Lifeways Community Care Limited

Lifeways Community Care (Chorley)

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

This inspection took place on 5 July 2016 and it was unannounced.

Lifeways is a national supported living scheme. It provides support for people living in the community with their family or in group home settings and caters for people with a diverse range of needs, such as learning disabilities, autism and acquired brain injuries. People using the service are enabled to live as independently as possible and are supported to maintain their interests on a daily basis. The agency office is located in Chorley town centre, being easily accessible by public transport. At the time of this inspection there were 76 people who used the services of the Chorley office.

At the time of our visit to the agency office the registered manager was on duty. He had been in post for a number of years. 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.

The last inspection of this service took place over four days during July and September 2015. At that time the service was found to be in breach of regulations in relation to safeguarding service users from abuse and improper treatment, safe care and treatment, staffing, person centred care and good governance. Lifeways [Chorley] was awarded an overall rating of 'Requires improvement' at that time.

During this inspection we established that some recent restructuring developments had taken place and we found that significant improvements had been made in all areas, which was pleasing to see.

Risks to the health, safety and wellbeing of people who used the service had been appropriately assessed and managed effectively. Where risks were identified these were addressed through robust care planning. However, we noted an occasional gap in dating, signing and recording of information. We made a recommendation about this.

The care planning system was in general person centred providing clear guidance for staff about people's needs and how these needs were to be best met. The plans of care had been reviewed periodically. However, more regular reviews would demonstrate that any updates had been considered. A recommendation was made about this.

The service had reported any safeguarding concerns to the relevant authorities. However, there was an isolated incident where staff had noticed a bruise of unknown origin on a person's arm. This had not been referred under safeguarding procedures because the individual was bumping into furniture very regularly. We made a recommendation about this.

Suitable arrangements were in place to ensure that sufficient staff were deployed, who had the necessary

skills and knowledge to meet people's needs safely. Recruitment practices adopted by the agency were robust. Appropriate background checks had been conducted, which meant that the safety and well being of those who used the service was adequately protected.

Records showed that Mental Capacity Assessments had been conducted, in order to determine capacity levels. However, it was not always clear how outcomes had been achieved. A recommendation was made about this.

The rights of people who were not able to consent to their care was consistently protected as the service worked in accordance with the Mental Capacity Act and associated legislation. People's privacy and dignity was consistently respected.

Suitable arrangements were in place to ensure that sufficient staff were deployed, who had the necessary skills and knowledge to meet people's needs safely. Recruitment practices adopted by the agency were robust. Appropriate background checks had been conducted, which meant that the safety and well being of those who used the service was adequately protected.

There were effective systems in place for monitoring the safety and quality of the service. Audits viewed had identified any areas which were in need of improvement and action was taken to address these shortfalls.

Complaints were managed well and people we spoke with were aware of how to raise concerns, should they need to do so. Systems were in place to ensure that any complaints received were responded to in a timely manner and a thorough investigation was conducted. The service had reported any safeguarding concerns to the relevant authorities. However, there was an isolated incident where staff had noticed a bruise of unknown origin on a person's arm. This had not been referred under safeguarding procedures because the individual was bumping into furniture very regularly. We made a recommendation about this.

Procedures for managing people's medicines were found to be satisfactory. This helped to protect people who used the service from the unsafe management of medications. The service worked well with a range of community professionals. This helped to ensure that people's health care needs were being appropriately met.

People we spoke with were highly complimentary about the staff team. They felt that they were treated in a kind, caring and respectful manner. People expressed their satisfaction about where they lived and the activities they were supported to enjoy.

Regular meetings were held for those who used the service. This enabled people to discuss topics of interest in an open forum and people's views were also gained through processes, such as satisfaction surveys.

During this inspection we found that improvements had been made and we did not identify any breaches of regulations.

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

This service was safe.

Risks to the health, safety and wellbeing of people who used the service had been appropriately assessed and were being well managed. Risk assessments were very person centred, taking into account all relevant information.

