

Lifeways Community Care Limited

Wycar Leys Bulwell

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 7 and 10 September 2018 and was unannounced. This was the first inspection of the service since the change of provider to Lifeways in September 2017. The service had been previously registered under a different provider.

Wycar Leys Bulwell is a care home for a maximum number of 22 people with learning disabilities. It consists of three buildings which are known as The Cottage, Homestead and Middleton House. There were a total of 19 people accommodated during our inspection.

There was a registered manager in place at the time of this 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.

People received safe and effective care from staff. The staff team was a mix of established staff and more recently recruited staff, all had a good understanding of the various types of harm and their roles and responsibilities in reporting any safeguarding concerns.

Risks to people's individual needs and their home environment had been assessed. Staff had information available about how to meet people's needs, including action required to reduce and manage known risks. When incidents occurred these were recorded and details updated in people's care plans.

There had been a recent reduction in core staffing numbers and the service used agency staff to maintain sufficient staffing across the service. There were sufficient numbers of staff to meet people's care needs. Staff were recruited safely. Staff received regular training and supervision and were able to reflect on the care and support they delivered and identified further training requirements.

People receiving support had their rights protected under the Mental Capacity Act 2005. The staff were knowledgeable about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and applications for DoLS had been made appropriately. Staff gained consent from people whenever they could and, where people lacked mental capacity, we saw that arrangements were in place for staff to act in their best interests.

People received appropriate support with their medicines. Staff had received training in supporting people with their medicines and staff had their competency assessed.

People were supported to eat and drink sufficient amounts to meet their nutritional needs. External health professionals were involved in the person's care when required.

Care plans were being updated and these reflected people's individual needs and personal wishes. Where

possible people and their representatives were involved in the development of their care plans.

The service encouraged feedback from people or their representatives about the service they received. A complaints process was in place. People were able to express themselves when they were not happy about something. A formal complaints procedure was in place and people's representatives felt able to make a complaint and felt confident that the management would respond appropriately.

People's representatives told us they were happy with most aspects of the service provided and spoke positively of staff and registered manager. People received care and support from kind, caring and compassionate staff, who respected their privacy and dignity at all times.

The people, their representatives and the staff team had confidence in the registered manager and the way the service was run. The staff team did not feel supported by the larger organisation.

Systems had been recently introduced to monitor and improve the quality of the service provided but this needed to be sustained. The vision and values of the staff team were caring and person-centred to make sure people were at the heart of the service.

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 knew how to keep people safe and understood their responsibilities to protect the people from the risk of harm.

Risks to the people's health and safety were managed and plans were in place to enable staff to support them safely.

Sufficient staff were deployed to meet people's needs and where recruited safely.

People were supported with their medicines safely.

Is the service effective?

Good ●

The service was effective.

Staff were trained and had suitable knowledge and skills to provide effective support.

Staff knew about the Mental Capacity Act 2005 and its implications for the people in a care setting. Staff knew how to ensure they promoted people's freedom and protected their rights.

People were supported to eat and drink sufficient amounts to meet their nutritional needs. External health professionals were involved in people's care when needed.

Is the service caring?

Good ●

The service was caring.

Staff were kind when supporting people to meet their care and support needs.

People were encouraged to make decisions relating to the care and support they received.

People had access to advocacy services.

Staff respected and supported people in a manner that promoted their privacy and dignity.

Is the service responsive?

Good ●

The service was responsive.

There was appropriate information available to staff about the people's care needs.

People received a service that was flexible to their needs.

People and their representatives were able to give feedback about the service they received.

People and their representatives had access to a complaints procedure.

Is the service well-led?

Requires Improvement ●

The service was not always well-led

Staff felt effectively supported by the registered manager, but not by the provider.

Systems had been introduced to monitor the quality of care and to ensure that people received good care from staff. We need this to be sustained over a longer period to reflect its effectiveness.

Staff were able to share their thoughts about the service and felt this was valued by the registered manager.

The provider was aware of their regulatory responsibilities.

Wycar Leys Bulwell

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 unannounced inspection took place on 7 and 10 September 2018 and was carried out by three inspectors and one inspection manager.

