

Lifeways Community Care Limited

Lifeways Community Care

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Good



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

The inspection took place on the 10 and 11 June 2015 and was announced. We gave the provider 48 hours' notice that we would be visiting the service. This was because the service provides domiciliary care and we wanted to be sure that staff would be available.

Lifeways Community Care is registered to provide personal care services to people in their own homes or in a supported living environment. People who use the services have a physical disability, an eating disorder, learning disability or autistic spectrum disorder. On the

day of the inspection, 46 people were receiving support from the service either in their own home or in a supported living environment. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

Summary of findings

People felt the service they received from care staff was delivered in a safe manner. Care staff told us they knew how to keep people safe from harm.

While people and relatives told us that medicines were being administered to their satisfaction, we found no evidence to show that care staff competency to administer medicines was being checked.

Whilst care staff told us they were able to access training, the evidence we saw indicated that care staff were not all completing training consistently to ensure they had the appropriate skills and knowledge to support people.

People told us that their consent was being sought before support was given.

Where people lacked capacity we found that the provider ensured the Mental Capacity Act (2005) legislation was being adhered to. This ensured where people lacked capacity their human rights were not being restricted.

Where people needed support to eat and drink, this was being done. However, the guidelines available to care staff were not sufficiently clear to ensure care staff would consistently know the appropriate process to follow.

People told us that care staff were caring, kind and compassionate with how they supported them.

People's privacy and dignity was being respected.

People and relatives told us they were involved in how their support needs were assessed, and they made all the decisions as to how their support needs were met by care staff be that they were living in their own home or in a supported living environment.

People who lived in supported living accommodation told us their preferences were being appropriately met by care staff.

People knew how to share any concerns they had by way of using the provider's complaints procedure. People also told us they received a questionnaire where they were able to share their views on the quality of the support they received.

Records were not being completed consistently or accurately enough to ensure people's support needs would be met consistently.

People and relatives told us they were able to give their views on the service by way of completing an annual questionnaire provided by the provider.

We found that the provider had a system in place to check on the quality of service people received. However, the system was not effective in ensuring the quality of the service people received.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People told us they were safe within the service.

People told us their medicines were administered to them how they wanted.

People who used the service in their own home and those who lived in a supported living complex told us there was enough staff to support them.

Good



Is the service effective?

Some aspects of the service were not always effective.

Care staff were not all receiving consistent and regular training to ensure they had the skills and knowledge to support people.

People gave consent before support was given. The provider ensured people's human rights were not being restricted as is required within the Mental Capacity Act.

The guidance available for staff on how to support specific needs of people was not always clear.

Requires improvement



Is the service caring?

The service was caring.

People told us the care staff were caring, compassionate and kind.

People's privacy, dignity and independence was respected by the way care staff supported them.

Good



Is the service responsive?

The service was responsive.

People were supported to ensure their preferences were being met how they wanted.

People were aware of the provider's complaints procedure and how to raise any concerns they had in an appropriate format.

Good



Is the service well-led?

The service was not always well led.

Care staff were not receiving regular checks to ensure they were competent to administer medicines.

People's support needs were being met the way they wanted but records did not always reflect consistently and accurately what people's support needs were.

Requires improvement



Summary of findings

<p>The quality of the service was not being audited by the provider effectively to ensure people received high quality support.</p>	
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Lifeways Community Care

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.

Our inspection took place on 10 and 11 June 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. Due to how small the service is the manager is often out of the office supporting staff and we needed to be sure that someone would be in.

The inspection was carried out by one inspector.

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

information is then used to help us plan our inspection. To plan our inspection we also reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents, safeguarding alerts which they are required to send us by law.

We requested information about the service from the Local Authority (LA). They have responsibility for funding people who used the service and monitoring its quality. We were provided with information we used as part of the planning process for our inspection.

We visited the provider's main office location. We spoke with a total of five people who used the service either in person or via the telephone. We spoke to a further three members of staff on the day of the inspection and the registered manager. After the inspection visit we undertook telephone calls to four relatives of four people who received services from the provider and another member of staff. We reviewed the care records of three people that used the service, reviewed the records for four members of staff and records related to the management of the service.