The recruitment practices adopted by the service were found to be robust and therefore protected those who used the service. The staff team were well trained and knowledgeable about the needs of those in their care. Sufficient staff were deployed to ensure that people were kept safe.

People were protected against the risks associated with use and management of medicines. People received their medicines at the times they needed them and in a safe way.

Is the service effective?

Good

This service was effective.

The rights of those who did not have capacity to consent to their care and support were consistently protected, in accordance with the Mental Capacity Act and associated guidelines.

The staff team were well supervised and appropriately trained. This helped to ensure that those who worked for the service had the necessary skills and knowledge to carry out their roles in an effective manner.

Those who used the service were supported to gain access to relevant health care, when it was needed.

Is the service caring?

Good

This service was caring.

People's privacy and dignity was consistently respected and they were supported to maintain their independence as for as possible.

People spoke highly about the care staff and felt they were treated in a kind and caring manner at all times.

People told us they could influence the support they received.

Is the service responsive?

Good

This service was responsive.

The needs of prospective service users were thoroughly assessed before a package of care was agreed, so that the staff team were confident that they could provide the care and support required by each person who wished to use the services of Lifeways [Chorley].

The plans of care were well written, person centred documents, providing staff with clear guidance about people's assessed needs and how these were to be best met.

The views of those who used the service and their representatives was obtained and feedback received was taken into account. Complaints were managed well and people were listened to in a supportive manner.

Those who used the service were helped to maintain their interests and were supported to participate in activities which they enjoyed.

Is the service well-led?

Good

This service was well-led.

The processes adopted by the organisation to assess and monitor the quality of service provided by Lifeways [Chorley] were robust.

Relevant information was cascaded to the staff team through regular meetings and supervision sessions. Those who used the service also received important information through regular meetings.

Effective systems were in place to ensure that any potential learning from adverse incidents, such as accidents was identified and cascaded to the staff team.

Lifeways Community Care (Chorley)

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.

This inspection took place on 5 July 2016 and was unannounced, which meant the provider was not aware it would be taking place until we arrived.

The inspection team consisted of five adult social care inspectors, a pharmacy inspector and two experts by experience. An expert by experience is a person who has experience of the type of service being inspected. Their role is to find out what it is like to use the service by speaking with those receiving care and support and their relatives where possible.

Prior to our inspection we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents and safeguarding incidents. We also looked at the information we had received from other sources, such as the local authority and people who used the service.

A Provider Information Return [PIR] was sent to us within the timeframe requested. A PIR provides us with some statistics and key information about the service.

At the time of our inspection there were 76 people receiving support from Lifeways [Chorley]. We visited seven houses in the community and spoke with 26 people and two relatives. We also spoke with 12 members of staff and the registered manager of the service.

We carried out a pathway tracking exercise. This involved us examining the care records of 12 people closely

to assess how well their needs were being met and how any risks to their safety and wellbeing were managed.

We consulted four community professionals prior to the inspection, including professionals from the local authority. We received feedback from three of them.

We reviewed a variety of records, including six staff personnel and training files, records of complaints and completed audits. We examined medicines administration records and looked at the stock of medicines in some of the houses we visited.

Good

Is the service safe?

Our findings

Everyone we spoke with said they felt safe using the services of Lifeways (Chorley) and that there were always sufficient staff deployed. When we asked one person if he felt his care workers provided safe care and support he replied, "They're brilliant. They're always on hand. They always help me to the best of their ability. I have no complaints." An example he gave was, "I feel safe in my wheelchair. They never leave me on my own. There is always a carer with me when I go out. I feel completely safe." This individual told us he felt valued and respected by the staff who supported him and that he could exercise choice and control over his life style. He added, "The carers encourage me to speak out if I am not happy. I would speak to a carer or my mum and dad." Another person gave us an example of her experience in relation to feeling safe. She said, "I'm hoisted. I always feel safe. I feel safe with everything. There is nothing I don't feel safe with." Another person told us there was no problem about how he was supported with his medication. He told us he usually received the same staff and that they always turned up on time. Although he did comment, "Sometimes I have agency staff when they [Lifeways] are short staffed. The agency staff are all right."