Before the inspection, the provider completed a Provider Information return (PIR). A PIR 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. Prior to our inspection, we also reviewed information we held about the service. This included information received and statutory notifications about the provider. A notification is information about important events, which the provider is required to send us by law.

We contacted local commissioners of the service, Healthwatch and health and social care professionals involved with the service to obtain their views about the quality of the care provided by the service.

Most of the people living at the service were not able to fully express their views by talking with us and some chose not to interact with us at all. During the visit we observed the care of 10 people, spoke with five care staff, two assistant team leaders, two team leaders, two deputy managers, the area manager, the regional director and the registered manager.

We visited each of the buildings that form the care home and we looked at the care plans for five people, the staff training and induction records for staff, four people's medicine records and the quality assurance audits that the registered manager and their team completed. We also looked at information shared with us from professional commissioners of services.

After our inspection we spoke with four relatives.

The inspection was completed by three inspectors and one inspection manager.

Is the service safe?

Our findings

During our inspection we observed people being supported safely by staff. Many people required one to one staff support and two to one staff support when out in the community. One person told us, "It's alright here." From our discussions with relatives they told us people were supported safely. One relative said, "They will always let me know if something happens i.e. Safeguarding."

Relatives told us they felt that their family member was safe and protected from harm. One relative told us, "I feel [family member] is safe within the home, and is always within sight of a carer, any anxieties [family member] does display or potentially dangerous situations [family member] becomes involved in, can be acted upon [by staff] really quickly. This is a new system since Lifeways [current provider] took over; previously whoever was caring for [family member] would only need to be aware of [family member] presence in the building/grounds."

Recently CQC had received a high number of notifications of incidents of alleged harm and possible injury. These were sent in to us and the local safeguarding authority by the registered manager who had recently took up the position. Some of the incidents were historic, but nevertheless the registered manager and regional management for the provider had investigated them. We were satisfied in how these had been investigated and appropriate action taken by the service to safeguard people from harm.

Staff were aware of the signs and symptoms of any harm or abuse and were alert to these. They were able to describe to us the types of concerns that might arise and present a risk to the person they supported. Staff told us if they had any concerns about the safety or wellbeing of a person they would take immediate action and report their concerns to the management. One staff member said, "We have had safeguarding training. Training is classroom based and good. When the new provider took over we had the chance to read through the [safeguarding] policies and procedures they introduced." A safeguarding policy was in place and records checked confirmed staff had attended safeguarding adults training.

Risk assessments provided staff with the required information about how risks should be managed to protect the person receiving care. Where people were deemed to be at risk, these risks were monitored and reviewed regularly. One example was of a one person who would self-harm when they were anxious, but would not use any implements. Detailed information was listed in their risk assessments about triggers and behaviour management support. We spoke to staff about how they support this person when they became anxious. Staff clearly explained the person's needs and how best to support them in such situations. These responses matched information recorded in the person's care file confirming staff knew how to support people safely. Staff took appropriate action following accidents and incidents to ensure people's safety, including the review following an incident, of risk assessments and care plans in order to minimise the risk of re-occurrence. The incidents were analysed to identify patterns and any actions that could be taken to prevent them happening again.

We checked people's bedroom furniture to make sure it was safely secured. We found several people's wardrobes and drawers were not safely secured and no risk assessments were in place that confirmed

people did not require this. Securing the wardrobes would reduce the risk of any incidents or accidents that could occur in people's bedrooms. We spoke with registered manager and area manager about this and they confirmed they would take the appropriate action needed to make sure people were safe in their rooms. A relative told us, "Any maintenance issues within [family member's] room are dealt with promptly, which also adds to the feeling of safety.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for people using the service. These plans provided staff with guidance on how to support people to evacuate their home in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

We checked the recruitment files of seven staff members. Safe recruitment and selection processes were followed. These contained the relevant documentation required to enable the provider to make safe recruitment choices. Each file contained references, proof of identity and the relevant health checks for each member of staff. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

People living at the service were involved in recruitment. A team leader told us how they involve residents in recruitment by, "Asking new candidates to arrive ten to fifteen minutes before the interview and seating them with a cup of tea in the lounge area to see how they interact with the residents." Relatives also said they had been invited to the service to learn about the recruitment and selection process for new staff. Relatives told us they found this very helpful.

