Lifeways Community Care Limited

Lifeways Community Care (Halifax)

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Lifeways Community Care (Halifax) is a supporting living service providing personal care to people living in West and North Yorkshire. The service provides support to people with mental health needs, people with a learning disability and autistic people. The service provides supported living services across West Yorkshire and North Yorkshire. At the time of our inspection there were 65 people using the service across 25 'supported living' settings.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The service could not show how they met some principles of Right support, right care, right culture.

Right Support:
People were not safe and were at risk of avoidable harm.

The service did not always balance risk management with people's rights.

The provider had failed to tell us about significant events such as allegations of abuse, which meant they did not fulfil their legal responsibility and we were unable to monitor the service.

Accidents and incidents were not always investigated or dealt with appropriately. The provider did not have an accurate overview of what was happening in the service or an effective analysis of learning to improve the service.

People were usually 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 usually supported this practice.

People lived in accommodation that was designed to fit into the local residential area.

Right Care:

People's needs were not always met.

The service did not always focus on people's quality of life and care delivery was not always person-centred.

Care and activities were not always planned in a way that met people's individual needs.

People's communication needs were not met, and information was not shared in a way that people could understand.

Risks to people were not always assessed and managed safely. Two family members told us their relatives were not safe.

The service did not manage medicines safely.

People who used the service told us they were happy with the staff who supported them. One said, "Staff are nice." Another described staff as "Great". Staff were observed interacting positively with people and asking people what they wanted to do. We saw staff knew people well.

People were protected from abuse. The provider had improved their arrangements for safeguarding people's finances.

Right Culture:
There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The service did not always make sure staff had time to give people the support they needed.

Staff told us they had received appropriate training, but we did not receive training records to confirm this.

Governance systems were not effective and did not ensure people were kept safe and received high quality of care and support in line with their personal needs.

People's experience of how concerns were dealt with varied. The service worked with other professionals when they had concerns about people's health and wellbeing.

Recruitment processes were robust and ensured staff were suitable to work with people who used the service.

The management team were responsive to the inspection findings. The provider also gave assurances they had started taking action to improve systems and processes. They gave examples of recruiting additional managers and introducing more robust governance arrangements.

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 (published 3 December 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, medicines, safeguarding

people from abuse and management arrangements. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lifeways Community Care (Halifax) on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, safe care and treatment, staffing, failure to notify significant events and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

The breach, relating to the provider failing to notify CQC, is being dealt with outside of the inspection process. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with local authorities to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our responsive findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our responsive findings below.

Lifeways Community Care (Halifax)

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by five inspectors 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.

Service and service type
This service provides care and support to people living in 25 '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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection, there was not a registered manager in post. A manager had submitted an application which will be assessed.

Notice of inspection
This inspection was announced.

We gave a short period notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection. We also announced visits to the 'supported living' settings because we needed to make sure people consented to a home visit from an inspector.

Inspection activity started on 3 August 2022 and ended on 9 September 2022. On 3 August 2022 one inspector visited the registered office. On 10 August five inspectors visited 10 'supported living' settings. On 11 August 2022 an Expert by Experience spoke to some people who used the service and family members via telephone. Between 10 August and 1 September, we spoke with staff and on 9 September 2022 we provided feedback to the provider.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from local authorities, clinical commissioning groups and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service, five family members and 16 staff including the service manager who had submitted an application to register as the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 12 people's care records and medication records. We looked at three staff recruitment files and a variety of records relating to the management of the service.

After the inspection
We shared the main findings of this inspection with local authorities who were commissioning care and support.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not always assessed and managed safely. People did not always have risk assessments or other records that showed measures were in place to keep them safe. For example, we saw two people had multiple falls, but reviews were not completed to reduce the risk of repeat events. The management team took action once we brought this to their attention.
- Equipment to help keep people safe was not always used appropriately. For example, at one setting, two people should have had fobs to call for assistance, but one person's fob had broken several months before the inspection. Staff had given the working fob to the person who they thought required it most. The setting manager took action once we brought this to their attention.
- The service did not robustly demonstrate they balanced risk management with people's rights. At one setting, records showed door sensors were in place and tested monthly to make sure they were working. However, there was no assessment or guidance to show these were appropriate to meet people's needs. The setting manager recognised these were a restriction and confirmed these would be disabled with immediate effect.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The service did not always make sure staff had time to give people the support they needed. We saw several examples where the staffing hours provided to individuals did not meet the number of hours that were agreed with commissioners of care. For example, at one setting, one person should have received 56.5 hours over a week but had only received 49 hours.
- The service had introduced a system for monitoring commissioned versus delivered staff hours, but this was not yet fully effective. The new system had identified shortfalls in the amount of delivered hours at some settings but was not being used consistently across the service. The service manager told us this was being further developed.
- Staffing arrangements varied and feedback from relatives and staff reflected this. Some told us there were not enough staff, but others said the staffing arrangements were appropriate. For example, a member of staff told us people were unable to go out as often as they should because of staffing issues. A relative raised a concern about the high number of staff changes.