A relative told us, " He (family member) is very safe there. They (the staff) know him inside out and he them." And another commented, "There are enough staff. He receives 24 hour care. They give him his meds and there has never been a problem."

It was apparent when viewing risk assessments that this was a person centred process. The assessments took into account all the relevant information, the person's individual circumstances and any changes in a person's needs were also considered. We saw that a range of risk assessments were completed within people's support plans. These covered potential risks to people's health, as well as those associated with activities and daily living. They were very person centred, outlining individual risks and providing staff with clear guidance of how to support people in order to minimise the possibility of potential harm.

One person's care plan contained an extremely well detailed risk assessment in relation to their epilepsy. Risks associated with activities of daily living had been carefully assessed and any risk identified had been recorded with associated actions to reduce the possibility of harm. We noted there remained a focus on individuals' need for independence and privacy whilst agreeing individual strategies to help safeguard those who used the service.

Accident and incident records were detailed and regular audits had been conducted. This helped to identify any recurring patterns or incidents specific to individual people. Fire risk assessments and PEEPs (Personal Emergency Evacuation Plans) were in place. These were, in general very person centred and provided guidance for staff about the support a person would need to evacuate the building in the event of an emergency. They included details about how people would need to be supported to remain calm. However, we found an occasional gap in the dating, signing and recording of information and one person's PEEP did not include a full picture of the support they may have required. Their PEEP stated there were no factors that would prevent them from evacuation, but part of their care plan stated they 'may panic in an emergency.' We recommend that all recorded information is dated, signed and corresponds with people's current identified needs.

A range of checks were carried out on a regular basis to help ensure the safety of the properties and equipment was maintained. These checks included fire alarm, water temperature and electrical appliance checks. A gas safety certificate was available to show all appliances were checked on a periodic basis by an external contractor. This helped to ensure people were kept safe and free from harm.

Health and safety training was provided as part of the mandatory training programme to help ensure all staff had an understanding of safe working practices. A contingency plan was in place, which provided staff with the information they would require in the event of an emergency such as, power failure or in the event of a flood.

Training for the staff team in relation to safeguarding was part of each staff member's mandatory training programme. All staff we spoke with were aware of safeguarding procedures and how to escalate any safeguarding concerns. Staff spoken with were confident that managers from the service would deal with any concerns raised in an appropriate manner.

The service was generally open and transparent about reporting any safeguarding incidents to the relevant authorities, such as the Care Quality Commission [CQC] and the Local Authority. However, the records of one person showed that they had sustained a bruise of unknown origin to the arm. This had not been referred under safeguarding procedures. When we talked to the staff team about this we were told that the individual concerned 'bumped into things all the time' and that was why it had not been reported. We recommend that the safeguarding team is contacted, so that a discussion can be held and a decision made about referring each incident, involving this individual under safeguarding procedures.

We were aware from discussions with external professionals that some parts of the service had suffered from a lack of consistency in terms of staffing. However, we were advised at the time of the inspection by community professionals that this situation had improved. This information was supported by our findings.

We spoke with the service manager who advised us that after a large recruitment effort all the services benefitted from a static staff team. This meant there was no need to use agency staff and that each property was staffed with people who knew that part of the service well. Rotas viewed confirmed support was provided by a stable staff team and that agency staff were not used. This was also commented upon by some people we spoke with who used the service. One person said, "It's much better to have the same staff. I didn't like it when we used to get people we didn't know." Rotas demonstrated that ample staffing was provided for people to go about their chosen activities on a regular basis. The registered manager told us the service recruited to 110% of commissioned hours. This helped to ensure that adequate numbers of staff were appointed to provide the care and support needed by those people who used the service.