Is the service safe?

Our findings

A person we spoke with said, “I do feel relaxed and safe”. Another person said, “I do feel safe when staff support me”. A relative we spoke with said, “Yeah he is definitely safe”. Care staff we spoke with were able to explain different forms of abuse and knew how to recognise abuse. Care staff told us what action they would take where people were at risk of abuse. One member of the care staff said, “Any abuse seen would be reported to my line manager”. Other care staff we spoke with were aware of the provider’s safeguarding procedure and also confirmed they had received training in safeguarding. Although the evidence we saw indicated that not all the care staff had completed this training. We found that the provider raised safeguarding alerts with the local authority as they were required to do, and kept us informed as requirement within the law.

Care staff we spoke with were able to explain how risks to people were managed. One member of the care staff said, “Whenever we take out [person’s name] we always have to have two members of staff”. Another member of the care staff told us that the people they supported all had to use a wheel chair when they went out and a lap belt was always used to ensure they did not slip forward out of the wheel chair. We saw documentation to show risk assessments were being used to identify risks to how people were being supported and the action required to reduce any risks.

People we spoke with told us they were happy with how care staff administered their medicines. One person who lived in a supported living environment said, “Staff do give me my medicines on time”. Another person who received support within their own home said, “I have no concerns with how I get my medicines”. Care staff we spoke with were able to explain how people’s medicines were administered and what they had to do if someone refused their medicine. We were able to see evidence on people’s files which indicated that the provider had a system in place so care staff could record when people were given their medicines. Where people refused their medicines the provider had systems in place to monitor this.

Where people lived in a supported living environment and were administered medicines ‘as and when required’ there were clear protocols in place to give care staff the appropriate guidance as to when to administer these medicines. Staff we spoke with were able to explain under what circumstances people received these medicines and explained that these medicines had to be prescribed by a doctor. Care staff confirmed they were aware of the protocols in place and followed them.

One person we were able to visit at their home told us that there was always enough staff to support them. Another person said, “Staff are always on time”. Relatives we spoke with had no concerns as to there being enough staff. One relative of a person who lived in a supported living accommodation said, “Whenever I visit [person’s name] there is always enough staff on shift”. Care staff we spoke with felt there was enough staff to enable them to support people how they wanted. Although one member of the care staff said, “There is not always enough staff so we can take people out where we need two members of staff”, we found no evidence that there was not enough staff to support people as had been planned or how they wanted. One relative we spoke with told us that their relative was always able to go out when they wanted with two members of staff. We highlighted the concern raised by one member of the care staff about staffing levels with the registered manager who confirmed they would discuss with team leaders who managed the care staff in the supported living complexes to ensure that the right amount of staff contracted to support people on an individual basis were available at all times.

The care staff we spoke with told us that they completed a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. The checks had been carried out as part of the legal requirements to ensure care staff were able to work with people and any potential risk of harm could be reduced. We found that the provider had a robust recruitment process in place so they were able to ensure all new recruits had the appropriate skills, knowledge and experience to be appointed. We found that references were being sought from previous employers to check the character of potential staff.

Is the service effective?

Our findings

Care staff we spoke with told us they were able to get training but it was not always regular. One member of the care staff said, “I get training in moving and handling, dysphagia, autism and fire safety”. Whilst the evidence we saw confirmed that the provider had a range of training courses available for care staff not all care staff were completing training regularly to ensure their skills and knowledge was up to date. For example, a member of the care staff who completed dysphagia training some years previous, had not received any update on training since. The registered manager acknowledged that training for staff needed to be improved but also advised that not all staff would receive specialist training where they were not supporting someone with that specific support need.

