

Lifeways Community Care Limited

# Lifeways Community Care (Stoke)

## Inspection report

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## Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

We inspected Lifeways Community Care on 17 January 2017. The inspection visit was announced two days before we visited so we could be sure the manager, staff and people were available to speak with us. This was the first time the service had been inspected.

Lifeways is registered to provide personal care and support to people living in their own homes. Some people lived together in shared accommodation under tenancy agreements and were supported with their care needs by Lifeways. There were 58 people using the service at the time of our inspection visit. The service offered support to people several visits per day, and on a 24 hour basis, where staff were in the person's home at all times. The service supported younger adults with a range of physical and learning disabilities and autistic spectrum disorder. People had a range of complex care needs associated with their condition.

A requirement of the provider's registration is that they have a registered manager. 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 and associated Regulations about how the service is run. There was not a registered manager in post at the time of our inspection visit. However, the area manager was managing the service when we inspected. We refer to the area manager as the manager in the body of this report.

Staff received training in safeguarding adults and understood the correct procedure to follow if they had any concerns about people's safety. All necessary checks had been completed before new staff started work at the home to make sure, as far as possible, they were safe to work with the people who lived there. The manager and staff identified risks to people who used the service and took action to manage identified risks and keep people safe.

There were enough staff employed at the service to care for people safely and effectively. People were supported by a staff team that knew them well. New staff completed an induction programme when they started work to ensure they had the skills they needed to support people effectively. Staff received refresher training and had their practice observed to ensure they had the necessary skills to support people. Staff had regular meetings with their manager in which their performance and development was discussed and development plans were agreed.

People's care was planned with them, and the support of their relatives and staff at Lifeways. This helped to ensure care matched people's individual needs, abilities and preferences.

People were supported to maintain their purpose and pleasure in life. Activities, hobbies and interests were based around each person's preferences. Events and activities were organised both inside and outside their home. Staff offered people ways to maintain and develop their independence and increase their life skills.

The manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their freedom. The manager had made applications to the local authority where people's freedom was restricted, in accordance with DoLS and the MCA.

Staff were described as being caring and kind. Staff respected people's decisions to make their own choices and supported people to maintain and develop their independence.

People were supported with their health needs and had access to a range of healthcare professionals where a need had been identified. There were systems in place to ensure medicines were administered safely. People were encouraged to eat a balanced diet that took account of their preferences and nutritional needs.

People who used the service and their relatives, were encouraged to share their views about how the service was run. People knew how to make a complaint if they needed to. Feedback gathered by the provider from people and their relatives was used to drive forward improvements.

Good quality assurance procedures were in place to ensure the quality of the service was maintained, these included regular checks of people's care plans, medicines administration and staff's practice. Accidents and incidents were monitored and investigated, and actions were taken to minimise the risks of a re-occurrence.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

People felt safe with staff in their own homes. People received support from staff who understood the risks relating to people's care and supported people safely. Staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough staff to provide the support people required day and night. People received their medicines as prescribed and there was a thorough staff recruitment process to ensure staff were of a suitable character.

### Is the service effective?

Good ●

The service was effective.

Staff completed training and were supervised to ensure they had the right skills and knowledge to support people effectively. The managers understood the principles of the Mental Capacity Act 2005 and staff respected decisions people made about their care. People who required support with their nutritional needs received support to prepare food and drink and people were supported to access healthcare services.

### Is the service caring?

Good ●

The service was caring.

People were supported by staff who they considered kind and who respected people's privacy and promoted their independence. People received care and support from consistent staff that understood their individual needs.

### Is the service responsive?

Good ●

The service was responsive.

People and their relatives were fully involved in decisions about their care. People's care needs were assessed and people received a service that was based on their personal preferences. Staff understood people's individual needs and were kept up to date about changes in people's care. People knew how to make

a complaint and the provider acted in response to improve their services.

**Is the service well-led?**

The service was well-led.

Although there was no registered manager at the service, people told us the service was well led. Managers supported staff to provide care which focused on the needs of the individual. Staff felt supported to do their work and felt able to raise any concerns with the management team. The managers provided good leadership and regularly reviewed the quality of service provided.

**Good** ●

# Lifeways Community Care (Stoke)

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 17 January 2017. The inspection visit was announced two days before we visited so we could be sure the manager, staff and people were available to speak with us. The inspection was conducted by one inspector.