We found policies and procedures were in place to help ensure safety in the recruitment of staff. Prospective employees were asked to undertake checks prior to employment to help ensure they were not a risk to vulnerable people. We reviewed recruitment records of six staff members and found that robust recruitment procedures had been followed, including Disclosure and Barring Service (DBS) checks and suitable references had been sought. The Disclosure and Barring Service allows providers to check if prospective employees have had any convictions, so they can make a decision about employing or not employing the individual. Records showed that DBS checks were renewed every three years, which was considered to be good practice.

We spoke with staff members about the recruitment procedures adopted by the agency, who confirmed that all relevant checks had been conducted before they were able to start working for Lifeways (Chorley). Records showed that Lifeways was an equal opportunities employer, which afforded all applicants the same

opportunities, irrespective of gender, race, culture or disability. Rigorous interviews had also been conducted to ensure prospective employees were suitable candidates for employment. All employees worked a probationary period to ensure their work performance was satisfactory and to decide if they wished to continue with their employment.

During our inspection we assessed the management of medicines. We looked at a sample of medication administration records (MARs) and other records for nine people who lived in three different supported living houses. We spoke with the house managers and three other members of staff about the safe management of medicines, including creams and nutritional supplements.

We found that medicines were stored appropriately and were locked away securely to ensure that they were not misused. Medicines could be accounted for easily as records were clear and accurate. A check of records and stocks showed that people had been given their medicines correctly. Where medicines had not been given, care workers had clearly recorded the reason why. There was an effective system of stock control in place with little or no excess stock.

Risk assessments and care plans were in place to support people to take their medicines safely. These included detailed information for care workers to follow, to enable them to administer medicines consistently and correctly, whilst respecting people's individual needs and preferences.

Medicines were only handled by trained care workers who had been assessed as competent to administer medicines safely. One support worker told us that he had not received medication training and felt he was not competent to administer medication. However, he would not be on duty without someone who was appropriately trained. He was unsure if anyone in his care was prescribed rescue medication, despite one person being prescribed this drug for epileptic seizures. We spoke with the registered manager about this, who confirmed this care worker had in actual fact received medication training, but had not yet been signed off as competent However, it was established that the rescue medication had been prescribed for a significant length of time, but had not been needed for a long time. A review of this individual's medication will be arranged with the GP, to establish if it is still needed.

Regular audits (checks) were carried out to determine how well the service managed medicines. We saw evidence that where concerns had been identified, action had been taken to address the concerns and further improve medicines management within the service.

One person we spoke with managed their own medicines. We were able to confirm that there were appropriate risk assessments in place to determine if they needed any support. They told us, "I do my own tablets. I have a locked cupboard. I didn't use to do them, but I'm more independent now. I can get help if I need it though."

We looked at a random selection of financial records and found that people's capacity in relation to managing their own finances had been assessed and best interest decision meetings had been held where people lacked the capacity to make their own financial decisions. Clear financial transactions were appropriately recorded. People's monies were checked at each handover and regular audits were conducted. This helped to ensure that people were safeguarded from financial abuse.

Good

Is the service effective?

Our findings

At the time of this inspection there were 76 people who used the service. Everyone we spoke with agreed that staff were well trained and competent. People told us that they were happy with the care and support delivered. Comments we received included, "It's a very good service"; "I like all the staff who work here. They [the staff] are friendly and always on hand if I need help"; "The staff are very good"; "They [the staff] always ask me how I want things done"; "The care is good"; "The staff help me to cook my food. They encourage me to do it myself, but are there if I need help. I always choose what I want"; "If I am ill the staff are always at hand. They would ring a GP if I needed one. They help me with my health checks"; "They (the staff) seem to know what they are doing." And "I trust my support staff more than I trust anyone else."

One person we spoke with us told us what he would do if he was not happy with the service he received. He commented, "If I am not happy with any of the support staff I would tell my Team Leader and she would get them changed. She told me at the beginning that if I was ever unhappy with anyone, she would try to resolve the situation or move them on." He added, "I've told all my support staff to let me do things on my own as I want to be independent."

