Lifeways Community Care Limited

Lifeways Community Care (Poole)

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

Overall summary

This inspection was announced and took place on 22 and 23 June 2015. We told the provider two days before our visit that we would be coming to ensure that the people we needed to talk to would be available. At our last inspection in June 2014 we did not identify any concerns.

Lifeways Community Care (Poole) is registered to provide personal care to people in their own homes. The agency's office is based in Poole and provides support to people in Bournemouth, Poole and Christchurch and Sherborne in Dorset.

The registered manager has been in post since September 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Some of the people we visited had complex needs and were not able to tell us about their experiences. We saw that those people and one person who spoke with us were happy and relaxed with staff.

People received care and support in a personalised way. Staff knew people well and understood their needs and the way they communicated. We found that people received the health, personal and social care support they needed.

People's medicines were managed safely.

One person told us they felt safe and other people were relaxed with staff which may have indicated they were comfortable with staff. Staff knew how to recognise any signs of abuse and how they could report any allegations. Learning from any safeguarding investigations was shared with staff and actions taken to minimise any further incidents.

Any risks to people's safety were assessed and managed to minimise risks. We saw people were supported to take part and try new activities and experiences in their homes and in the community.

Staff were caring and treated people with dignity and respect. People and staff had good relationships. People had access to the local community and had individual activities provided.

Staff received an induction, core training and some specialist training so they had the skills and knowledge to meet people's needs. Regular agency staff were used so people had consistent staff teams.

People knew how to raise concerns or complaints. People and relatives were regularly consulted by the provider using surveys and person centred planning meetings.

The culture within the service was personalised and open. There was a clear management structure and staff and people felt comfortable talking to the managers about any issues and were sure that any concerns would be addressed. There were systems in place to monitor the safety and quality of the service provided.

Summary of findings

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 safe.

Medicines were managed safely.

Staff knew how to recognise and report any allegations of abuse.

We found staff were recruited safely and there were enough staff to make sure people had the care and support they needed.

Any risks to people were identified and managed in order to keep people safe.

Good

Is the service effective?
The service was effective.

Staff received training to ensure they could carry out their roles effectively. Supervision processes were in place to enable staff to receive feedback on their performance and identify further training needs.

Staff demonstrated a good understanding of The Mental Capacity Act 2005 and people were asked for their consent before support was given to them.

People were offered a variety of choice of food and drink. People who had specialist dietary needs had these met.

People accessed the services of healthcare professionals as appropriate.

Good

Is the service caring?
The service was caring.

Care was provided with kindness and compassion by staff who treated people with respect and dignity.

Staff understood how to provide care in a dignified manner and respected people's right to privacy.

Family and friends were made welcome and continued to play a part in in their family member's care and support.

Good

Is the service responsive?
The service was responsive to people and their needs.

Staff understood people's complex ways of communicating and responded to their verbal and non-verbal communication and gestures.

People were supported to pursue activities and interests that were important to them.

People knew how to complain or raise concerns about the service. Staff knew how to support people to do this.

Good

Summary of findings

Is the service well-led?

Good

The service was well-led. Observations and feedback from people, staff and professionals showed us the service had an improving, positive and open culture.

Feedback was regularly sought from people, staff and relatives. Actions were taken in response to any feedback received.

There were systems in place to monitor the safety and quality of the service. There was learning from accidents, incident and investigations into allegations of abuse.

Lifeways Community Care (Poole)

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

One inspector carried out the inspection over two days on 22 and 23 June 2015. We told the provider two days before our visit that we would be coming to ensure that the people we needed to talk to would be available.

We visited four different supported living services run by the provider. We spoke with and met five people in their own homes. We spoke with four care workers, two service managers, the registered manager and the provider's quality manager.

Some of the people we met had complex ways of communicating and were not able to tell us their experiences of the service. All of the people we visited had 24 hour personal care and support packages from Lifeways Community Care (Poole). We observed the way staff supported people in their homes.

We looked at three people's care and support records and records about how the service was managed. This included four staffing recruitment records, audits, meeting minutes and quality assurance records.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at incidents that they had notified us about. We also contacted four commissioners and health and social care professionals who work with people using the service to obtain their views.