We reviewed the information we held about the service. We looked at information received from statutory notifications the provider had sent to us and information from the commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who find appropriate care and support services which are paid for by the local authority.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they planned to make. We found the PIR reflected the service provided.

We spoke with the area manager, two service managers and a senior service manager during our inspection visit. We asked seven health and social care professionals to provide us with feedback on the service, as they regularly visited people in their homes. We received feedback from three professionals.

We contacted twenty members of staff via email and telephone to ask for their feedback on the service. We received feedback from one member of staff verbally and from two staff members via email.

We spoke with one person who used the service. Because some people were unable to talk with us due to their complex care needs, we asked their relatives or advocates to provide us with feedback on the care their relation received. We spoke with one person's advocate, received email feedback from one person's relative, and spoke with four people's relatives.

We reviewed four people's care plans to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the service's quality assurance audits and records of complaints.

## Is the service safe?

### Our findings

Some of the people who used the service had difficulty in communicating verbally with us, so it was difficult to ask specific questions about feeling safe. However, we spoke with one person who told us they felt safe and they enjoyed living in their home. People's relatives told us they felt their family member was safe. One relative said, "I have no worries." Another relative told us, "We are able to go on holiday without worrying about [Name] whilst we are away, we are confident they are happy and safe."

People were supported by staff who understood their needs and knew how to protect people from the risk of abuse. Staff attended safeguarding training regularly. This training included information on how staff could raise issues with the provider and other agencies if they were concerned about the risk of abuse. Staff told us the training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone's safety. The provider had a procedure in place to notify us when they made referrals to the local authority safeguarding team where an investigation was required. This required them to keep us informed of the outcome of the referral and any actions they had taken that ensured people were protected.

The provider's recruitment process ensured risks to people's safety were minimised. The provider's recruitment procedures ensured staff were of a suitable character to work with people in their own homes. Staff told us and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started work. One member of staff said, "I had a DBS check and 2 references checked before starting." The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

The provider had contingency plans for managing unforeseen circumstances which might impact on the delivery of the service. For example, emergencies such as fire or staff absences were planned for.

There was a procedure to identify and manage risks associated with people's care. People had an assessment of their care needs completed at the start of the service that identified any potential risks to providing their care and support. Risk assessments were up to date, were reviewed regularly and included instructions for staff on how risks to people could be minimised or managed. For example, one person was at risk of becoming anxious if their routine was disrupted. The risk assessment included information on what might happen if the person became anxious, and how staff could recognise the signs of this. There was information about what triggered the person's anxiety, and how such triggers should be avoided. Plans also included how staff could reduce the person's anxiety by using distraction techniques. Staff confirmed they referred to the information in risk assessments and care records to manage such risks to people's wellbeing.

People we spoke with told us there were enough staff to meet their needs as staff always attended their scheduled calls, and arrived on time. One person's relative said, "[Name] has one to one care, and staff are always on time."

Staff also agreed there were enough staff to care for people effectively. The manager responsible for scheduling calls confirmed there were enough care staff to cover all the calls people required. The manager confirmed there were no vacancies at the service and there was no need to use temporary or agency staff.

We looked at how medicines were managed by staff. Some people administered their own medicines or their relatives helped them with this. Relatives told us people who received support from staff to take their medicines received their prescribed medicines safely.

Staff told us they administered medicines to people as prescribed. They received training in the effective administration of medicines. This included regular checks by the trainer on staff's competency to give medicines safely. Care staff recorded in people's records that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this. Completed MARs were checked for any gaps or errors by care staff during visits and by senior staff during spot checks and regular audits. Completed MARs were returned to the office every month for auditing. These procedures made sure people were given their medicines safely and as prescribed.

There were effective procedures in place to advise staff when people needed to take their medicines. This was important as some people received medicines on an 'as required' basis such as pain relief. Instructions were given to staff about when people needed to receive their medicines, and care records showed how people might display signs of pain if they were unable to communicate this to staff verbally. One member of staff described how they respond if people refused their medicines saying, "If people refuse their prescribed medicines, we would check whether they understood the risks this might pose to their health, and we would also get advice from their doctor or pharmacist to ensure people were treated appropriately."