A relative told us, "They (the staff) are very well trained. He (family member) needs total care and he is PEG fed (nutrition provided directly through the abdominal wall). They treat him very well."

When we talked with people about access to health care professionals, we were told, "My key worker takes me to the dentist"; "I go to the dentist on my own" and "If I am ill they (the staff) call the doctor." A relative told us, "(Name removed) is cleaner and healthier and they [the staff] make sure his mouth is clean all the time." We talked with people about maintaining their independence. Comments we received included, "Yes I go out on my own"; "I am more independent than others who live here." And "I am very happy here. I can choose what I want to do." A relative said, "They (the staff) have done a marvellous job with him. He is much better looked after there than in hospital." And another told us, "I don't know about a care plan but they keep us informed about everything."

We talked with people who used the service about the arrangements for mealtimes. Their comments included, "I like cooking my own food. I get help to do it, but I like doing it myself. I can decide what I have. There is always plenty to choose from"; "We choose the menu and I help to cook"; "I help to prepare the food." And "We go and do the shopping together. We choose what we want. We can have anything really."

Care plans we saw contained details of peoples' medical histories and any on-going support they required. We saw some good examples of close joint working with community health care professionals, such as mental health workers, which helped ensure people got the support they required.

We saw some examples of well detailed care plans in relation to peoples' individual conditions. For example, the care plan of one person who had epilepsy contained a good deal of information for staff about how to support them in this area.

Records were in place of health appointments attended by people and any professional guidelines were clearly recorded. These records showed that staff identified potential issues and supported people to access health care when they required it. For example, support staff had noticed a suspicious looking mole on one person's skin and had supported them to have this investigated straight away. Staff had made a referral to the epilepsy specialist to request a review of medication on behalf of another person who used the service. One person we spoke with told us, "They [the staff] are the best at making sure I get healthcare. Last year I had a horrible bug, with sickness and diarrhoea. The carers went out and got all the right things for me. They were brilliant."

People's care plans also contained information about the support they required to access routine health care and we could see that people were enabled to access various services. For instance, cervical cancer screening checks, well-men's clinics, dental, foot and optical care. Each person had a hospital passport in place which contained important information about their care and support needs. These documents were designed for the purpose of providing external professionals, such as hospital staff with this information, should the person be admitted to another service.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Whilst DoLS procedures do not apply to supported living environments. The provider should have systems in place to identify when people are at risk of unlawful restrictions which may amount to deprivation of their liberty and to ensure any such situations are brought before the court of protection (COP). The COP is a high court set up to deal with such issues and protect people's rights.

Records showed that Mental Capacity Assessments had been conducted, in order to determine capacity levels. However, these records could have provided a little more clarity to show how outcomes had been achieved. We made a recommendation about this.

We found that each person, who used the service or their appointed representative had signed to give consent for each aspect of their care and support. A checklist was also in place, which enabled staff to identify if any restrictive practices were taking place. Decisions were made in the best interest of the individual and these were decision specific. However, care needs to be taken when copying and pasting information, so that each record is specific to the individual and so that the person centred element is not lost.

Individual menu plans were in place for each person who used the service. These showed that people were consistently offered choices about what they ate and were provided with a varied and nutritious diet, which was in line with their individual preferences.

During the course of our inspection we looked at the personnel records of six members of staff, who had

been employed by Lifeways [Chorley] for varying periods of time and held different positions within the organisation.

All staff we spoke with confirmed access to regular supervision and felt that their managers were supportive. One service manager explained that team leaders conducted supervision for the care staff working in the houses and service managers completed supervision for the team leaders. Another service manager advised that all new staff members were required to undergo a twelve week induction programme at the start of their employment, in line with the nationally recognised care certificate. This included ten classroom based training days during which learning modules were provided in areas such as, fire awareness, safeguarding, health and safety and DoLS (Deprivation of Liberty Safeguards).