The care staff we spoke with told us they were able to get support when needed. One member of staff said, “My team leader is a part of our team and offers support when I need it”. Another member of the care staff we spoke with said, “I do get regular supervision and can attend staff meetings”. We saw evidence to confirm that regular supervision and staff meetings were taking place as a method of offering support to care staff. The provider also had an appraisal system and induction process in place as part of their recruitment process. Care staff we spoke with confirmed they had an appraisal annually and as part of their induction when they were recruited they were able to shadow care staff to gain the appropriate skills and knowledge they would need for their role.

All the people we spoke with made positive comments about the care staff. One person said, “The staff are very skilful and know what they are doing”. One relative said, “You could not wish for better carers”.

People we spoke with who lived in a supported living environment told us they were able to see a doctor if they needed. Relatives we spoke with told us that they had no concerns with people being able to access health care through the support given by staff. Whilst people living in their own home were able to get support from care staff if needed. For example, care staff contacting a doctor for someone when they needed it. Care staff we spoke with confirmed that when people in a supported living complex needed to see a doctor or had a routine appointment at their dentist they would accompany them to get to their appointments. One person we spoke with had a car and

told us, “Staff take me where ever I want to go”. We found where people were seen by a health care professional, for example a dentist or optician appropriate records were being kept of these appointments. In a supported living environment health action plans were being used to identify people’s health care needs. We found that not all the sections of some people’s health action plans were being completed to show the support people would need. For example, where someone needed an annual wellbeing check this was not recorded. We found these sections of the plan were blank. We discussed this with the registered manager who acknowledged this and told us the sections in question should have been marked as not applicable, and this would be raised with team leaders to ensure documentation is completed appropriately.

All the people we were able to speak with told us their consent was sought before care staff supported them. One person said, “I do give consent to staff to support me”. Another person said, “Staff would not support me without my consent”. A relative said, “Staff know that when [person’s name] is happy and smiling she is giving consent”. Care staff we spoke with told us they explained the support they were going to give so consent could be given first and where people lacked capacity to give consent relatives supported them with information about people in their best interest.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires domiciliary care providers to submit applications to deprive someone of their liberty through the Court of protection. The registered manager told us that a number of applications had recently been submitted where people were being restricted and were unable to give their consent. Care staff we spoke with confirmed they had received training in MCA and DoLS and were able to explain the impact of this on people’s human rights.

Not all people using the service received support with eating and drinking in their own home. Where people lived in a supported living environment they told us that the meals they had to eat was chosen by them and that staff did not decide what they had to eat. One person said, “The food I eat is what I want and buy”. Another person said, “If I

Is the service effective?

want a drink I can get one or just tell the staff". All the relatives told us that people were able to eat and drink what they wanted, when they wanted. We found from what we were told by people and care staff that food shopping was done once per week and staff supported people to buy the food they liked and wanted. Where people were unable to go out, staff with the support of relatives bought the meals people wanted.

People who received support in their own homes had limited support from staff. One person said, "Staff are available when needed to warm up a meal for me". We found that the support people received did vary based on the environment in which they lived.

We found that where people in receipt of a service were in a supported living environment, the provider had systems in place to ensure people's nutrition was being monitored appropriately. For example, where people were at risk of

putting on excess weight, regular monitoring of their weight was taking place where needed and advice being sought from a dietician. Where a speech and language therapist was needed to provide guidance to care staff as to how people should be supported who had a eating or drinking disorder, this was being done. We found that care staff had a general understanding of required support around food and hydration but, as a result of direction given by external Professionals, the documents being followed by care staff where someone had a eating or drinking disorder were not always clear enough to ensure that staff would understand the appropriate process to follow. We saw no evidence of the actions taken to rectify the situation. The registered manager who acknowledged that the guidance staff were following was not clear enough to ensure people's safety. The registered manager confirmed that the concerns identified had already been raised with the appropriate health care professionals.

Is the service caring?