The provider failed to ensure there were sufficient numbers of suitable staff to meet people's needs. This

was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who used the service told us they were happy with the staff who supported them. One said, "I like the staff, they look after me." Staff were observed interacting positively with people and asking people what they wanted to do. We saw staff knew people well.
● Recruitment processes were robust and ensured staff were suitable to work with people who used the service.

Using medicines safely
● The service did not manage medicines safely.
● Systems in place to manage medicines were not always effective. For example, we observed one person being supported by staff with medication, but there was no medication administration record. At another setting, medicines were stored in an unlocked wardrobe in the staff sleep in room.
● Medication administration records (MARs) did not always include important information. For example, at two settings handwritten MARs were used but staff had not recorded directions around administration. One person's medicine container stated this should be given with or after food. The MAR did not include this information and staff confirmed the person's medicine was administered before breakfast. The setting manager followed this up with the pharmacist once we brought it to their attention.
● At one setting, guidance was not in place for 'as required' medicines. This meant staff did not have information about the specific circumstances when these medicines should be given. At another setting, people had clear guidance for 'as required' medicines. Inconsistent approaches to the safe management of medication placed people at risk of harm.

Medicine management systems were not always safe and placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The system for learning lessons was not effective or reliable. Accidents and incidents were not always investigated or dealt with appropriately. For example, one person had three falls in August 2022 and was admitted to hospital after the third fall. The person's risk assessment and support plan had not been reviewed to check if any additional measures were required.
● The provider did not have an accurate overview of what was happening in the service because systems for recording accidents and incidents were not robust. They shared an accident and incident overview, but this did not include all events. For example, three medicine errors in May and June 2022 were not included. The provider had introduced an electronic system to improve their recording, reporting and learning lessons process but this was only in the early stages and not fully effective.

The lack of effective risk management processes meant people were not protected from harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Systems were in place for controlling and preventing infection. Settings we visited looked clean. Four relatives told us the environment was always clean and they did not have any concerns about infection control. One person said, "My house is clean."
● Staff told us they had access to supplies of personal protective equipment (PPE). However, we saw several

examples where staff were not wearing face masks even though national guidance stated these should always be worn. The provider agreed to follow this up with all staff and ensure they were following safe practice guidance.

Systems and processes to safeguard people from the risk of abuse

● Staff said they had received safeguarding training and knew how to report concerns. They were confident the management team would take appropriate action.

● People who used the service told us they felt safe. However, two relatives told us they were not confident their relatives were safe. They said they had discussed their concerns with the provider, but only one relative felt things had improved since they raised a concern.

● Prior to the inspection, we received concerns about people's finances which were reported and investigated by the Police. The investigation is on-going. The provider told us they had introduced more robust systems to protect people's finances, which included a clear protocol for managing people's monies, purchasing items, receipts and monitoring expenditure. Staff and records confirmed financial checks were in place although at one setting management checks had not been completed.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- The service did not always work in a person-centred way to meet the needs of people with a learning disability and autistic people. For example, one person's care records stated they liked to assist staff to do the household weekly shopping. Staff confirmed the person did not participate in the household shopping because the shopping was done on a Tuesday when the person attended a day centre.
- The service did not always plan care and support to make sure it was personalised. For example, one person's care plan stated the person required supervision if medicine was put in their food or drink. A team leader said the information in the care plan was not relevant to the person.
- People's care was not always reviewed which meant some information was no longer relevant. For example, one person had a personal choice record which was detailed and specific but had not been reviewed since March 2018 and was out of date.
- People were not involved in developing their support plan and their individual circumstances were not always considered. For example, a care record updated in July 2022 described a person as, 'Presenting as frustrated with behaviours at the moment.' Staff recorded they felt, 'This may be due to lack of routine in daily life now they are not at the day centre.' Staff confirmed the person had been attending day centre since July 2022.
- At another setting, two people's support plans were reviewed the day before the visit, but these were completed when both people had been attending day centres. A relative raised a concern with us because the service had not involved them in developing the person's care and support.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were not met, and information was not shared in a way that people could understand. For example, one person's support plan stated they used 'sign language to help staff understand me and I am happy to teach you sign language, Makaton' The team leader said they had not been taught Makaton by the person and the person had not done this with other staff.