The policies and procedures of the agency were also part of the induction programme. Records we saw confirmed this information to be accurate. One of the personnel records we looked at did not contain completed paperwork in relation to the individual's first formal review and their objectives. However, we did see a completed six month probationary review, which showed that the employee had completed their probationary period satisfactorily. The registered manager told us that the company were in the process of developing an induction programme specifically for management staff and that this was near completion.

New staff members were also provided with the opportunity to shadow experienced members of staff. It was confirmed that new staff were supernumerary to rotas during their shadowing period. We were told that all inexperienced staff were matched with a 'buddy', which helped them to gain confidence and to increase their knowledge base.

We found evidence that a range of mandatory training was provided for staff, as well as learning in relation to the needs of the people they supported. For example, we visited a property where two people with Acquired Brain Injuries lived. We were able to confirm that all staff supporting them had been provided with training in this specialised area. We were also told by the registered manager that training for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) had recently been separated from safeguard training and now had its own status within the training programme.

Records showed that additional learning modules, such as autism, epilepsy awareness and diabetes were provided. These courses were generally completed through e-learning methods.

The training matrix showed that a good percentage of the staff team had completed mandatory training modules, such as safeguarding, health and safety, first aid, reflective practice, medication awareness, MCA and DoLS and person centred care. Evidence was available to show that if any mandatory training became overdue, because of the employees failure to complete, then work was suspended for the staff member until the specific training was signed off.

Staff training was monitored by the service managers on a monthly basis. This enabled them to identify when staff were due to receive any updates. Staff we spoke with commented favourably about the training they had been provided. One staff member said, "They've had me on some brilliant courses. I loved the ABI (Acquired Brian Injury) so much I did it twice!" Another told us, "They pay us for training and pay expenses. I think that is really good." We were told that staff members on induction had 'Return to classroom sessions', which enabled them to discuss their experiences and to identify any additional support needed or learning they had gained from their practical experiences.

Detailed individual performance objectives and personal development plans were in place for all service managers, which included a variety of sections linked to goals and objectives and covered areas, such as the

reduction of agency staff in line with the organisations recruitment policy, training, quality audit scores and contracted hours versus commissioned hours. This helped to ensure the management team were working together to improve the quality of service provided.

During our inspection we spoke with a wide range of staff members and managers, both within the community and at the agency office. These included care workers, service managers, the learning and development manager and the registered manager. It was confirmed that staff were able to request additional training, as was needed and records showed that this had taken place. A recently developed apprentice programme was shared with us, which was a one year course.

One service manager told us that she regularly visited the services in her area. This enabled her to ensure that people received the care and support they needed and to establish if the staff team were appropriately matched with those who lived at the individual houses. The matching process was an integral part of recruitment and person centred planning. The interests, ages and beliefs of those who used the service were matched with new staff members, in order to promote good and fulfilled relationships. Those who used the service were involved in the interviewing of new staff members and their thoughts and opinions were taken into consideration during the selection process. Interviews were held at the houses, so that prospective employees could observe the day to day activity and so those who lived at the house could decide on the applicant's suitability. This process provided people with the best opportunities and maintained their interests whilst using the service.

Good

Is the service caring?

Our findings

People who used the service were very positive about the care they received and the attitude of their care workers. They felt that staff respected their privacy and dignity whilst meeting their personal care needs. One person described his carers as, 'helpful', 'kind' and 'caring.' He said, "We have got a nickname for our Team Leader. We call her 'Mother Hen', because she cares for everybody like her own."

People were also happy about how staff communicated with them. One person told us, "If they [the staff] have a problem with me they can speak to me, or if I have a problem with them I can go to them." Another said, "They [the staff] have just made my life a lot easier since having my brain tumour. They are doing their best to get me back to the way I used to be. Staff don't tell us what to do. They ask us if we want to do something. If not, they think of other options. If we don't want to do something they don't make us do it."