Our findings

All the people and relatives we spoke with told us the care staff were really nice. One person said, “Staff are nice, caring and friendly”. Another person said, “Staff are great and they are never late”. One relative said, “Staff are professional, caring and considerate”. Another told us the care staff are like family and in respect of one member of the care staff they said, “Like a substitute mum”. Our observations of a member of the care staff supporting a person was that they were considerate of the fact that they were in someone else’s home. The way in which the support was given was in a caring manner rather than task based and care staff respected people’s space. A member of the care staff we spoke with was able to explain how they entered someone’s home in comparison to working in a supported living environment where they would knock a person’s bedroom door. How they ensured the person knew they were in their home. For example, they always spoke up when greeting the person so they knew they were there.

Care staff supported someone to meet us in the office and they were able to share their views on the supported living service they received. The person told us the support they received from staff was what they wanted and they made all their own decisions about the support they received. One relative said, “I am very happy with the service. Staff don’t just care for [person’s name] but they love him as well”. We found that people were involved in the care planning process. People were able to say what they wanted, and where they lacked the capacity to do so the provider had processes in place where people could be supported to do so. For example, advocates were available to people where they were living in a supported living environment.

One person said, “I have my own car and staff will drive me wherever I want to go”. Another person said, “I make my own decisions as to how I am supported”. Our observations confirmed what we were told by people. One relative said, “Staff do listen to [person’s name]. He gets the best”. Another relative told us that they were not always kept informed, while another told us that care staff kept them up to date regularly. We shared this with the registered manager so they had the opportunity to ensure staff were keeping relatives up to date consistently. The care staff we spoke with all told us that their role was to listen to what people wanted. One member of the care staff said, “People are involved in all the decisions that affect the support we give them”. We found from the care staff we spoke with that they all had a good understanding as to why people should be involved in how they received the support they needed.

We found that where people’s capacity was such that they were unable to make daily decisions on the support they received, their relatives were involved in ensuring care staff knew about their support needs. For example what time they like to go to bed or get up on a morning.

People we spoke with who lived in their own home or in a supported living environment told us their dignity and privacy was respected by care staff. One person said, “I can manage to wash and dress myself, but staff are near if I need help”. Relatives we spoke with told us that care staff did respect people’s privacy and dignity. One relative said, “Staff do respect [person’s name] dignity and privacy. His independence is promoted as he is able to do as much as he can for himself”. We observed a member of staff support someone respecting their dignity to use the toilet and the door was closed and the member of staff stood close by in case they were needed.

Is the service responsive?

Our findings

All the people we spoke with told us an assessment was completed on their support needs and they were given a copy of their care plan. One person said, “I am sure I have a copy of my care plan”. Relatives we spoke with confirmed this. One relative said, “We were involved in the assessment process and we do have a copy of [person’s name] care plan. We have a review in a few weeks”. We saw evidence to support what people and relatives told us, with the support that people needed clearly identified. Care staff were able to explain how they supported people and they had a good understanding of people’s needs.

People and relatives told us that the support they received was being reviewed regularly. One person said, “I had a review today with the team leader”. A relative said, “I have attended reviews. We saw evidence where a relative attended a review but the person receiving the service who had capacity was not involved. The registered manager was unable to confirm why the person was not involved in their own review. We were unable to establish if this was a recording issue as we were unable to follow this up with the person concerned. The care staff we spoke with confirmed that reviews were taking place and they involved people and or their relatives. We found there was no consistent process in place to record or show what was reviewed and discussed. Care staff noted a date on the care plan to show that a review had taken place. We saw on one file a review form that had been used on one occasion. We discussed our findings with the registered manager who acknowledge there was inconsistencies and would endeavour to ensure that as part of the implementation of the new care planning process an appropriate form would be introduced for recording the outcome of reviews.

One person said, “I go to church three times per month and I also love to go to the pub”. Another person said, “I love to go out in my car and staff drive me”. Relatives we spoke

with told us that people were able to take part in the activities they wanted and care staff supported them to do so. One relative of a person who lived in supported living accommodation said, “People go out shopping together like a family unit. That is good”. Care staff we spoke with were able to identify the things people liked to do and how they supported them to do this. One person said, “I love to do gardening and staff take me to the garden centre”. We saw evidence recorded in people’s care plan to identify the things they like to do, so care staff would be able to ensure these activities were incorporated into the support they gave people.