## Is the service effective?

### Our findings

All of the people we spoke with told us staff had the skills they needed to support them effectively. One person's relative said, "Staff have two 14 hour shadow shifts with other experienced staff, and come and meet us as a family, before they support [Name]. If staff ever need any training, it is always forthcoming." One visiting professional commented, "Ivy Cottage (a place where more than one person lived and received care from the service) has an excellent team of staff. They offer a high standard of care and support to individuals and are highly skilled in meeting the needs of individuals with complex needs." They added; "Staff are trained in administration of medication, using specialist feeding tubes and administering emergency epilepsy medication."

Staff told us they had induction in people's home with the people they supported as well as attending a recognised induction programme, to ensure they had the skills they needed to support people. Staff told us their induction included working alongside an experienced member of staff, and training courses tailored to meet the needs of people they supported. One staff member said, "I had to attend a week-long induction training course and work 2 shadow shifts before starting properly." The induction training was based on the 'Skills for Care' standards and provided staff with a 'Care Certificate' a recognised qualification at the end of the induction period.

Staff told us in addition to completing the induction programme; they had a probationary period and were regularly assessed to check they had the right skills and attitudes required to support people. Probationary periods were usually for a six month period, or were continued until staff were competent in their role. Checks on staff's competency were completed regularly to ensure they continued to have the right skills and attitudes.

Records confirmed care staff received regular training to keep their skills up to date and provide effective care to people. This included training in supporting people to move safely, medicine administration and safeguarding adults. Staff also had specialist training in certain areas, depending on the needs of each person they supported. For example, some staff received training in epilepsy if the person they supported had the condition.

Staff told us they had regular meetings with their manager to make sure they understood their role. Regular checks on staff competency we discussed at these meetings, which made sure they put their learning and knowledge into practice. Meetings were held every two-three months, and staff had an annual appraisal to review their performance, discuss their objectives and any personal development requirements. One member of staff said, "At any time we can request a job chat or team meeting and our service manager is usually very prompt in acting on it."

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 managers understood their responsibilities under the MCA. They told us there was no one using the service at the time of our inspection that lacked the capacity to make all of their own decisions about how they lived their daily lives. We were told some people lacked capacity to make certain complex decisions, for example how they managed their finances. These people had somebody who could support them to make these decisions in their best interest, for example a relative or advocate. Where people lacked the capacity to make complex decisions we saw 'best interests' decisions had been made following a mental capacity assessment, in conjunction with health professionals and people's representatives.

All staff had completed training in the MCA and knew they should assume people had the capacity to make their own decisions, unless it was established they could not. Staff knew they should seek people's consent before providing care and support. Staff said the people they supported could generally make everyday decisions for themselves. We asked people if staff asked for their consent before they provided care, they said they did. One member of care staff said, "I support a young person who has cerebral palsy and autism and requires full support to lead a full and varied life. People are treated with dignity and respect by all staff. I try to make sure my client makes their own choices regarding their care."

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Although no-one had a DoLS in place at the time of our inspection visit, the manager had applied to the supervisory body for the authority to deprive people of their liberty, because their care plans included restrictions to their liberty, rights and choices. People were waiting for a DoLS assessment from the local authority to review whether a DoLS authorisation should be progressed.

People had choice and flexibility about the meals they ate. People could choose to prepare and cook food in their own home, or received support from staff to prepare and cook food according to their individual needs and preferences. Staff supported people with planning menus they might enjoy, and assisted people to shop for the food they liked. Where people had specific nutritional needs, staff supported them to prepare food that met those needs. For example, one person required their food to be 'soft' to reduce the risk of them choking. We saw meals were planned which took account of their needs.

The provider worked in partnership with other health and social care professionals to support people's health. People had a health plan which formed part of their care records, this detailed all the information about any health conditions they may have and how staff and other health professionals should support them. The manager confirmed people visited their doctor or hospital consultants, occupational therapists, the speech and language team and other health professionals on a regular basis. Records confirmed people had seen health professionals when there was a change in their health. Care records included a section to record when people were seen or attended visits with these professionals and any advice given was recorded for staff to follow.

One social care professional commented, "There is joint working with all professionals to meet the needs of individuals. Any changes in needs or concerns are raised with social care and health professionals. Recent joint working with health and social care resulted in the correct support being delivered for an individual who has had a prolonged stay in hospital." they added, "Staff are aware of how to refer to health professionals, social care and safeguarding when needed."

