Lifeways Community Care Limited

Lifeways Community Care (Dudley)

Inspection report

West Plaza
144 High Street
West Bromwich
West Midlands
B70 6JJ

Tel: 01216550901

Date of inspection visit:
11 May 2017
12 May 2017

Date of publication:
27 December 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

The inspection took place on 11 and 12 May 2017 and was unannounced. This was the first rated inspection of this service since it re- registered with us in August 2016 after changing their address and the location name. There had been no change of provider.

Lifeways Community Care Limited (Dudley) is registered to provide personal care services to people in their own homes or supported living. People the service supports have a range of needs including physical disability and learning disability. On the day of the inspection, 35 people were receiving support.

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.

People felt safe and care staff knew how to keep them safe having had safeguarding training. There was, however, not always enough care staff for the supported living service in which the provider had recently started to provide care. People were able to get the support they needed with their medicines.

While the provider adhered to the requirements of the Mental Capacity Act (2005) to ensure people's human rights were not unlawfully restricted, care staff were not always aware of the best interest decision. Care staff did not always have the skills and knowledge required to support people as they needed. People were able to access health care when needed.

People were able to access an advocate when needed. People were supported in a kind and compassionate manner. People's privacy dignity and independence was respected and people were able to make decisions as to how they were supported.

Whilst the provider ensured people were able to share their views as part of an assessment and care planning process, people's equality and diversity was not considered as part of the process. The provider's complaints process enabled people to raise concerns they had.

We found whilst 'spot checks' and audits were taking place, they were not sufficiently effective in identifying areas of concerns within the service that needed to be improved. Comprehensive and accurate care records were not consistently available in the provider's office to illustrate how people were being supported, how risks were being managed and the content of care reviews. People's views were gathered to evaluate the quality of the service they received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found that there was not always enough care staff to support people safely.

While risk assessments were in place, they were not taking place on a consistent basis.

People felt safe within the service.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider demonstrated an understanding of their role within the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However we found where people's human rights were being restricted care staff did not always know the best interest decision.

Whilst staff were able to access support when needed they were not consistently receiving training to ensure they had the skills and knowledge to support people and not restrict their human rights.

People were able to access healthcare when needed.

Is the service caring?

Good

The service was caring.

The care staff that supported people did this in a caring, kind and compassionate way.

People decided and made decisions as to how they were supported by care staff.

People's independence, dignity and privacy were respected.

Is the service responsive?

Good

The service was responsive.

People's equality and diverse needs were not being considered as part of the care planning process, but the registered manager had plans in place to ensure this would be done.

People were able to share their views and make decisions as part of the assessment and support planning process.

People were able to share their views as part of a complaints process.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records were not being kept consistently. Where people had specific health risks these were not being clearly identified on people's care records to care staff.

The spot checks and audits being done were not always effective in identifying areas of concerns within the service.

People were able to share their views by completing quality assurance questionnaires.

Lifeways Community Care (Dudley)

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 checked 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 11 and 12 May 2017 and was unannounced. The inspection was conducted by one inspector.

The provider completed a Provider Information Return. 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. We reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We requested information about the service from the local authority. They have responsibility for funding and monitoring the quality of the service. The information we were provided with we used as part of our planning for the inspection of this service.

We spoke to three people, two relatives, three members of care staff, an advocate, the registered manager and the regional operations director. We looked at the care records for four people, the recruitment and training records for four members of staff and records used for the management of the service; for example, staff duty sheets, accident records and records used for auditing the quality of the service.

Requires Improvement

Is the service safe?

Our findings

The provider had recently started to provide care at a new supported living service. Relatives, care staff and the local authority [who commissioned the service] told us that there was not always enough care staff to support the person receiving this service. We found that the person who used the service did not receive the support they expected as agreed within their support plan. This had impacted on the quality of care the person received. Once this concern had been identified, the provider took action to ensure there was enough care staff available to meet this person's needs. This included the recruitment of a new service manager, team leaders and care staff. We were provided with a copy of the provider's improvement action plan that they were working in conjunction with the local authority on to make the necessary improvements.

People we spoke with in other parts of the service told us that care staff were available at the agreed times to support them. A person said, "There is enough staff to support me". A relative said, "There is enough staff", and a care staff member also confirmed this. We found there was enough care staff within other parts of the service people received.

