six-monthly basis. Nothing had been supplied at the time of drafting this report to confirm this. There were also no documented staff checks since October 2016 of the hoists, slings, wheelchairs or bedrails for these two people. This was despite the forms stating for checks to occur at least monthly. This all indicated failures to ensure that equipment used to provide care to people was safe for use and used safely.

The above evidence demonstrates failures to ensure that people's care and treatment was being provided safely, which is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had addressed some of our previous safety concerns. At our last inspection, three people living at the Buckinghamshire scheme were identified as being at choking risk, but staff working there had not had training on that. At this inspection, records showed that of the four staff working there regularly in April, three had had this training. Staff told us this occurred soon after our last inspection. There had also been epilepsy awareness training, as some people at that scheme had epilepsy.

At another scheme, staff told us of someone having a choking incident that had resulted in medical attention. They told us of imminent dysphagia (choking) training for staff working with that person. We saw records of the involvement of the speech and language therapist (SALT) in reviewing that person's eating risks since the incident. Guidance on how to safely support them with eating was on display in their kitchen as a reminder for staff. A staff member we spoke with was aware of the relevant points of that guidance.

The manager explained that dysphagia training had been provided to staff attending to people at greatest choking risk. We were shown that further training, for other staff working with people at risk of choking, had been booked, and that relevant staff had had competency assessments completed in respect of supporting people at risk of choking to eat safely. One person was able to confirm that they felt safe with the support staff provided them with for eating and drinking. This person was identified as being at choking risk.

At our last inspection, some staff had not had an annual competency check of their ability to safely support people to take medicines. The provider told us this was updated at the scheme where it was most needed. The provider was no longer supporting people at this scheme at the time of this inspection. However, the provider's oversight training records showed for all care staff at this service, up-to-date medicines competency assessments had risen from 49% at the last inspection to 70% at this one. We checked for individual staff involved in medicines errors in 2017, and found that their competency had been reassessed following the errors. The manager showed us action plans for continuing to increase the percentage further.

At our last inspection, staff were working excessive hours at the Buckinghamshire scheme. Checks of the staff roster for the first three weeks of April found that the average hours per week had reduced. Some staff told us of volunteering to work extra hours, and a small amount of agency staff had also worked. It was positive to note that a team leader, a manager and area manager were also working at that scheme, in contrast to our findings at the previous inspection.

Whilst we noted concerns in respect of providing people with safe care at some schemes, safety check records for some other people were generally up-to-date. This included, where applicable, for hoists and slings, wheelchairs, bed-rails, and temperatures for bath water, fridges and medicines cabinets. One person confirmed that staff undertook these checks for them. We saw records confirming that overhead hoists had been professionally checked and were safe to use. A staff member told us they had recently completed online training on the safe use of bed-rails that required annual refresher. There were records of monthly bed-rails safety checks for this person, including clear guidance on what risks to check on.

We saw that some people were supported to keep their flats clean, and one person confirmed that staff wore disposable gloves when providing them with personal care.

Shortly before this inspection, the provider notified us of an incident suggesting potential concerns relating to the management of fire safety within one of the supported living schemes that this service was providing care at. This inspection examined those risks within the context of the provider's registration for personal care in people's own homes; however, the London Fire Brigade is taking the lead for investigating the fire.

There were records of regular fire safety checks by Lifeways staff at each scheme. Fire drills took place in line with recommendations from fire safety risk assessments, although we noted that they were limited to office hours across the last year. There were personal emergency evacuation plans in place for each person, most of which had been reviewed in the last year to ensure they reflected the person's current needs. Most staff had completed classroom-based fire safety training within the previous three years, as per the provider's expectations, and there were plans to address any shortfalls. There were ongoing reviews of fire safety at each service in light of a recent incident relating to the management of fire safety, to ensure risks were being mitigated where possible. For example, fire-safety closure devices were now on order for one scheme, to hold fire doors open so as to enable people's independence but which closed if the fire alarm went off.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found the service not to be consistently responsive. This was because people did not consistently receive care that was responsive to their individual needs and preferences. In particular, at one scheme, people were not often supported to access the community. This meant the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider for this regulatory breach because of the potential impact on people using the service.

