

Lifeways Community Care Limited

Lifeways Community Care (South Shields)

Inspection report

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Requires Improvement ●

Is the service caring?

Inadequate ●

Is the service responsive?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

Lifeways Community Care (South Shields), provides residential care for up to four people. At the time of inspection, three people were using the service.

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

People had not always received person-centred care or received the emotional support as outlined in their care plans. Staff told us the service was very regimented and at times institutional. People had not always been allowed to choose their own range of activities.

Systems in place had not been effective in protecting people from abuse. Staff told us they were aware of the whistleblowing policy and had identified and raised concerns with both the registered manager and the senior service manager. These concerns were regarding poor practice and management culture within the service, but nothing ever changed.

Management of the service had not successfully identified the issues we found during the inspection. This included inappropriate actions which had been recorded in one person's care plans not being fully investigated. Outstanding actions in relation to premises safety checks had not been followed up or completed. People's hospital passports did not always contain up-to-date information to allow people to receive safe and consistent care if they were admitted to hospital.

The majority of staff told us they did not feel supported, listened to, or valued by their registered manager and senior service manager, and they often felt stressed and demotivated. Staff had attended regular team meetings and supervision sessions with the registered manager/team leader. However, the majority of staff told us they had not found these meetings to be of any benefit.

Management had failed to follow the provider's own organisational process, regarding the investigation of internal concerns and one external investigation.

Staff had received training to support them in their role. Staff, relatives and a visiting professional told us people received safe care.

Robust infection control procedures were in place for people, staff and visiting professionals to the service.

People's communication needs were assessed and recorded in their care plan. During the inspection staff were seen to engage with each person in their unique way and people responded very well.

The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons, lack of choice and control, limited inclusion e.g. people did not have choice in their range of activities.

The senior service manager present during inspection, was very open and honest with the inspector during and after the inspection process. They listened to all feedback provided, and they and the provider, took immediate action to address the concerns which had been raised.

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 June 2018).

Why we inspected

We received concerns in relation to the management of the service and a potential closed culture environment. As a result, we undertook a focused inspection to review the key questions of safe, caring, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key question. We therefore did not inspect this. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. Please see the safe, caring, responsive and well-led sections of this full report.

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.

We have identified breaches in regulations 9, 10, 12, 13 and 17 at this inspection.

Follow up

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 six 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate ●

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Lifeways Community Care (South Shields)

Detailed findings

Background to this inspection

The inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection team consisted of one inspector.

Service and service type

This service is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection

We gave the service 19 hours' notice of the inspection. This supported the home and us to manage any potential risks associated with COVID-19.

What we did before the inspection

We reviewed information available to us since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from commissioners and professionals who work with the service, including the local authority safeguarding adults' team.

During the inspection

We spoke with the senior service manager and we reviewed a range of records.

After the inspection

We reviewed a number of care records, and continued to receive information from the senior service manager and area manager to confirm the inspection findings. We also spoke with the acting manager, one team leader, 10 care staff, three relatives and one visiting professional over the telephone. We also sought written feedback from other professionals but did not receive a response to our request.



Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse. Safeguarding issues identified during inspection had not been identified or recognised by the registered manager or senior service managers. This had resulted in a lack of action to address those issues identified.
- The provider had a safeguarding policy in place for staff to access. However, some staff we spoke with told us they had previously raised issues regarding safeguarding matters within the service, but these concerns had not been actioned at either location or regional level.
- The provider had a whistleblowing policy in place. Staff we spoke with had differing levels of confidence regarding the whistle-blowing process. Some staff said they were confident and knew how to raise concerns; some staff said they didn't know how to raise concerns; some staff said they felt it would be pointless to raise concerns as when they had raised concerns previously nothing had happened.

The above is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

We spoke to the senior service manager regarding the concerns identified during and after inspection. They shared with us how work had already commenced to investigate and address the issues identified.