## Is the service caring?

### Our findings

All of the people we spoke with told us staff had a kind and caring attitude. One person said, "All of the staff are friendly." A person's relative told us, "My wife and I are happy with the service being provided by Lifeways. The carers are extremely focussed on [Name's] needs and moods." They added, "Every time I see [Name] they have a smile on their face, the staff are so good." A health professional said, "Staff appear caring in their approach with people." A commissioner of the service commented, "I have found staff to be competent and committed, and most importantly have a positive and caring attitude."

People were cared for by a consistent team of staff, which helped them feel secure and maintained consistent care. Staff had a good understanding of people's care and support needs, because they supported the same people, so they knew people's likes and preferences. One relative said, "We've been using the service for the last seven years, we have regular staff that know [Name] well."

Where people had more than one member of staff supporting them the manager sent staff rotas each week to inform them which staff would be visiting their homes. Where people were supported by staff 24 hours each day, people were also assigned a specific member of staff called a keyworker. Keyworkers were responsible for maintaining a special relationship with each person, ensuring each person's social and practical needs were met.

People told us they were involved in making decisions about their care, which included choosing the staff that supported them. Each person was involved in the recruitment of new members of staff to their 'team', which involved meeting the member of staff before they started work to ensure they were compatible. The manager said, "This process ensures people are happy with their staff. If at any time someone was not happy, we would meet with them and change staffing around their individual needs and preferences."

People's relatives told us they frequently saw how staff cared for their relation when they visited them. One relative told us staff always treated their relation with respect and dignity. They said, "The staff are amazing, we are very lucky."

People were encouraged to develop personal and life skills to help them maintain and develop their independence. Each person was asked whether they wanted to develop social or life skills, including activities such as cooking and doing their own laundry. Plans were written down with the person and staff to identify which activities they needed help and encouragement in. The manager explained that enabling people to develop their skills improved people's options and their sense of self-worth.

The provider helped people to express their views, as they made sure people could communicate these daily through the use of communication techniques. Staff used tried and trusted methods of communicating with people, such as sign language and easy-read printed documents and picture cards.

The importance of people maintaining meaningful relationships with family and friends was recognised; people were encouraged to have family and friends visit them at home, or staff supported them to visit their

family. One person's records showed they visited their family, or their family visited them, every week to ensure they maintained a loving relationship.

Relatives told us staff maintained their relation's privacy. This included respecting people needed time alone. The provider ensured confidential information about people was not accessible to unauthorised individuals. Records were kept securely so that personal information about people was protected. People had a copy of their care records in their home and could choose who had access to these.

## Is the service responsive?

### Our findings

People's relatives told us staff were responsive to the needs of their relation. Comments included; "Staff will do things for [Name] even on their day off. They go the extra mile".

People's care and support was planned in partnership with them and people who were important to them, which enabled the provider to deliver person centred care. Care records showed people themselves had been consulted. This was confirmed by the manager and in the PIR we received before our inspection visit. One relative commented, "We are always consulted about the care." A staff member said, "My client's family are consulted about any decisions that need to be made regarding her care. They are an important part of her life and see her on a regular basis."

Care records were comprehensive and written so staff understood people's needs and abilities. A new format of care records had recently been introduced across the service to offer staff more detailed information about people's individual needs. For example, care plans included information on maintaining the person's health, their support needs, and their personal preferences. Records showed what food people enjoyed, their life history, people important to them, and what activities and hobbies they liked. A commissioner of the service said, "I find records to be of a good standard." Care records were regularly checked so people's records reflected their current support needs. This involved yearly reviews, monthly reviews, meetings with the person and an analysis of people's behaviours and any accidents and incidents. One social care professional commented, "Social care professionals are also involved in this process through the annual reviews." This ensured that where people's needs had changed, staff had the most up to date information available to meet those needs.

Daily care records detailing the care each person received were kept up to date by staff. These daily care records were used to handover information to the next member of staff coming in, if there was no face to face handover meeting between staff. Where people received support from staff over a 24 hour period, there was a meeting at the start of each shift to handover each person's care to another member of staff. Staff also maintained a communication book to exchange information. One member of staff said, "Any and all changes are logged and also written in the staff communication book. We also have appointment records which are updated whenever one of the service users attends any appointment." This meant staff were kept up to date with any changes to the person's health or care needs.

We looked at the activities, interests and hobbies people enjoyed. Each person had an activity plan drawn up to meet their personal preferences. We saw people's routines differed from person to person, which showed activities were planned for each individual. For example, people went to the theatre, on holidays and trips out sightseeing, people went to see their family and visited their local community centre. One person's relative told us, "[Name] is always able to choose what they want to do, they go out and do things every day." They added, "Staff are always looking for opportunities they might enjoy."