We found that risk assessments were completed as the provider had told us in their provider information return (PIR); however they were not undertaken consistently. Care staff we spoke with had a good understanding of people's risks and told us that risk assessment documentation was available where people were supported in their homes. We saw risk assessments for managing risks to people choking, medicines and the use of moving and handling equipment. At a recent visit from the local authority they found that where people went out of their home and they were at risk, that the appropriate risk assessments were not being carried out. We also found this to be the case.

A person said, "If I am in pain I can get pain relief". We found where medicines were being administered 'as and when required', such as for pain relief, this was being given as prescribed. The provider had systems and policies in place to give care staff the guidance they would need to manage and administer medicines safely. We found that care staff who administered medicines were unable to do so until they had completed the appropriate training. A care staff member said, "I have had to do medicines training and my competency is checked regularly". We were able to confirm this. Medicines Administration Records (MAR) was being used to record when medicines had been given. Whilst we saw no gaps on the records we saw, the local authority told us that as part of their recent visit they found 49 times where there were errors with how the medicines were being administered in April. The registered manager told us they had already taken action to address this. Further care staff training, competency and knowledge checks and a care staff meeting had taken place.

A person said, "I do feel safe with the staff". A relative said, "I do feel [person's name] is safe". Care staff we spoke with were able to explain how people were kept safe and where people were at risk what action they would take to reduce the risk. A care staff member said, "I have had safeguarding training". The provider told us in their provider information return (PIR) that all care staff had to undertake safeguarding training and had a refresher training course through the local authority. They also told us that a knowledge checklist was

being used to check care staff awareness, understanding and responsibility which staff confirmed. We were able to confirm that safeguarding training was taking place.

We found that a recruitment process was in place that ensured only the right care staff were employed, which the provider had told us in their PIR. We found that a Disclosure and Barring Service (DBS) check was being used as part of the recruitment process before care staff were appointed. These checks were carried out to ensure care staff were safe to work with people who used the service. References were sought and systems were in place to check care staff identification. Care staff we spoke with confirmed this. This ensured people that they were being supported by care staff that had been appropriately recruited.

We found that where accidents and incidents occurred, care staff knew how to manage these and they were being reported as required. Care staff were able to explain the incident logs they completed and how these were used. The provider had a work book that was used to check on how the service was being managed and where accidents and incidents had taken place these were noted as part of this process. We found that trends were analysed to reduce the levels of accidents, incidents and risks to people's safety.

Requires Improvement

Is the service effective?

Our findings

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. The application procedures where personal care is being provided must be made to the Court of Protection.

A person said, "Staff do check with me before they do anything". Care staff we spoke with were able to explain how people's consent was sought where they lacked capacity or were unable to verbalise their views. Care staff told us they used people's gestures and their knowledge of them to determine whether they were giving consent. We found that the provider understood their responsibilities under the MCA and knew people could not be restricted unlawfully. We found that where an approval was needed to restrict people to keep them safe, DoLS applications were made with the rationale for these explained. The provider told us in their provider information return (PIR) that an up to date 'decision making profile' was used to show where best interests decision were made. For example, a best interest decision had been made about the use of a lap belt. However, care staff we spoke with were not aware of a best interest decision being made and was unaware that the lap belt was a form of restriction.

Care staff had a mixed view as to whether they had received training in the MCA and DoLS. One care staff member said, "I did complete this training as part of my induction". Another care staff member told us they had only done this training briefly as part of their induction some years previously. We found that staff knowledge and understanding was limited as they had not done any recent training since they went through their induction.

The provider told us in their PIR that people had health action plans to show how their health care needs were being managed. Care staff we spoke with confirmed these documents were being used which we were able to confirm to show how people's health care was being managed. A relative said, "Have no concerns [person's name] is able to see healthcare professionals, they have seen the dentist recently". We saw that people were able to see a dentist, doctor and other healthcare professionals when needed.

A person said, "Staff do know how to support me". A relative said, "Not all staff have the necessary skills and knowledge to support [person's name]. Staff do not always know how to operate the hoist. This was because they had not had the appropriate training". The majority of care staff we spoke with told us they were able to get support when needed, however on occasions care staff felt when they had agency staff to support them these staff did not always have the relevant skills and knowledge. The provider told us in their PIR that they ensured all care staff had the correct skills and knowledge to carry out their duties by ensuring they completed the necessary training. They told us that an area for improvement over the next 12 months was to ensure care staff completed refresher training to update their knowledge.