Assessing risk, safety monitoring and management;

- Risk assessments were not always in place or up-to date for people. One risk assessment for one person had not been reviewed since May 2019, despite the document stating the risk assessment should be reviewed every six months. Another risk assessment did not include all of the recommendations which had been provided by the speech and language therapy team, following one person's swallowing assessment. In addition, hospital passports for two people did not include updated information to ensure staff in hospital would know how to care for those people safely.
- Premises safety checks were completed on a regular basis. However not all issues identified following these checks had been actioned. For example, a review of the fire risk assessment which had been completed on 6 August 2019 identified actions as still outstanding. A legionella survey had been completed on 8 March 2018 which had identified issues requiring action. The recommendation from the legionella report was for a further survey to be completed before March 2020. No evidence was available to support this survey had been completed in 2020 or the outstanding issues actioned.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

- Staff were up-to-date with their safeguarding training.
- Relatives we spoke with told us they felt people received safe care. Comments included, "I have no issues about [Person's name] care. [Person] has everything at their whim 100% - staff know [Person] really well," and "Yes, [Person's name] gets safe care. I wouldn't hesitate to speak to [registered manager's name] if I had any concerns." One visiting professional told us, "People are safe there. Staff know people well."

Staffing and recruitment

- Staff recruitment was safe.
- Staffing levels were at an appropriate level on the day of inspection.
- We spoke with one member of staff who told us, "Staffing levels are okay. Rotas have recently been changed around which is better."

Learning lessons when things go wrong;

- No evidence was available to support where any incidents had been used as a 'learning tool' to identify where changes were required.

We spoke to the senior service manager who assured us, lessons had been learnt from the inspection and changes would be made urgently.

Using medicines safely

- People's medicines were managed safely.
- Staff who administered medicine to people had received appropriate training and had their competency in this area checked. Staff told us they felt confident to carry out this task.
- Regular audits were completed of people's medicine administration records to promote the application of best practice in medicines management by staff.

Preventing and controlling infection

- Robust infection control procedures were in place. Staff had received training in infection control which they applied in practice in their roles.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not always treated with compassion and there were breaches of dignity; some staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People had not always been treated with kindness or respect by some staff. Some staff told us people had been regularly ignored and spoken to in an abrupt tone. Staff told us, this had resulted in people becoming upset which had triggered and escalated their behaviour.
- The provider had failed to identify or have oversight to ensure all staff who supported people living in the service, supported and cared for people, with care, kindness and respect.
- Staff told us they had tried their best to provide care which was kind and compassionate. However, they admitted it had been very hard working in an environment which was so regimented and intimidating.
- People's independence had not always been encouraged or supported. For example, where people had made, or expressed independent choices regarding their activities.

The above is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect

- During inspection staff were seen to treat people with kindness and respect. Positive interactions were seen and people responded well to these. Staff were able to tell us people's preferences, their likes and dislikes. Comments included, "[Person's name] loves pizza. We are going to review our weekly menus which means [Person's name] can now have a pizza which they have wanted to have for ages," and "The lads are fab! Their mood and spirits have lifted. I've never seen them so happy."
- Relatives told us they felt people were well looked after. Comments included, "I have no concerns. From the moment [Person's name] went there I couldn't have wished for more."

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

- No information was available to review regarding how people felt about the care they received.
- Relatives told us they were regularly consulted regarding people's care.

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or always delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive care which was person-centred or care delivered in a way to suit their individual needs. Management had not always engaged with people in an appropriate manner. This had resulted in people not always being able to do what they wanted, resulting in people's liberty being restricted. A review of one person's care plan stated, when they became distressed and emotional, staff should speak to them in a calm manner to find out why this is happening. However, some staff had not always followed this care plan. This had resulted in the persons behaviours becoming escalated and them not being able to take part in activities of their choice.
- The majority of staff told us there was a regimental approach to people's care and routines, with little or no choice for people. Staff told us they had raised their concerns with management and had suggested new ideas for people, but no action was taken in respect of this.
- People had not always been supported to access and attend appropriate activities or activities of their choice.

The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care

We shared this feedback with the senior service manager. They agreed to look into these concerns and take appropriate action to ensure people's choice and the suitability of activities was reviewed as a matter of urgency.

- Care plans were reviewed and updated on a regular basis.
- People were supported to maintain contact with their relatives during the coronavirus pandemic. Staff ensured relatives received regular updates regarding their family member's well-being and care.

Improving care quality in response to complaints or concerns

- Complaints had not always been handled in line with the provider's own policy. One complaint had been received on 21 April 2020 and the acknowledgement letter had not been sent until 21 May 2020. The provider's own policy stated acknowledgement letters should be sent to the complainant within three days of receipt of the complaint. In addition, no further communication had been sent to the complainant to keep them updated regarding the progress of their complaint.
- Relatives we spoke with knew the complaint process.