● Information was not presented to people in a person-centred way. At some settings, hospital passports were developed using an easy read format so people could understand the information. However, support plans were not provided in an accessible format. This meant the service had not considered if information was presented in a way that met people's individual needs.
● People's choice and control about their care was limited. People had communication support plans, but these were not always followed. For example, one person's plan stated, 'Staff could support me to complete activity plans and involve me in the writing of my daily notes.' There was no evidence the person had been involved in writing daily notes or completing the activity plan.

The provider failed to enable and support people to understand and participate in decisions about their care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Activities were not always part of people's planned care and support. The provider had a system to support people to plan activities, but we saw this was not always implemented and activities were decided on an ad-hoc basis. Some people's care records showed activities were limited. For example, one person had watched DVDs for 11 continuous days and on three other days no activities were recorded. There was no evidence to show the person had been involved in planning their activities. A setting manager said activity planners should be used to ensure people were supported to engage in varied and meaningful activities.
● Activities did not always meet people's individual needs. People had identified activity preferences, but these were not always met. For example, one person wanted to go swimming but there was no evidence this was offered. Another person had identified goals which included wanting to go to the gym, see a comedian and go to a show; these goals were not met. Another person's goals record was blank.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Although the service did not always ensure people were supported to take part in activities that were relevant to their interests, we saw examples where some people had engaged in activities they had enjoyed. One person told us, "I am having my nails done this afternoon, I love having my nails done, I choose my colours." Another person told us they were very excited because they were having a birthday party at the weekend and said, "I just can't stop thinking about it."

Improving care quality in response to complaints or concerns
● The service had a system for responding to concerns and complaints. People's experience of how concerns were dealt with varied. Some relatives and staff felt concerns were resolved whereas others felt they were not. One relative told us they had complained because their relative was not receiving support in the community even though this had been agreed. They said, "Since I complained things have improved."
● The provider shared a summary record which showed they had acted when concerns were received. The service manager said they continued to develop their system and process for managing compliant and concerns.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider could not demonstrate they had safe effective systems in place. During the visit to the registered office we were informed care records were held at each individual setting. However, during setting visits, we were told some records had been taken to the office. We requested an overview of staff training but did not receive this. This meant we were unable to review some documentation requested.
- The provider had completed quality audits, but these were not effective and did not drive the required improvements. We saw the quality team had visited one service on 26 July 2022 and identified some immediate actions, but these were not in place when we visited two weeks later. For example, the setting had been told they needed to introduce checks for visitors. However, when we arrived, the signing in and temperature recording log and thermometer could not be located.
- Leaders did not have the knowledge, experience and oversight to lead a safe service. This placed people at increased risk of harm.

Systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

- The new management team were more visible in the service. Several people told us they recently had contact with the new service manager and regional manager. One member of staff said, "We didn't see senior managers, there was even one service manager that I never met. The regional manager came yesterday and seems to know we need to make improvements and it has not yet happened."
- The management team were responsive to the inspection findings. The provider also gave assurances they had started taking action to improve systems and processes. They gave examples of recruiting additional managers and introducing more robust governance arrangements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service did not have a clear, person-centred vision. Leaders did not have effective systems that ensured service delivery met best practice for supporting people with a learning disability and autistic people.

● Information to monitor people's outcomes was unreliable. For example, at one setting, care records stated two people had transport passes which enabled them to travel via bus or train, but records did not evidence how often people used these. The setting manager said they would need to review all the daily records. This meant it was difficult to assess if people's needs were met.
● Record keeping was sometimes poor. For example, at one setting, there were missing sections of care records. At another setting, daily records lacked evidence of a person-centred approach.
● Different systems were used across the service and some members of the management team were unclear what was the correct process to follow, for example, to report accidents and incidents. One member of staff said, "We are aware things are in a mess, but they are not explaining to people we are in a mess. Each service is run differently."

Systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● Some staff felt listened to and attended regular meetings. Staff said team meetings were informative and an opportunity to speak out.

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
● The provider had failed to tell CQC about significant events such as allegations of abuse, which meant they did not fulfil their legal responsibility and we were unable to monitor what was happening at the service. This was raised as a concern with the provider in April 2022. The provider submitted a number of notifications retrospectively but during the inspection we found, reporting of incidents was still unreliable.

Failure to submit required notifications meant CQC were not made aware of some notifiable events so were unable to carry out their monitoring role. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Registration) Regulations 2014.

We will review our regulatory response, for the failure to submit required notifications, outside of the inspection process.

Working in partnership with others
● The service worked in partnership with others. Care records showed staff consulted and liaised with health and social care professionals when they had concerns about people's health and wellbeing.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and support was appropriate to meet people's needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risk was assessed and managed. The provider failed to ensure medicines were managed safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure governance arrangements were effective which meant people were at risk of receiving poor care.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staffing arrangements were appropriate to meet people's needs.