Following the inspection, the registered manager sent us information about actions they had taken following our feedback and the staff training records and the training plan.

Good

Is the service safe?

Our findings

One person told us they were safe and they knew who they could talk to if they didn't feel safe. They said, "If was worried or scared I would talk to XXX (service manager) and he sorts it out". We observed that other people who did not communicate verbally were relaxed in the company of staff. One person smiled and laughed when the staff member supporting them spoke with them. Another person was clearly comfortable in the presence of staff and responded with smiles and single words when staff interacted with them.

All of the staff had received training in safeguarding vulnerable adults from abuse as part of their induction and ongoing training. All of the staff we spoke with knew the different types of the abuse and were confident about how they could report any allegations.

The registered manager had reported any allegations of abuse to both the local authority and CQC. They had cooperated fully with any safeguarding investigations. We saw they had taken action following investigations to make sure that any learning was shared with staff. Staff and service managers were able to give examples of how improvements had been made over the last six months following safeguarding investigations earlier in the year. This included improved relationships with the health and social care professionals working with people. Two local authorities told us the service was proactive in making and discussing any safeguarding referrals with them.

Staff had been trained in the administration of medicines and records showed they had their competency assessed to make sure they were safe to administer medicines. Staff we spoke with were knowledgeable about each person's medicines and how and when to administer them.

We looked at the medicines plans, administration and monitoring systems in place for people. The three people had received their medicines as prescribed. There were clear PRN 'as needed' medicines plans in place for people. Staff were able to describe the circumstances when they administered any 'as needed' medicines. This reflected what was written in people's medicine and positive behaviour support plans.

We found people had effective risk assessments and plans in place. These covered their home environment, nutrition, medicines, access to the community, behaviours which may challenge others, condition specific risks (such as Pica, which is an appetite for substances that are largely non-nutritive, such as paper, clay, metal, chalk, soil, glass, or sand) and epilepsy management. There was a positive focus on risk taking so that people were able to try and experience new activities. For example, one person was going swimming after not leaving their home for many years.

The staffing levels for each person were based on their assessed needs and determined by their funding authority. All of the people we visited had one to one staffing and 24 hour care packages.

The registered manager and staff told us that most of the time people were supported by regular staff teams who knew their needs well. Regular agency staff were used where possible so that people were supported by staff they knew. Lifeways Community Care had been actively recruiting to vacant posts that were being covered by agency staff. We saw from records that the agency staff use had reduced during the month prior to the inspection. The provider had employed a worker whose role was specifically focused on recruitment and retention of staff. The registered manager and service managers told us that the calibre of staff recruited recently were of a high standard. Any staff that had left the service recently had been for positive reasons and career development. A number of staff had recently returned to work at Lifeways Community Care.

We looked at four staff recruitment records and spoke with one member of staff about their recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked with people in their homes. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

We looked at the maintenance and service records for people's equipment in their homes and found that equipment had been serviced as required.

Good

Is the service effective?

Our findings

Staff told us they had one to one support, job chats (informal recorded support sessions) and annual development meetings and felt well supported by managers to fulfil their roles. We saw records of these meetings and annual development plans in staff files. Staff spoke highly of the support they received from their line managers. One staff member said they had considered leaving six months ago but the changes in their line manager meant they now felt well supported and invested in. They said, "I can now see myself having a career in Lifeways".

The registered manager showed us the new induction programme and workbook for staff. The induction programme had recently been increased from five days to eight days. Care workers completed core training that included the provider's compulsory training. For example, infection control, moving and handling, food safety and nutrition, medicines management and emergency aid. The induction also included the staff's roles and responsibilities, information about the provider, key policies and procedures, information about the people they would be working with and their homes. In addition to this new staff completed the Care Certificate, which is a nationally recognised induction standard. Staff we spoke with had a good understanding of their roles and a member of staff told us the induction had prepared them for working at the service.

The provider sent us the training plan and staff training records. We saw that staff completed core training that included the provider's compulsory and specialist training. For example, staff were trained to meet the specialist needs of each person they were supporting. Staff supporting one person had recently attended training from the Prada Willi Syndrome Association. Another person and their staff team had recently completed a course in British Sign Language. This meant that the person and their staff team could now fully communicate with each other.