Information about how people could make a complaint was included in each person's service user guide, which they received when they started using the service. Complaint information was provided to people in

an 'easy to read' format using large font sizes and pictures to make this accessible to people who used the service. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. A typical comment was, "I don't have any complaints."

The senior service manager discussed recent complaints with us. There was a complaints log in place to identify any trends and patterns from complaints. However, only two complaints had been received at the service in the last year. One complaint involved the use of agency staff. The service manager explained that since the complaint, all use of agency staff had been ceased. When complaints were received a manager met with the complainant to resolve the issue to their satisfaction. This demonstrated the provider acted to improve services following feedback.

## Is the service well-led?

### Our findings

There was not a registered manager in post at the time of our inspection visit. The previous registered manager had left in April 2016. The service was being managed by the area manager, who was also due to leave the service in February 2017. Alternative arrangements for the management of the service had not been made at the time we conducted our inspection visit. However, service managers were in place to manage different areas of Lifeways.

The area manager was part of a management team which included a senior service manager, and two other service managers. We spoke to all three of the service manager's during our inspection visit, who managed different aspects of the service by geographical locations. In addition to service managers, each team had a team leader who liaised directly with care staff. Care staff confirmed there was also an 'on call' telephone number they could contact 24/7 to speak with a manager if they needed to. This provided staff with leadership advice whenever they needed it. One member of staff said, "The service manager visits weekly. There is also always a Team Leader available as a level 1 on call and a manager as a level 2 on call." One health professional commented, "I feel that the current service managers are visible and lead the teams well."

We asked people's relatives, commissioners and health professionals whether they felt the service was well-led. They said they did. One relative told us the service their relation received was 'Excellent'.

The area manager and service managers attended a range of discussion forums and training sessions provided by the local authority and external stakeholders to maintain contact with external agencies and to keep up to date with changes in the care sector. Any learning about best practice, or developments in care were shared at meetings with other managers. Information was then cascaded on to care staff through their team meetings.

The manager and provider promoted an open culture by encouraging staff to raise any issues of concern either through regular one to one meetings with their line manager, or through regular team meetings. We saw team meetings were minuted and staff were given an opportunity to raise any issues through any other business. Issues of concern were then escalated to regular manager's meetings. One member of staff said, "We have regular team meetings and the staff all communicate with one another as needed."

We reviewed the minutes of a recent managers meeting where staffing levels had been discussed. It was agreed as an action that by 2017 all agency staff usage would be eradicated at the service. This was to increase continuity of care and maintain a consistent quality of care. This action had been achieved.

The provider recognised the valuable contribution staff made to their service. The provider had recently introduced a staff recognition scheme, and a 'staff making a difference award' which allowed other staff and people to nominate staff for their good practice.

The values of the provider were embedded in the ethos of the service, which were to put people at the heart

of what they did. Aims and objectives of the provider included maximising people's choices and independence, helping to reduce people's social isolation and maximise their enjoyment in life. We saw evidence of this being put into practice, people were always consulted about their health and care needs, each person made choices about their everyday lives including activities they might enjoy, but also who supported them in their own home.

The provider's quality assurance system included asking people, visitors and relatives about their views of the service. A yearly quality assurance survey was undertaken asking people what they thought of their care. The responses to the most recent survey showed a high level of satisfaction, and relatives confirmed they were regularly asked for their feedback.

The provider directed managers to complete regular checks of different aspects of the service. This was to highlight any issues in the quality of the care provided, and to drive forward improvements. For example, managers conducted regular weekly checks on medicines, monthly checks were also made including checks on medication administration, care records, and procedures. Each service manager filled in a monthly report in the form of a workbook, about each person's care package or each supported living service. Workbooks were provided to the area manager for review. Any actions or areas of improvement were analysed by the provider. This was to identify any patterns and trends across service, to share learning.

The provider monitored accidents and incidents across their service to make sure appropriate action was taken when necessary. Records showed, for example, medicine errors, accidents and incidents were analysed by the time and location of the incident, the possible causes and the actions taken. Actions taken as a result of analysis included re training staff and sharing updated information with staff. People's care records were kept up to date with changes in people's care and health needs. In addition, risk assessments were regularly reviewed in response to people's changing needs and in response to investigations into incidents and any learning that arose from them.