There were sufficient staff to meet people's needs. A staff member said, "The rotas are clearer for staff and the staffing levels have improved since the new company took over [September 2017]. We used to have eight staff in the mornings whereas we now have eleven." On inspection we noted agency staff on shift they were seen to be allowed sufficient time to read the care plan of the person they were going to support. We saw another agency staff member supporting a person and it was clear from our observations that they were very familiar with the person's needs. This person had been working at the service for over a month.

People's medicines were well managed by staff so that people received them safely. We reviewed five examples of medicines administration. There were clear records to show when each person's medicines were given. There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. There was a clear audit trail that defined what action was taken following errors, such as medicines retraining and competency tests. When necessary, medicine errors had been reported to the local authority and the registered manager had followed the guidance for the professional duty of candour. We saw secure storage arrangements in the three different parts of the premises.

The registered manager told us staff had received regular medication competency checks as part of the arrangements in place to ensure medicines were being administered safely by staff that had this responsibility. We looked at three examples of the completed checks which confirmed those staff assessed were competent to support people to take their medicines.

We saw the process in place to make sure people's clothes were laundered and kept separately in a secure laundry room for each home, which the staff member told us, was used to ensure individual clothing did not get mixed up and to minimise cross infection.

Some people's rooms and communal areas in all of the three homes would have benefited from more regular cleaning. The registered manager told us the service did not employ dedicated cleaning staff. Cleaning had been included for some people as part of the goals contained in their support plans and that the care team used some of their time to undertake cleaning duties. One staff member told us, "The one area I think we could improve on staffing wise is that the cleaning schedules can impact on the time we have to provide care." The operations director and the registered manager told us that they were reviewing this arrangement so that they could be clearer about how much time this was taking for staff so that if needed more dedicated time would be made available for staff to clean.

Policies and practices in the service ensured people were protected by the prevention and control of infection. For example, staff had received induction and training on infection control and prevention. Staff who supported people with food preparation had received food and hygiene training.

During our inspection, one person became agitated and upset at lunchtime. We observed staff respond quickly to calmly support the person without the need for physical intervention. Staff used quiet communication and gestures to de-escalate and calm the person. Staff also ensured other people and visitors were kept safe and additional staff were made available to provide support if they had been needed. The person became calm and the situation did not result in an incident occurring. This information would be recorded in the person's day file enabling staff during shift handover to be aware of any changes in people's behaviour prior to them starting their shift.

Is the service effective?

Our findings

People received effective care from staff who understood their needs. Relatives confirmed people were well looked after. A relative told us, "They [the new provider] are more efficient now."

Assessments of the people's care and support needs were in place. These assessments along with more recent reviews and referral information from local authorities were used to review and update individual care plans and risk assessments. A relative told us, "I am regularly informed of meetings, concerning [family member's] care and participate in annual reviews. I am attending a meeting on [date] regarding the new support plan - to identify what skills and traits new staff need when dealing with adults with challenging behaviour."

Care plans were being transferred into a new format, which were written with the person and/or their representatives. The layout of the plan was simple and easy to understand and contained information that was relevant and person centred to the individual. They contained appropriate information about people's needs, life histories and preferences. We also reviewed some care files that were in the old format. These were difficult to follow and had too much information, much of which was historical information which would not be required on a daily basis. A staff member said, "I think the care plans have been improved in the last four months. Now much easier to read." Another staff member commented that the new care plans, "Are brilliant." Some care plans on the old format did not always show people's preferences with staff gender. The registered manager agreed to consult with people and their representative to make sure these were added in the new care files.

As part of our inspection we used the people's preferred method of communication to ask them for their views about the care they received. Staff supported a person to take the time they needed to consider and communicate their response to us. The person communicated that they liked living at the service, that they liked the food and that they liked the activities at the service.