Some of the staff had been trained in the Mental Capacity Act 2005, and the staff we spoke with had a good understanding about this and making decisions that were in people's best interests.

Mental capacity assessments and best interest decision were in place for most people in relation to specific decisions. For example, there was a best interest decision in place for the use of a sedative medicine when one person visited the dentist. This was to reduce the person's distress and anxiety. This had been agreed by the person's family members, staff and health and social care professionals involved with them. However, we did identify that for two people, mental capacity assessments and best interest decisions were not in place for positive behaviour support plans that included some restrictions. The registered and service manager took immediate action and completed these assessments and consulted with health and social care professionals to agree these specific decisions. The registered manager confirmed by email they had reviewed all positive behaviour support plans in place across the service and taken action to consult professionals where the person did not have the capacity to agree to these plans.

People's nutritional needs were assessed, monitored and planned for. Each person had a plan that detailed the person's likes, dislikes, types and consistency of food and drink and the type of equipment people needed. For example, one person's plan detailed the consistency of their food, how they needed to be sat and what type of specialist spoon they used to eat with. When we visited this person's home the staff showed us the person's menu and described how they supported the person to eat and drink. This reflected what was in the person's plan and the guidance from the SALT (Speech and Language Therapist).

People had access to specialist health care professionals, such as community mental health and learning disability nurses, dieticians, occupational therapists, speech and language therapists and specialist consultants. One person had recently had their sensory needs assessed by an occupational therapist. The outcome of the assessments was that the staff were supporting the individual to meet all of their sensory needs in their home and community.

Each person had a health plan that was supported by pictures to make it easier for them to understand and included important information about them if they went into to hospital.

People's health needs were assessed and planned for to make sure they received the care they needed. For example, one person had epilepsy and there was an epilepsy care plan in place that included at what point staff were to call emergency services. Staff were very

Good

Is the service effective?

knowledgeable about the person and how they presented when they were having a seizure and what action they needed to take. We saw detailed monitoring records were kept to be shared with the person's GP and consultant.

Good

Is the service caring?

Our findings

One person told us they liked all the staff that supported them. During our visits to people's houses we observed staff providing supporting to people. They were respected by staff and treated with kindness and compassion. Staff showed affection for people and recognised and knew them as individuals. Staff were very positive about people, their strengths and abilities. They were passionate about the people they supported and how they could support people to maximise their abilities. Staff told us how they were encouraging people to try new things and they were proud of when people achieved their goals. There was an understanding from staff that any behaviours that may have challenged others were about the individual trying to communicate and this was not viewed in a negative way.

We saw that people who did not communicate verbally gave staff eye contact and were responsive to staff when staff spoke with them. One person responded with a smile when staff showed them their walking boots as a sign that they were going to go to the person's allotment.

From observations and speaking with staff we found they knew people and understood their preferences. We found that people's care plans included how people made their preferences and choices in their everyday lives. Where people did not communicate verbally, we observed staff giving some people simple verbal choices and using objects of reference (these are objects that represent the activity the person is being given information about, for example, a cup is used to offer the person a drink). Staff were able to tell us how each person made their preferences known.

Care workers knew about keeping people's personal information confidential. Care plans were personalised and included details of how care workers could encourage people to maintain their independence. People told us and we saw care workers provided care and support in ways that promoted people's independence. One person told us staff encouraged them to cook and clean their house.

Good

Is the service responsive?

Our findings

During our visits to people's homes, all of our observations showed us that staff were responsive to people's needs. Staff responded to people's verbal and non-verbal gestures and communication.

All of the staff we met and spoke with understood people's complex ways of communicating. This reflected what was in people's communication plans or communication passports. These were documents that people kept with them to show other people how they communicated and what they liked and did not like. Staff were able to explain how people let them know if they wanted anything. For example, one person would take the staff's hand and lead them to what they wanted. Another person smiled and tapped their head rhythmically and staff explained they knew when they were upset because they would grunt and take their t shirt off. All of this information about how the person communicated was also included their care plan.