We found that the provider ensured care staff had access to a programme of training that all care staff were expected to complete and this was being monitored to ensure the training was completed. Care staff were also able to access training where people had specific risks to how they were supported, for example a risk of choking, epilepsy and where people had behaviour that challenged. A care staff member said, "I do feel supported and I am able to do training". We found that the provider ensured care staff were able to meet regularly where they were able to discuss issues affecting their work in a group and get guidance as required. Care staff we spoke with confirmed they were able to attend staff meetings.

The provider told us in their PIR that care staff received supervision on a regular basis and we saw records that confirmed this. A care staff member said, "I do get supervision and once a year I have an appraisal". We found the provider had a system in place which was used to monitor that the standards expected by managers were being met in how care staff provided support to people. We found that an induction process was in place, which care staff told us they were required to complete. This process also consisted of care staff having to complete the care certificate. The care certificate is a national common set of care induction standards in the care sector, which all newly appointed care staff are required to go through as part of their induction. A recently appointed member of staff said, "I have completed the care certificate as part of my induction".

A person said, "I can eat and drink whatever I want". A relative said, "[person's name] is able to get a drink and staff know what he can't eat due to his risk of choking". Care staff we spoke with told us people decided what they had to eat and drink". Care staff were able to show they had an understanding and were able to explain how people who had specific dietary needs were being supported and how they were encouraged to eat food that met their nutritional needs. We found that where a dietician or a speech and language therapist (SALT) was needed, care staff had the guidance they needed to support people to eat and drink.

Good

Is the service caring?

Our findings

A person said, "Staff are kind". A relative said, "Staff are kind, caring and compassionate towards [person's name]".

Care staff we spoke with were able to demonstrate a good understanding of the people they supported. They knew the risks to people and explained how people were supported to live fulfilling lives. Care staff spoke about people in a kind and caring manner and knew how to communicate with people. A care staff member said, "[Person's name] likes to use Makaton to communicate and I always ensure that is how I communicate".

A relative told us that they were involved on a daily basis with the care staff as a way of supporting the decision making process around the support a person received. Care staff we spoke with told us that they encouraged people to make as many decisions as they were able to on a daily basis. We found from what people told us that they made decisions as to how they were supported. For example, they decided where they went on holiday. A person we spoke with confirmed this. We found that people were able to make as many decisions as they were able, staff supported and listened to what people wanted. We found that the provider used various communication methods to enable people to understand and share their views where they could. People who were able to use online systems as a way of communicating were encouraged to do so as a way of sharing their views.

We found that advocacy services were available to people where they were in need of this support. [An advocate service are independent professional who support people to share their views where people need support to do so]. An advocate we spoke with told us that they were able to support people where they needed the support and the provider encouraged people to use these services to share their views and make decisions.

People we spoke with told us that care staff respected their privacy, dignity and independence. A person told us, "I go to college and staff support me to be independent". A relative said, "Staff are respectful and they always knock [person's name] bedroom door before they enter". A care staff member said, "I always respect people's dignity and close doors and curtains during personal care type tasks". We found that care staff understood their role in respecting people's privacy, dignity and independence and was able to explain how this was done. The provider told us in their PIR that care staff were required to complete a dignity and respect policy knowledge checklist and they observations were carried out in supervision to check care staff's competency. Care staff we spoke with were able to show a good understanding of the importance of people's privacy and dignity being respected in how they supported them.

Good

Is the service responsive?

Our findings

We found that the provider had an equality and diversity policy in place and care staff confirmed they had training in understanding how to promote people's diverse needs so they were able to ensure their equality. Care staff knew what people's likes, cultural and religious requirements were. However we found care staff lacked an understanding of the importance of knowing about people's diverse needs in relation to their sexuality and other preferences they may have had. Whilst some information was being gathered during the assessment process about people's likes, information was not being gathered about people's equality and diversity. The registered manager told us this information was not being gathered as part of the assessment process and would discuss this with their managers so action could be taken to implement this.