People had health action plans in place which took into account their individual health care support needs. They also had hospital passports which outlined their health and communication needs for professionals when they attended hospital.

The service made sure that the needs of people were met consistently by staff who have the right knowledge, qualifications, skills and experience. We reviewed records that showed new staff had a thorough induction that consisted of five days of face to face training. All new staff had completed an induction booklet which also enrolled them onto the Care Certificate. The certificate is a set of standards that health and social care workers are expected to adhere to. This told us that staff received a detailed induction programme that promoted good practice and was supportive to staff. Staff confirmed this and told us their induction gave them the skills and confidence to develop and carry out their role and responsibilities effectively. A member of staff said, "Training is now mostly face to face in groups which is better than e-learning." Another staff member told us, "No staff work alone until their induction is signed off."

Records we checked confirmed training was up to date. Records showed that staff had completed various training, some examples include, safeguarding, mental capacity act, moving and handling, medicine management, first aid infection control, MAPA (Management of Actual or Potential Aggression) and more recently NAPPI (Non-Abusive Psychological and Physical Intervention) training.

One team leader told us they had completed manual handling training (train the trainer) which enabled them to deliver this training to staff at the service. The service had a large staff team and having staff in house that can deliver core training on site enabled the service to be responsive to people's needs.

The registered manager told us that when it had been needed, staff had received training in specific areas to enable them to support people in line with their needs. For example, one staff member told us how four of the staff team had been trained to support a person who experienced dysphagia (swallowing difficulties). At the end of all training sessions staff are given workbooks to complete which are reviewed and marked by their line managers to demonstrate their knowledge of a particular subject.

Staff told us that they received regular supervision and records checked confirmed this. However, when we viewed the organisation's supervision planner it showed some people had not received supervision in a timely manner. The planner also listed staff appraisal dates, training completed and any training that may be due. The recently appointed registered manager confirmed a supervision planner was now in place to make sure everyone received one to one support in their roles.

People needed support with meal preparation. This information was available in people's support plans. Staff explained they support people with their shopping and then prepare or assist people with making healthy meals. Details of people's food and fluid intake were recorded daily. Where required people's weight was monitored monthly.

In one area of the service, we observed people having lunch together and most ate in the kitchen dining area, others in their room or in quieter rooms. People and staff ate together so as to make mealtime a positive shared experience for all. Where people needed support with eating their meal this was provided. Drinks were offered to people. Lunch looked well presented, appetising and nutritious. People were offered seconds', some happily accepted. A relative told us, "They offer [family member] a choice at mealtimes. And the food does look well presented." If people were not happy with something at mealtimes they could change things. A staff member told us, "A service user wanted to have a pot [ceramic] plate [to eat their meal in] rather than a plastic one." This was provided. At various times throughout the day people were supported to make their own hot or cold drink in the home's communal kitchen area.

Staff supported people to manage their day to day finances. We checked the balance of monies in two cash boxes and noted finance records had been signed and checked correctly by staff.

Details of health and social care professionals were listed in people's care plans. One person required regular bi-monthly dental treatment and was supported by their relative to attend these. The relative told us the service effectively took over this support and, "Staff go to the dental visits now [with family member]." Staff had supported another person seek the professional guidance from a speech and language therapist to aid with mealtimes and to reduce the risk of choking.

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. We saw examples of where some people did not have full mental capacity to make some decisions and there were appropriate assessments that led to specific plans to direct staff to act in people's best interests.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that appropriate DoLS applications had been completed and authorisations were in place.

The requirements and principles of the MCA were being followed. Staff told us they always worked with people and encouraged people to make their own choices where possible. All staff had had training on MCA and were clear with the principles of the MCA and how they were applied in everyday work.

We noted that people's rooms had been set out, arranged and decorated in ways which staff indicated had been decided through communications with people. One person agreed to show us their room. We saw it had been personalised with their chosen decoration. The person told us how they liked listening to music and showed us they had access to personal headphones so they could listen to the music of their choice anywhere they wanted to.

Is the service caring?