At this inspection, we found that the provider had addressed some of the above concerns relating to responsiveness, but others remained.

At the Buckinghamshire scheme, the people living there, who were dependent on staff support, were still not often accessing the community, contrary to plans made in that respect and despite two of them having designated cars for that purpose.

According to care delivery records across the first 20 days of April, one person was supported by staff to go out four times. This was despite physiotherapist advice in their care plan for daily walks, for example at the park next to the home. They were noted to be sleeping on the sofa during the day on seven occasions. Their care plan stated, "Without motivating, I will lay down and go to sleep."

Another person went out with staff support eight times in the same period, but was also recorded as being upset not to go to an Easter party at a weekly club that they usually attended. Staffing rosters showed that the usual extra staff member had not attended to provide the support to go to the club. Both people's care plans stated that they liked going out.

Staff told us that they supported these people to go out where possible; however, it had to be timed right as one person living at the scheme needed two staff to support them at times during the day and two staff were also needed at mealtimes due to people's support and safety needs. Staff stated that people used to go out more, but that staffing arrangements prevented this from occurring. We saw that staffing rosters at the scheme provided two staff at all times of day plus a third staff member once a week to help two people attend a recreational club. This had not changed since our last inspection. The management team told us there was ongoing discussion with the funding authority to finance additional staffing resources. However, the evidence above, of little support to access the community, demonstrates ongoing failures to support these two people to receive care that met their needs and reflected their preferences.

At the same scheme, records showed that none of the three people had been weighed since October 2016. A staff member told us that everyone attended a health service in the community to have their weight checked, but that this had not occurred recently due to staffing difficulties. We noted that two people used wheelchairs and so would not be able to weight-bear on standard scales to measure their weight. The care plan for one of these people stated for monthly weight checks as part of health monitoring. This also shows failures to provide care that met people's needs.

The above evidence is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other concerns we had from the last inspection had been addressed. At the Buckinghamshire scheme, food was now being blended or mashed, where needed for individuals, into component parts. This helped people to be able to taste different parts of the meal. We also saw that some people had adapted equipment to help them to eat independently. One person at that scheme had an identified preference for female staff to provide personal care support. Recent staff rosters showed that this was now usually adhered to, and was a familiar staff member where not.

At a Barnet scheme, we found that there was less reliance on agency staff than at our previous inspection. This helped people to receive care from staff who they knew and who were more likely to be able to provide care that met their needs and preferences. Staff at that scheme confirmed that there had been some recruitment of new staff. One person at this scheme confirmed that there was always staff to support them.

Staff we spoke with at all schemes knew people's individual needs well. We saw many examples of staff providing support in line with those needs, such as with meal support and going to planned community activities. Staff told us of one person having a number of chest infections, but with input from community health professionals, causes were identified and support was adjusted to minimise the risk of reoccurrences. We saw staff providing support in line with the adjusted support plan. Records and staff feedback at two different schemes also indicated that two people's medicines had been reduced after consultation with their prescribers. This in turn improved people's quality of life.

Records and staff feedback demonstrated little use of sedative PRN (as-needed) medicines that some people had been prescribed. This helped to indicate that for these people, the care was meeting their needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons failed to ensure that care of service users is appropriate, meets their needs, and reflects their preferences. Regulation 9(1)(a)(b)(c)

The enforcement action we took:

We served a Warning Notice on the Registered Provider to become compliant with the regulation by 30 June 2017.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to ensure that care and treatment is provided in a safe way to service users, including through: - assessing the risks to the health and safety of service users of receiving care, and doing all that is reasonably practicable to mitigate any such risks, - ensuring that staff have the competence and skills to provide care or treatment to service users safely, - ensuring that the equipment used for care to a service user is safe for such use and used in a safe way, - the proper and safe management of medicines, and - preventing, detecting and controlling the spread of infections. Regulation 12(1)(2)(a)(b)(c)(e)(g)(i)

The enforcement action we took:

We served a Warning Notice on the Registered Provider to become compliant with the regulation by 30 June 2017.