Lifeways Community Care Limited

# Lifeways Community Care (Chesterfield)

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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 |

# Summary of findings

## Overall summary

About the service
Lifeways Community Care (Chesterfield) are registered to provide personal care and support to people either living in the community in their own homes or to people who live in shared accommodation under tenancy agreements, self-contained bungalows or apartments within the community. At the time of the inspection the service was supporting 78 people of which 30 were under the regulated activity of personal care.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found

The provider had not always used their audits effectively to reflect on actions. The changes in staffing had impacted on the required checks not being completed and actions followed through. The staff had not always been supported in a formal way, this meant we could not be sure all aspects of improvement would be recorded or considered.

Staff had not always received training to support their role and this could have an impact on the care people received. Although there were enough staff to support people's needs the use of agency had created a culture of uncertainty for some people.

People felt safe and protected from the risk of harm or infections. When they received regular staff, they felt this enhanced their care experience. Medicines were managed safely. Risk assessments had been completed and any guidance provided. Lessons had been learnt and shared to reduce ongoing risks. Staff had been recruited safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff supported people to have daily choices and encouraged their independence.

Peoples health care was promoted, and measures taken to improve their wellbeing. Pre-assessments had been completed to reflect bespoke needs and matching to other people who they would share accommodation with. From initial assessments care plans had been developed which included preferences and information to ensure the person received the correct support at the right time.

People were able to receive information in a variety of formats and their communication was supported by a range of methods. Individuals cultural and spiritual needs were supported. Activities were on offer to people which including using local services and day care settings.

Peoples dignity was respected, and relationship had been developed. Any complaints were addressed, and people had been given some opportunities to express their thoughts on the service.

New initiatives were being developed to encourage more co production on all aspects of the services. This involved partnership working and driving improvements.

The provider had displayed their rating and ensured we received notifications about events which had occurred at the service.

The service applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people using the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: The last rating for this service was Good ( 22 June 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br>The service was safe.<br>Details are in our safe findings below. | **Good** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was caring.<br>Details are in our caring findings below. | **Good** |
| **Is the service responsive?**<br>The service was responsive.<br>Details are in our responsive findings below | **Good** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our well-Led findings below. | **Requires Improvement** |

# Lifeways Community Care (Chesterfield)

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this occasion the Expert by Experience completed telephone calls to people who use the service and their relatives.

Service and service type
This service provides care and support to people living in supported living settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service one working days' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. We also wanted to ensure there would be people at home to speak with us.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We gave the provider the opportunity to share with us any information they felt relevant to the inspection.

During the inspection-
We spoke with seven people who used the service in person. We also spoke with seven people and four relatives by telephone, to share with us their experience of the care provided. We spoke with ten members of staff including the regional quality manager and area manager, registered manager, team leaders and support workers.

We reviewed a range of records. This included four people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at training data and other quality assurance records.

Good

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm. One person told us, "I feel safe, staff keep a really good eye on me. If anything is wrong, staff pick up on it."
- People were protected from the risk of abuse. There was a policy which clearly described how to keep people safe from the risk of harm. Staff we spoke with were aware of the policy and were provided with regular training to ensure that they could recognise the signs of abuse and report concerns confidently. One person said, "Staff respect me and if my door is shut they will knock and warn me before entering. That makes me feel safe."
- We saw that when safeguard concerns had been raised these were investigated and the learning shared with the staff and the organisation.

Assessing risk, safety monitoring and management

- Risk assessments were in place which covered individual needs and the home environment.

We saw that risk assessments covered people's needs in relation to moving and handling, this included guidance provided following an assessment by an occupational therapist.

- Some people were at risk of choking; health care assessments had been obtained and these were followed. Where people had made a decision about the consistency of their meals which was not in line with the assessment, de-chocker were in place. A de- choker is a devise which uses suction to remove an obstruction.
- Risk management was personalised and encouraged independence. For some people this meant support to budget and manage their money. Other people had an appointeeship or family arrangements to manage their money.
- People had an individual evacuation plan. these ensured that people would be able to evacuate their home safely in the event of an emergency. We saw that for some people the fire service had been consulted and additional sensors linked to the fire station were in place. The door had also been changed to accommodate a thumb turning lock, so that the person could exit the property without the need of a key.

Staffing and recruitment

- Staffing levels were overall enough to ensure that people's needs could be met. Some people told us they had regular staff and they were happy with the arrangement in place. Other people told us they had recently received support from agency staff and this was not always as suitable to meeting their needs. We have reflected on this aspect in the well led section of this report.
- The registered provider had a process for ensuring that staff were recruited safely. Records showed that pre-employment checks were undertaken prior to staff commencing employment. Staff had Disclosure and Baring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal

convictions. Staff we spoke with confirmed this approach had been taken as part of their recruitment process.

Using medicines safely

● People receive safe support with their medicine. One person told us, "Staff sort the medicine out and they record it."