Other comments we received included: "The staff are brilliant"; "It's really nice here"; "I am happy with the staff. It is better now they are the same staff"; "I can't fault any one of them [the staff]. They are all lovely to me"; "They [the staff] are there when I need them. They know if I am feeling a bit down and they help me cheer up"; "The staff are very nice, they treat me well"; "The staff are very good"; "I was involved in it [the care plan]. I met with the Team Leader"; "They are good. I have no complaints. They are easy to talk to. They have a friendly attitude and are easy to approach"; "When I have a shower, the staff make sure my door is closed and afterwards they make sure I am covered with a towel." And "When I go to wheelchair tennis, they are always there in the background."

A relative told us, "They [the staff] are absolutely marvellous. They are more than carers. They go over and above." And "They take an interest in him." Service users we spoke with said they had their own room if they want some private time and staff respected that.

We observed staff interacting well with those who used the service. These observations were very positive. It was apparent that the staff teams shared genuine, warm relationships with those who used the service. There were plenty of jovial chats and pleasant banter between the staff and people who lived at the houses.

Staff were seen to approach people in a kind, respectful and patient manner, taking time to listen to them and support them at their own pace. We observed one member of staff assisting an individual in a special way, specific to their preferences. When we asked one person if staff knocked on their bedroom door they laughed and said, "Well! Of course they do!!" We saw that people were supported in a way that promoted their privacy and dignity. One person's care plan contained very good information about managing risks associated with their epilepsy whilst promoting their privacy and dignity.

People were supported to access advocacy services, if they so wished. An advocate is an independent person, who would act on behalf of someone who used the service, to help them make decisions, which were in their best interests. Information about Lifeways (Chorley) could be produced in a variety of different formats, if needed. For example, in large print, Braille or on CD for those with varying degrees of sight loss and in alternative languages for those whose first language was not English. This provided everyone with

equal opportunities, by enabling them to have access to the same information, despite their nationality, age or disability.

Much attention had been paid within people's care plans to their individual wishes and the things that mattered to them. One person's care plan stated, 'Listen and respect my choices.' Another read, 'I want to be supported by female staff only.' We established that people's wishes and preferences were respected. One person we spoke with told us, "When my fiancée comes round, if we are in the front room they'll [the staff] go in the dining room or go upstairs doing paperwork. Or they can stay in with us. They always ask us if we want to be on our own."

There was a good level of detail about people's individual methods of communication and how people might express themselves non-verbally. This helped staff to support people to express their views and decisions and enabled everyone to have the same opportunities as each other, irrespective of any disability. One support plan we saw included an end of life plan, which had been developed with the individual and their parents. This was produced in an easy read pictorial format, so that the individual was able to access the information more easily.

A Quality Focus Group made up of people who used the services of Lifeways in the Lancashire area, discussed what a quality service was and the people in attendance made posters to provide a visual display of what they thought a quality service looked like. This was a good example of involving people in driving up quality.

Good

Is the service responsive?

Our findings

Everyone we spoke with said they would know how to make a complaint and who to talk to, but nobody had any concerns at all. People generally had active lifestyles and were supported to maintain their interests. We were told, "I like it here"; "I go swimming and I like sewing"; "I like going shopping and spending my money"; "I like going on holiday"; "I am going on a bike ride today"; "I go out in the car"; "I get to pick my activities and can change them if I want to. I deal with my own money. They always ask me how I want things doing. If I am going on an activity they ask me before if I want to do it and if I am happy to do it"; "If I wanted to complain I would tell my mum or dad or my Team Leader. I have never made a complaint." And "I go to church and like eating cake."

A relative commented, "He [family member] is much better there [at his home] than in hospital. He loves being there."

During the course of our inspection we looked at the care files of twelve people who used the service. Some of these were viewed in people's houses and others were seen at the agency office. We found that essential information and personal details were completed to a very good standard.

Records showed that detailed needs assessments had been completed before a package of care was arranged. These covered areas, such as people's likes and dislikes, physical health, mobility, mental health, communication, eating and drinking, personal care and lifestyle. A person centred approach had been adopted by the service. This helped to ensure that people were supported in a way they wanted to be and helped to ensure the staff team were confident that they could provide the care and support needed by all those who used the service.