Our findings

People were relaxed and comfortable in the company of staff. Relatives confirmed that their family member received a caring service. A relative said, "[Staff are] helpful, kind and always ring if something happens." Another relative told us, "The current house managers [names] have formed a caring bond with [family member] and go out of their way to make certain that [family member] is up to date with fashion when it comes to buying clothes."

People and their relatives told us the staff were kind and caring. A relative told us, "My [family member] can be 'challenging' to say the least, but all staff without exception seem to have a soft spot for [family member]. Another relative said, "Staff are very caring towards [family member]. Staff always speak warmly of [family member]." Relatives told us the service would support people to send cards to them for special occasions. One relative shared, "All the family and friends of [family member] receive birthday cards and Christmas cards."

Positive interactions were observed between staff and people who lived at the service throughout the two day inspection. One person was getting ready to go out and staff calmly reminded the person to put their coat on. On other occasions when we saw people became anxious or distressed staff caringly reassured people by speaking with them and guiding them to either their room, to the quiet lounge or for a hot drink, which helped calm them. Staff happily encouraged people with daily tasks around the house. An example was during lunch time when staff supported some people clear tables and tidy up in the kitchen.

Relatives confirmed both they and their family member had been involved in reviews of people's care and support. Staff were not only knowledgeable about the support needs of the person they cared for but also how people may feel and react with different people visiting their home or when out in the community. When we asked a staff member to tell us about the person they supported, they were able to clearly describe the person's care needs and things that were of interest to them. Some people had phobias and a relative told us staff would never put the person at risk because staff used safe strategies to deal with anxiety when they were out in the community.

The registered manager's office was tucked away on the ground floor of one of the houses and not easy to access for people and staff. Since joining the service the registered manager decided to move their office to a more central location to be more visible and available to people and staff throughout the day.

Where possible people receiving care had been provided with information about their care, in a way they could understand. The provision of accessible information is a regulated equality objective. This means all care providers are expected to demonstrate how they include people in the care planning process. For example, by the use of alternative methods when needed such as alternative languages, larger font or use of more pictures in documents.

Relatives told us that the staff communicated with them regularly and they were consulted whenever a change was needed in the way their family member was supported. Some people had named advocates

recorded in their care plans. Other people could access advocacy support when required. Independent advocates represent people's wishes and what is in their best interest without giving their personal opinion and without representing the views of the service, NHS or the local authority.

People received care that respected their dignity and privacy. Staff were able to describe the actions they took when providing care to protect people's privacy and dignity. We noted that all rooms had a lock on the door to enable people to choose to maintain their privacy in ways they wished. The locks were secure but could be opened by people from the inside without a key.

Staff told us that they had received guidance about and understood how to correctly manage and maintain confidentiality. We noted the care staff understood the importance of respecting people's private information and they confirmed they only disclosed it to people such as health and social care professionals on a need-to-know basis.

All of the information about how the service was run was stored in the registered office. Care record files and information were stored in a locked office together with the computer system which was password protected so that only authorised persons could access this. The registered provider was sensitive in respecting and managing confidential information. Information was stored and managed in line with the General Data Protection Regulation. This is a new law that has strict rules of how people's information is managed.

Is the service responsive?

Our findings

People received a service that was responsive to their needs. One relative spoke to us about when their family member was admitted to hospital. They said they were, "Really really impressed when [family member] was in hospital. They had a staff member with [family member] throughout so when [family member] comes around [they had] a familiar face. Quite remarkable!" Another relative told us, "If I have a query I can phone at any time or email. Staff get back to me promptly."

Care plans were being updated and these written in a person-centred way with involvement of people and their representatives to gain an insight into people's life histories, care preferences, food preferences, likes and dislikes. Previous care files were difficult to follow and were more task focused and had not been reviewed regularly. New care plans were meaningful and confirmed people received the assistance needed as described in their care plan. We asked a relative if care was provided in the way their relative preferred and they replied, "[Family member] is getting the care, supervision and attention he needs."

Across the service people were supported by a core group of staff which enabled people to be supported safely and consistently. One relative said, "One nice touch in the corridor[s] is a staff photo board so that service users can see who is on duty during each shift." This not only helped people living at the service but also was also helpful for relatives and visitors to the service.