● We saw that regular reviews had been completed for people's medicine and any changes documented.

● Each house completed their own medicine checks to ensure there was enough stock to support people's administration needs.

Preventing and controlling infection

● People were protected from the risk of infections. The services we visited were kept clean, which minimised the risk of people acquiring an infection. Staff described and understood infection control procedures, and we saw they followed these, using personal protective equipment when required.

● Staff carried out a range of regular tasks to ensure the service was clean, this was often with the support of people. One person told us how they enjoyed washing up and keeping their room tidy.

Learning lessons when things go wrong

● Lessons had been learnt from events which had occurred. For example, people were at risk from scalding from hot water bottles. One person felt strongly about having a hot water bottle, a risk enablement meeting had been completed with a range of professionals to assess the risk and to consider how to support the person's wishes. Safety measures were put in place and an alternative hot water bottle was sourced. This leaning was shared with the providers other locations.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not always received training for their role. We reviewed the training information and this indicated that for some standard training, almost 50%, had expired and there was no planned date to complete these.
- Many of the training courses were required to be completed as E- learning. Some staff we spoke with had identified this was an issue for them as they did not have access to a computer. Other staff reflected that they found it more difficult to learn or retain information through this form of learning.
- The provider told us about their induction programme. This entailed standard courses followed by training which was bespoke to the people's needs they would be supporting. However, some staff had identified they had not received training in these bespoke areas. For example, one person used Makaton sign language and the staff member had not received any training for this. They told us they just had to pick it up as they worked alongside established staff. Makaton uses signs and symbols to help people communicate.
- Another staff member told us that they were required to administer Epilepsy rescue medicine, this staff member did not feel confident in this area as they had not received detailed training, only provided with reading material at the end of the medicine training. The person told us "I don't feel confident in administering the medicine and that's not fair to the person." The provider told us all staff had received competency assessments following medicines training.
- In a recent survey one person said, "Staff need a lot more training to help them understand the needs of people with learning difficulties. Asperger's. Mental Health problems." The response to this was that there was a new training package in place. However, we have identified this is not being monitored to ensure full compliance and understanding by the staff.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. 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 had the appropriate legal authority and were being met.

● People's capacity had been assessed and records showed that where people may be lacking the capacity to make particular decisions, a two-stage assessment of their capacity was carried out. However, for some people these needed to include more details in how the decision had been made and agreed. The provider acknowledged this and agreed to review how they record the information.

● People were asked to provide their consent to receive care and support. We saw that staff encouraged people to make daily choices and obtained their consent before commencing any care support.

● Some people had been referred to the local authority with regard to Court of Protection and the provider ensured the required support was available when needed to facilitate any assessments.

Adapting service, design, decoration to meet people's needs

● People had their own spaces in the homes and these were personalised to their needs.

● People told us they were encouraged to make choices about items in the home. These involved looking at information on computers or different choices in the shops.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had received an assessment before they considered moving into one of the homes. These included details about the persons preferences and needs.

● The provider had a separate team of staff who looked at the assessments to consider a matching process when a vacancy was identified in the homes. We reviewed a matching document which provided the details of how people's needs would be assessed and matched. Prior to any new admission there was a transitional period and social meetings to establish compatibility.

● Equipment was provided when needed to support people's needs. For example, one person did not sleep in a bed and preferred a recliner chair. Assessments had been completed to ensure the preferred option were made using the best equipment to reduce any risks. Their room had been adapted to support their needs.

Supporting people to eat and drink enough to maintain a balanced diet

● People were part of the planning of the meals in all the homes. Each home arranged a weekly meeting to plan the menu and people's preferences were taken into consideration.

● One person told us, "I choose my menu and staff help me with portion size and healthy options."

● When people had dietary needs, these were recorded, and meals tailored to these. One relative told us, "Staff cut up the food in to small pieces and guide them to avoid the risk of choking."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to manage their health care needs. One person told us, "Staff help me at the GP's or appointments."

● Care plans reflected health care needs and any guidance provided by them was documented and shared with staff. These included the range of professionals, dentist, nurses and specialist professionals for individual's health needs.

● Some people had been encouraged to take control of their health care. For example, one person took part in a charity walk, which involved them walking to and from the church they visited. Overtime this equated to a large distance which was supported by sponsorship. The person had benefited from the health outcome along with being able to be part of the fundraising efforts.

Good

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they were treated well. One person said, "I am happy with the care, I like the support I have."
- A relative we spoke with also reflected positive relationships saying, "The care plans are completed every year and lifeways do listen to us, [Name] is encouraged to pick their own clothes. They mainly have male staff as this works best for them and they help them go out to town or to visit me."
- People's relationships which were important to them were encouraged. Staff supported people to visit family members.
- Staff used a range of communication methods to ensure people were treated equally whatever their communication needs were. This was supported by detailed information in people's care plans.