We found that while care staff were not receiving specific training in equality and diversity, the support people received ensured their human rights were being respected. While the gender of people and the staff who supported them were not part of the assessment process, where concerns were identified arrangements were put in place. Minutes of a recent team meeting with staff identified the discussion that led to the care staff that supported someone being gender specific. This meant that female staff were required to support a female person with personal care.

People we spoke with told us they knew how to complain. One person said, “If I had a complaint I would speak to the manager”. Another person told us they would speak with the staff. Relatives we spoke with all confirmed they knew who to complain to but had never had to make a complaint. One relative told us they remembered being given a copy of the complaints process. Staff we spoke with had a good understanding of how a complaint should be handled and the support they would give someone to complain if they needed support to do so. We saw evidence to the provider’s complaints process which allowed for complaints to be logged while they were investigated and for trends to be monitored as a way of improving the service and it was available in other formats.

Is the service well-led?

Our findings

The people, relatives and care staff we spoke with all knew the registered manager and spoke highly of them. One relative said, “I have met the registered manager on a number of occasions”. We found that the registered manager knew about the service they were responsible for and was able to explain and answer questions we had about the service people received.

We found that audits and checks were taking place as a tool for monitoring the quality of the service people received. However, the system being used was not effective, for example care staff competency to administer medicines was not being checked consistently. Care staff we spoke with did not give a consistent response as to whether their competence to administer medicines was checked regularly. One member of the staff we spoke with said, “My competency is checked and I have to answer a load of questions”. While another member of staff said, “I haven’t had my competency checked since I had my medicine training two years ago”. We saw no evidence to confirm that this was being done. The team leader’s weekly check list we were given by the registered manager did not have listed any medicines checks that they would be expected to carry out, which would have given an indication as to how this was being done. We found no evidence of an effective system in place to ensure the effectiveness of the auditing being carried. The registered manager confirmed that as part of the new care planning process being implemented, the auditing system would be evaluated to ensure its effectiveness alongside the care staff competence to administer medicines.

We found there was no system in place to monitor and ensure care staff completed training appropriately. We found from the evidence we saw that staff were not attending training regularly. A member of the care staff had not done any updated training on for a number of years to ensure they had the knowledge and skills to support people appropriately.

We found no evidence that regular spot checks by the provider or monitoring arrangements were in place to ensure the quality of support people received.

While care staff we spoke with knew how to support people appropriately, we found that records were not consistent and always accurate. We were concerned that newly

appointed care staff could not rely on the information contained in people’s care records to ensure they supported people appropriately. There was a potential risk that these care staff would not have the appropriate information they would need to support people.

Our observations from the people we spoke with were that there was a culture of openness and people were encouraged to visit the office whenever they wanted. Where people or relatives had concerns, care staff would support them to raise their concerns.

People and relatives we spoke with told us that they were able to complete a questionnaire to share their views on the service and this was done on an annual basis. We found that the provider had a system in place to gather people’s views to help them understand areas for improvement. The information gathered was then analysed and where there were improvements to be made a plan of actions would be used to identify the work to be carried out, the timescales and who was responsible for the work. Care staff told us they did not get a questionnaire and the registered manager confirmed this would be discussed with the provider so care staff would be included in the future.

We found that an accident and incident procedure was in place so care staff had the appropriate guidance they would need to deal with these situations. Care staff we spoke with were able to explain how they would handle accidents and how these situations would be recorded. Evidence showed that accidents and incidents were being recorded and the potential for trends monitored as a way of reducing accidents and improving the service people received.

We found that a whistleblowing policy was in place to enable staff to raise concerns anonymously. Staff we spoke with were able to tell us about the policy and knew in what situation they would use it to raise concerns about how people were being supported.

The provider confirmed they had completed and returned the Provider Information Return (PIR) as we had requested, but the document was not available for the inspection process. We discussed the importance of this document with the registered manager. The registered manager was familiar and understood the requirements to notify us of events and understood the requirements for reporting any concerns to the appropriate external agencies.