The registered and service managers told us they were in the process of reviewing people's care plans and records to ensure they were simpler and easier for staff and people to follow. Since the last inspection the service had produced monthly records in a bound file for each person. This was so there were not multiple places for staff to record and minimise the risk of records getting mislaid. We saw that staff were recording all of the relevant information for one person in these records including all of the monitoring information needed. For example, this person needed to have the bowel movements monitored as this had an impact on how well the person felt and their behaviour. Staff explained that by using these monitoring records they were able to ensure the person had the 'as needed' medicines when they required them.

We saw from care records and speaking with people, staff and relatives that each person had the opportunity to be occupied both in their homes and in the community. People had access to activities that were important to them and had individual activity plans. For example, people had gone sailing, swimming, music clubs, had their own allotment and attended local social groups.

People and staff told us people had family and friends to visit them at their homes and they were supported to maintain important personal relationships. One person's parent regularly came to stay with them. Another person's relatives visited regularly and actively participated in the persons person centred planning days because the person did not communicate verbally.

People's cultural and religious needs were considered. For example, one person told us they were supported to attend their place of worship.

We looked at four people's assessments and care plans and saw that they had been reviewed when people's needs had changed. The registered manager and a service manager acknowledged that they had not yet held formal reviews and written the new style care plans with people and others that were important to them because they had been focussing on staff teams getting to know and understand how to support people. Staff we spoke with were very knowledgeable about people and were able to describe how they communicated and what support and care they needed. All of this information was included in the care plans.

One person told us they could raise concerns with any of the staff and they would sort their concerns out. One person said: "If I'm worried I talk to (service manager) and he always sorts it out". Staff we spoke with also had a good understanding of how people communicated when they were upset and how to support people to make a complaint.

There was a written and pictorial complaints procedure and each person's communication plan included details as to how they would let staff know if they were unhappy or worried. We looked at the one complaint received by the service over the last twelve months. We found this had been investigated and responded to minimise the risk of reoccurrence.

Good

Is the service well-led?

Our findings

Observations and feedback from people, staff, and professionals showed us the service had an improving, positive and open culture. This was because the registered manager and service managers had introduced more consultation with people, relatives and staff.

We met with the provider's quality manager. They explained the systems in place for involving and consulting people, staff and relatives. One person had been involved in the quality group and planned to be involved with two other people in looking at how they could be involved in the recruitment of staff.

The registered manager and service managers visited people's home's regularly and staff told us that this had made a big difference to how well people felt supported, involved and listened to compared to previous years.

Service managers reviewed incidents, complaints and safeguarding on a monthly basis and this was then reviewed by the registered manager and the provider's quality teams. From this information any trends were identified and used to develop action plans.

There was an annual quality audit completed by independent auditors. They used a tool that was designed around the CQC domains and provided data to focus on continuous improvements. People were written to following any visit to their home to thank them and to report on what was working well and what needed to be improved. These letters were supported by pictures to make it easier for people to understand.

The quality manager completed a quarterly quality review with the registered manager. This reviewed the results and outcomes from the service manager's monitoring, annual surveys, complaints, safeguarding, any contract monitoring reports and other monitoring systems in place. We saw that latest quarterly review and noted there was an action plan where shortfalls had been identified and the progress on meeting the shortfall. For example, one action was to consult with the local authority what behaviours needed to be recorded as incidents. Another action was to record the compliments received on a central log so this could be shared with staff.

In addition to these monitoring systems there were annual surveys with people who used the services, their representatives and health and social care professionals involved with individuals. From this and the other quality monitoring systems in place a local action plan was developed. These action plans were then reviewed on a monthly basis by the registered manager.

Staff told us they felt valued and that they were being actively consulted and involved in developing the new care plans for people. One staff member told us the service manager was asking them to write down what works well with people and how they worked with people as a team. They also said the service and registered managers were recognising they had the knowledge about people and that care plans could not be developed without the staff's input.

All of the staff we spoke with knew how to whistleblow and raise concerns. They were confident that any issues they raised would be addressed. We saw in staff records an example of where a staff member had whistleblown and what action had been taken in response.

We found, from staff records and from speaking with staff, they understood their roles and responsibilities. All staff were issued with a staff handbook, code of conduct and a clear description of their responsibilities and who they were accountable to. We saw from staff records and from discussion with the registered manager that any issues with a staff members' performance was followed up in annual appraisals, one to one support meetings or through the disciplinary process.