Relatives told us that the service kept them updated about their loved ones. One relative said, "Under the new management [family member] now has a new laptop in [their] room which [they are] proficient with and staff help [family member] to write emails home." This person enjoyed using their laptop in their room and their relative was pleased to see how much of positive impact it has had on their family member.

People had a variety of things planned ranging from swimming, cinema, bowling, meals out, shopping, to support on holidays and short breaks. A staff member said, "We are supporting [person's name] to go on holiday to Centre Parcs with two of the staff they know really well to support them." Activity plans were personalised to each person. One person's plan stated from 'Thursday (10am to 3pm) activity out in the community and meal'. We reviewed the notes for this day that confirmed the person had been out shopping and then enjoyed a KFC lunch.' Another person enjoyed walking and spa sessions. This was clearly recorded in the person's daily notes.

Activity plans were flexible and people were able to change their minds or refuse to take part in activities. Reviewing the records for one person, it stated they were meant to go out for a 'walk and dinner' but chose to have some personal time in their room listening to music. There had been some records viewed that had some gaps where activities had not taken place and no reason stated as to why. When we spoke to staff about this it was clear the activities had been offered but a brief note explaining the reason the person changed their mind would have been helpful.

We saw when people were going out on activities in the community they were always supported by either one or two staff. When people were travelling on public transport or in cars appropriate risk assessments

had been completed. The service had access to a seven seater vehicle which people could use. One person had access to their own motability vehicle which staff could drive. We looked through notes and it confirmed the person was using their car when out on activities.

It had been recently noted by the local authority that one person would benefit from a review of their risk assessment when travelling in a car. The registered manager was currently reviewing whether this was needed with the person and their representative. A staff member told us, "Another person who had recently moved to the service, from a [different provider] would not bathe or wash their hair...etc. Since coming here; bathes, washes hair, engages with staff. Previous [provider] didn't understand what was needed."

Staff were wearing lanyards with a picture of the person they were supporting. We saw when staff changed or needed to take a break they would hand over their lanyards to the new staff member. This made sure people and staff knew who was being supported.

Support plans contained information regarding people's diverse needs and staff understood the importance of people not becoming socially isolated. Care staff understood the importance of promoting equality and diversity. An example of this was supporting the people to maintain friendships and relationships with family. Staff assisted people to keep in touch with their relatives and friends through phone calls, emails and visits to family homes. One relative said, "[Family member] regularly calls home."

There was a clear procedure for staff to follow should a concern be raised. Staff were clear about how they would manage concerns or complaints. Staff explained they would try to find out what the problem was and try to resolve the matter. If staff were unable to do this, they would refer any complaints to the deputy manager's or the registered manager. A relative said, "I have always spoken up for [family member] when I'm not happy about something, and expect my views to be taken seriously and acted upon to remedy whatever the situation is. Up to now, they always have been acted upon." Another relative said, "If [family member] is ever ill, or involved in any kind of incident, a member of staff will either call us or come to speak to us during our weekly [day] visit to explain the problem/illness. This always happens, even if they're just informing us that [the family member] is been a little quiet and spent a lot of time in his room."

The service user guide contained information about how to make a complaint, which included details of how the service should respond to these. This was available in various formats to make sure the information was accessible to as many people as possible. We reviewed complaints and these had been dealt with appropriately.

At the time of the inspection, no person needed end of life care. Earlier in the report, we mentioned the service was updating care plans into the new format and saw people where possible and their relatives had also been consulted about their funeral wishes. This can be a difficult subject to approach for all involved and we saw the service had been thoughtful, caring and responsive in gathering people's wishes.

Is the service well-led?

Our findings

People, their relatives and staff told us the service was well led. A relative told us, "Since Lifeways have taken over Wycar Leys, I've been involved with two meetings, have been asked to complete forms offering my input on [family member's] care plan and have also provided a funeral plan for [family member]."

The service had clear values that focused on person centred care, delivered by a diverse workforce supported by a proactive registered manager. Staff had a clear understanding of the service but not so much of the larger organisation's vision and values.