Relatives we spoke with told us they were involved in the assessment and support plan process. A relative said, "I do have a copy of the assessment and support plan and I was involved in the process". Care staff we spoke with told us they were able to access people's care records so they knew how people wanted to be supported. We found that care records were in place and care staff were able to access them when needed. Care staff were also required to confirm when they had read these documents to ensure they understood how people were to be supported. People and relatives told us they were able to take part in reviews of the service they received. A relative said, "Reviews do happen I have one in June". The provider told us in their provider information return (PIR) that people and their relatives were encouraged to take part in the development of their support plan. However they were less clear about reviews and whether they took place.

A relative said, "I do know how to complain and who to complain to. I made a complaint which was dealt with". Care staff we spoke with told us that any complaints they had would be passed onto the manager to deal with. Care staff we spoke with understood the complaints process and the action they needed to take where a complaint was made. We found from what care staff told us that they encouraged people to raise complaints about the service where they were not happy. The provider told us in their PIR that a complaints and compliments policy was in place and they ensured all complaints were logged and analysed. We were able to confirm this and found that as part of complaints being logged, trends were being monitored to help reduce complaints and improve the service. We saw that complaints were monitored on a monthly basis as part of the system used to monitor the quality of the service.

Requires Improvement

Is the service well-led?

Our findings

We found that whilst care staff were able to tell us about the various documents they had to complete as part of care records being kept where people lived, copies of these were not available at the provider's office. We found that risk assessments and review paperwork were not available to us so we were unable to verify these documents were being used on a consistent basis. Care staff told us that meetings took place with people and their families about the service but paperwork was not being kept. We found that care records varied from one person's file to the next and while the provider told us they were in the process of implementing a new care records system this did not explain some of the missing documents.

Before our inspection the local authority told us from a recent visit to the service that they found that communication passports were not being used. A communication passport is used to support a person with communication difficulties who are unable to share their views easily. Care staff we spoke with were unclear as to whether these documents were being used and what they were used for. The registered manager told us that hospital passports were the documents care staff should be aware of and using, but we saw no evidence of this. The registered manager told us they would clarify what should be used and ensure care staff are clear and get the right document implemented within the service.

We found that where people had specific health risks for example, choking risks or living with diabetes the care records did not prominently highlight this so care staff would know the risk. On one person's care records we looked at we were half way through the file before the support plan identified the person was at risk of choking. The registered manager accepted that where people were at risk, a better system was needed to highlight this to care staff, especially where agency staff were being used as they would not know people very well.

We found that systems were in place so 'spot checks' and audits were carried out on the quality of the service. A staff member said, "The area manager and service manager do check the service". We found that spot checks and audits were taking place and the registered manager monitored this on a regular basis. For example, checks on the management of medicines we found were taking place. Checks and audits were not always effective as issues we identified during our inspection, for example with paperwork had not been picked up by these checks.

Most people we spoke with told us they thought the service was well led although one relative said, "The service is not always well led". They told us this was because there was not always enough care staff. Care staff we spoke with had a mixed view as to whether the service was well led. Some care staff felt the service could not be well led due to the lack of permanent care staff in parts of the service and the impact this had on people where they were not being supported on time or having their support needs met. Other care staff spoken with felt as action was being taken to recruit more staff, the service was well led. There was a registered manager in post and relatives and staff we spoke with knew who this person was. Care staff told us the registered manager visited their place of work regularly and spent time talking with people who received the service.

A whistle blowing policy was in place and information to remind care staff to use this was included in the provider's newsletter, which was distributed to the staff team. Care staff we spoke with were aware of the policy and was able to explain the circumstances where they would use the policy to keep people safe.

The provider told us in their provider information return (PIR) that they carried out annual satisfaction surveys to gather people's views on the service. They told us that responses were evaluated, analysed and improvements to be made were published so people knew the outcome. A person said, "I do get a questionnaire". A relative said, "I do complete questionnaires". Staff we spoke with told us they were able to share their views by completing a questionnaire. We saw that meetings took place with relatives and the local authority where improvement plans were discussed and relatives had the opportunity to share their views.

The provider had an out of hours service in place to support care staff while they were working at times of the day when the office was closed. For example; bank holiday, weekends or on evenings. Care staff we spoke with confirmed this was in place and that they have had to use the service to get support in an emergency or when they are short of staff.

The registered manager knew and understood their role for notifying us of all deaths, incidents of concern and safeguarding alerts as is required within the law.