End of life care and support

- Care plans seen, included information regarding end of life care.
- Staff had received training in end of life care.

Meeting people's communication needs

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

- People's communication needs were met. This information was identified as part of the assessment process and guidance was available in people's support plans for staff to read and understand who best to communicate with people.
- During the inspection staff were observed to communicate effectively with each person in their own identified way. People were seen to respond and engage well with staff.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of positive culture within the home and this had been raised as an issue. The majority of staff told us the culture and environment left them feeling stressed and de-motivated. The environment within the home was very regimented and not person-centred. One staff member told us they felt the service was institutional and had often felt uncomfortable when in the presence of the registered manager. An example of this was when one person became agitated and became very vocal. Instead of speaking to the person and using distraction techniques to calm them down, the registered manager had told staff "Ignore him totally."
- Staff told us they had formally raised issues in June 2020 with their senior service manager regarding the culture within the service, along with concerns regarding the registered manager's approach. However, as was in this case and with previous concerns raised directly with the registered manager, they told us nothing ever changed. It had got to the point where they had stopped raising issues as they felt it was useless to do so. One comment included, "I don't bother raising issues or suggesting new things as you always get knocked back down."
- The governance of the service at both location and organisational level was not always robust. Issues highlighted during the inspection had not been identified by the registered manager or senior service manager. For example, a lack of recognition where actions recorded within people's care plans indicated staff had not followed or acted appropriately when people had become upset.
- Information within some people's care plans which supported staff to care for people safely, had not been included in people's emergency healthcare passports. This posed a potential risk to the level of care people may receive if admitted to hospital.
- Premises safety checks had not been monitored to ensure identified issues or recommendations had been completed.
- The majority of staff told us they felt unsupported in their role. Staff received supervision sessions and attended team meetings. We received mixed comments regarding the effectiveness of these meetings. Comments included, "Yes I find these meetings useful, they are a good way of receiving information and I feel listened to," and "I felt intimidated during these meetings, I was always made to feel crap! Never any well done and always made to feel we weren't good enough to be there," and "I always felt as if I was something on the bottom of [registered manager's name] shoe."
- The majority of staff we spoke with told us they did not feel listened to, or felt encouraged to contribute to

making improvements within the service. Issues had been raised at both location and regional level without any apparent action being taken. Ideas for improvement to the lives of people living at the service were usually dismissed. Comments staff received included, "We have tried that before and it didn't work."

- Staff had been asked to complete questionnaires but told us they didn't feel comfortable in doing so as questionnaires were not anonymised.
- Feedback had not been sought from people living at the service.

The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We raised our concerns with the area manager and senior service manager for the service. They acknowledged there had been failings within the service as well as failings to follow up on those concerns raised through to a conclusion. They gave assurance if any future whistleblowing allegations, concerns or complaints were received, they will be reviewed and actioned by the regional human resources manager and regional director along with urgent action to address other concerns raised during inspection.

- Relatives we spoke with told us how they felt listened to and they felt people received person-centred care. Comments included, "[Person's name] has blossomed. I never thought [Person's name] would have this quality of life. Staff go beyond their role and treat him as family," and "I've never been shy of asking questions. If I've got a problem staff are always accommodating and address my concerns."
- The registered manager had notified the CQC of incidents in line with regulations and their legal responsibilities.
- Relatives we spoke with told us they felt involved with people's care and they told us they had received a questionnaire to complete.

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

- Concerns had been raised by parents with the senior service manager regarding the level of care their relative had received. The senior service manager told us these concerns were currently being investigated, but acknowledged the provider had failed to follow their own internal policies.

Continuous learning and improving care

- Continuous learning and ways of improving care were unable to be evidenced during the inspection.

Working in partnership with others

- The service worked well with partnership agencies and had continued to do so throughout the coronavirus pandemic. One professional told us, "Staff know the people they care for very well. They know how to distract people. Staff will follow my advice and are quick to get in contact with me if they have any concerns."

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
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure at times people received person-centred care as outlined in their care plans.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure all staff cared for people with kindness and compassion.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people were managed safely. Issues identified following premises safety checks had not been actioned.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to identify and act upon safeguarding issues which had been raised internally by staff.
Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had failed to have robust governance processes in place to monitor the overall performance and culture of the service.