Staff told us during the six-month period where there had been no registered manager, the larger organisation had let them down. Staff told us they still felt that the provider did not fully listen and deal with pertinent issues that were affecting them. An example being, some staff were still unsure about their employment status after they had transferred over to the new provider. We shared this with the registered manager who agreed to escalate this and share the outcomes with staff at their one to one supervisions.

This was a common theme shared by staff; that there had been limited leadership support, guidance and recognition from the provider for staff and managers who ran the service prior to the registered manager joining. We were told this had had a negative impact on staff morale. We spoke with the regional director and area manager who agreed to be more visible and available at the service. Enabling them to learn more about the day-to-day running of the service from the registered manager and their team.

Everyone we spoke with confirmed they valued the recent appointment of the registered manager. A relative said, "Early days [new provider] yet, but the feeling I have about the place is that everything is thorough and follows strict protocol."

Staff spoke confidently about the registered manager' and knew what was expected of them in their role. One staff member told us, "Yes [the registered manager] is very organised and makes us feel very comfortable." There were regular staff meetings that took place, which gave staff and the registered manager the opportunity to discuss and share progress about the service. A staff member said, "Team meetings are held on average every six weeks. If you don't attend the team meeting there is a record available for staff to read (in the staff room) so we don't miss out on anything we need to know about." Staff told us they could add items to the agenda if they wanted to raise anything and their suggestions and ideas had been listened to.

If staff had concerns about the management team they were aware of the provider's whistle blowing policy. A staff member said "We are clear about whistleblowing and know how to escalate concerns with Lifeways. If I had any issues I would be confident to raise them." There had been anonymous concerns shared with CQC and the local authority which had been shared with the provider and these had been investigated fully. The outcomes and actions taken were shared with all necessary agencies.

The registered manager and the staff team completed quality audits across the service. The registered

manager would review all the audits using an on line workbook which highlighted any issues and most were actioned appropriately. These workbooks could be accessed by the larger organisation to review trends and develop learning. Some examples of the audits completed were care file reviews, staff training and incident reviews. Some care plans in the older format were still being used but these were not always reviewed regularly. This showed the audits were not always effective in regularly assessing and monitoring the quality of service that people received. We shared this with the management and they confirmed this would be completed. The updating of all care plans needs to be completed and the new audit process needs to be sustained for a longer period to show its impact and effectiveness to the service.

Relatives confirmed they were engaged and involved in the development of the service. Annual surveys gave relatives and friends the opportunity to share feedback on the quality of the service provided.

Two deputy managers were carrying out on call duties (out of hours contact with management in case of emergency). Both carried out one week each (one on, one off). One deputy manager told us they worked long hours during the day with little recognition from the provider. This was not a sustainable model as it could not be maintained for long periods. Long hour working culture, coupled with very regular on call duties could lead to burn out or mistakes. We shared this with the provider and were advised that they were looking at reassessing the management structure to reflect the needs of the service.

Once the registered manager was appointed things had settled at the service. Communication between the registered manager, people, relatives, professionals and staff has had a positive impact on the service. Staff believe in the systems and process that the registered manager is trying to embed at the service to achieve positive outcomes for people. This was evident when talking with staff at all levels of the service and their comprehensive knowledge and understanding of people's needs whether in the service or out in the community. This was further supported by relatives and professionals we spoke with.

We saw that all conditions of registration with the CQC were being met. Incidents had been dealt with appropriately and reported to CQC and other authorities when needed. Notifications had been received which the provider was required by law to tell us about. This included allegations of harm and any serious accidents.

The registered manager and staff we spoke with were passionate about ensuring they provided high quality care to people receiving a service. Staff told us the registered manager was approachable and when issues were raised, they were dealt with. A staff member said, "[Registered manager] lets me know if there are things that I can do better." The staff member explained the registered manager and the management team would give constructive feedback and support at one to one supervision meetings.

The registered manager was part of a larger provider and as such was part of national forums where learning and best practise is shared with other providers offering similar services. The provider produced their own internal magazine and subscribed to journals and magazines from the health and social care sector to keep up to date with learning and development opportunities from the health and social care sector.