Supporting people to express their views and be involved in making decisions about their care

- Staff understood people's needs. One person told us, "Staff are nice, friendly and we have a bit of fun, singing and banter."
- One person told us they had been supported to develop their independence. They told us "I have been encouraged to do things. When I moved here, I was reluctant to shower, and I needed a lot of support. Now I am quite independent.".
- Staff we spoke with had established positive relationships and enjoyed their role. One person told us, "I love my job, I cannot imagine doing anything else. People become part of their life and now I advocate for them which feels rewarded."
- Some people had the support of independent advocates to assist their decision making. Lay advocates are independent of the service and can support people to make decisions and communicate their wishes.

Respecting and promoting people's privacy, dignity and independence

- Peoples dignity was respected. One person told us, "Staff ring the door bell and knock. They would not enter my bedroom without asking."
- People felt reassured by the staff. One person said, "It's good to have the staff there to remember any changes."
- All the people we spoke to reflected a positive experience with staff recognising the importance of personal space and respect. One person said, "I feel safe, I go to my room and it's my private space."

Good

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were in place and included personal details. These had been developed with the people and those of importance to them. One person said, "They ask me about my care and we have reviews."
- A new care planning system had been introduced. This was completed electronically and had links to additional areas when relevant. For example, if a long-term condition required a risk assessments or capacity assessment. All care plans were then printed and shared with staff within the homes. Staff told us they signed to confirm they had read any new or existing care plans.
- Other documents were in place to ensure the staff could be responsive in the case of an emergency or to support health care needs. For example, when a pendant alarm was in place or hospital grab sheet. A hospital grab sheet includes details, so a health care professional would have information about the person, for example, how they communicate, contact details and their preferences.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was provided in a range of formats so that people had the opportunity to receive it in a way they could understand. For example, easy read or large print.
- Staff supported people to use a range of communication aids, so they were able to make daily choices for example, Makaton, pictures and objects of reference. Where people were sight impaired they were supported with the spoken word.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to follow their interests and take part in activities appropriate to them. These including using the local community, for example, some people had links with the local church and social groups.
- People we spoke with told us they enjoyed a range of activities, these included swimming, bowling and shopping.

Improving care quality in response to complaints or concerns

- The provider had the processes in place to act on any complaints that had been received. We reviewed the complaints register and found they had been dealt with in line with the provider's complaints policy.

Providing the complainant with a letter of explanation with an outcome and any actions they had taken.
● People we spoke with felt confident to raise concerns and the information of how to do this was provided in an accessible format.

End of life care and support
● No one using the service currently required end of life support. However, people and their relatives had the opportunity to complete a 'last wishes form' to support this area of need.
● The last wishes process enabled people and relatives to ensure their views and wishes would be recorded and used to support their care needs. This could also include any equipment or anticipatory pain relief, to ensure they received dignity, comfort and choice.

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and staff did not always feel supported by the staffing provided. One relative said, "There's been a lot of change over and agency staff, which has placed doubt with the care they received, health appointments, and financial responsibilities recently."
- The area manager told us how they had made some changes to the staffing structure following the loss of several team leaders. The team leaders were responsible for the checks and the running of the homes. We saw these changes had currently had an impact on areas not being followed up. For example, house meetings and audits being completed, and actions being followed up.
- Staff felt they didn't always receive information about the organisation or it was provided in an electronic format and they had no access to review it.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's systems for assessing, monitoring and improving the quality and safety of the services that people were receiving were not always effective.
- Each house should have a 'Team Leader'. However, recently several team leaders had left. Although the provider had employed agency staff to support the service whilst they recruited, other areas of regular checks had been missed. For example, we found some medicine recording arrears and risk relating to the environment had not been considered.
- Audits had not identified medicine prescribing errors. In one of the homes we visited it was identified as required medicine protocols had not been reviewed since 2017.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff had not always received regular opportunities to discuss best practice. We reviewed supervision records and found some people had not been given a supervision meeting for over 12 months. Some staff confirmed this had an impact on them feeling unsupported and receiving the guidance for their role they required.
- People and relatives had been engaged through the completion of a questionnaire. The results of these had been collated, however the response to the concerns raised were generic and did not provide the details of how the provider would address the concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had displayed their most recent rating in the home and on their website.

● We checked our records which showed the registered manager had notified us of events in the home. A notification is information about important events which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service.

Continuous learning and improving care; Working in partnership with others

● The provider had developed a new initiative to encourage coproduction. We saw there was a national initiative and the outcomes were shared in the providers quarterly magazine. The group had been involved in making suggestions about the magazine layout and articles.

● A local initiative had been for people to have their own lanyard, this had been acknowledged and some people we spoke with were happy to display their lanyard when they attended meetings.

● Another element of co-production was people supporting checks and roles within their own home. For example, people completing cleaning rotas or safety checks.

● Partnerships had also been developed with health and social care professionals. These supported when changes were required for people's health care needs or hours of care to support people's wellbeing.