The care plans we saw were, in general well written, person centred documents. They were based on the needs and personal goals of each individual. They incorporated a section entitled, 'What is important to me?' Examples of this included, learning to cook, keeping fit and gaining employment.

The plans of care clearly focused on peoples' routines, goals and the progress people made towards their goals was constantly evaluated. We saw some good examples of very well detailed behaviour support and communication planning. This was done in a very positive manner and focused on the needs of the particular individuals. In one isolated case some minor contradictory information had been recorded and there was no plan of care in place for one medical condition. We established that the individual had not suffered an episode for more than 11 years. However, the registered manager agreed to implement the relevant care plan without delay.

In the care files we viewed there was an individual support agreement signed by the person and the service manager. This included undertakings such as, 'We will support you to live the way you choose' and 'We will help you to learn new skills.' There was some pictorial information provided in people's care plans to assist them in accessing the information more easily. For example, pictures of service managers and support workers were included in people's care records.

The support plans we saw contained good detail about people's life histories and specific routines, such as pictorial exercise programmes and evidence was available to show that those who used the service were fully involved in designing their own, individualised care packages. These records were very person centred, with people's likes, dislikes and preferences clearly recorded. For example, one support plan described how the individual preferred to take their medication. It read, 'I like to take my medication next to the dish washer. I take them off a spoon with my cars cup.'

One page profiles were in place for the people we pathway tracked. These allowed staff members to see at a glance how people needed to be supported. However, some of these were a little out of date and in need of updating. This would help to ensure that staff members were provided with current information about those in their care. Daily notes and handovers were in place to aid communication between staff. This helped to ensure that each staff team was provided with up to date information about those in their care.

Regular reviews of needs were recorded. These showed full involvement of the person and where appropriate, their representatives. The people we spoke with were fully aware of their care plans and what they contained. Any changes in need had been recorded well. However, several support plans we saw had not been reviewed for some time because changes in need were not apparent. However, it is recommended that care plan reviews are conducted more frequently, to demonstrate that people's needs have been reviewed and that records are current.

Staff members we spoke with about the care people needed were able to tell us in great detail about the support they provided, which accurately corresponded with the information and guidance provided in the support plans we saw.

Any specific health problems were monitored well. For example, monitoring sheets were being used for those who experienced epileptic seizures. These recorded the date, time, duration, recovery period and description of the seizure. This helped the staff team to closely monitor the individual's medical condition and to establish when external professional advice was needed. Preventative strategies had been developed with those who used the service. One good example was seen in a care plan which read, 'Ignore verbal abuse, but do not ignore me. Try to engage me in distractive conversation, such as about my family.'

One service manager told us that on occasions some service users were involved with the interviews of new staff. The records of one person showed that they had been involved in selecting their care workers and this was confirmed as being accurate information by the individual themselves. Their care file included a section about, 'What kind of person should support me and 'What skills should they need.' This person told us that they preferred female carers to help them and we noted that there were three female carers on duty on the day of our inspection. One person told us, "I chose this house. Well – I helped to choose it and decide on all the decorating and furniture. A third tenant will be coming, but they will only come if we like them. We will help to decide."

Health action plans were consistently in place within the care files we saw. These contained details of how peoples' health care needs should be appropriately met. Records showed that a wide range of community professionals were involved in the care and treatment of those who used the service and hospital passports had been developed for each person, whose care files we looked at. These documents were a summary of people's needs and contained any important information, which may be useful to medical staff, should a transfer to hospital be required.

An easy read complaints procedure was included within the Individual service agreements. One person commented, "I would always talk to the staff if I wasn't happy. They would want to know and they would

sort it out." Another told us, "My mum knows how to complain if we need to, but I don't think we will need to."

People's care plans were well detailed in terms of their preferred activities and the support they required to engage in their chosen pastimes. One person we spoke with was eagerly looking forward to a college course in September in IT. He told us, "I am starting college, but eventually I am going to do a degree." This person also enjoyed regular attendance at the Sea Cadets. He described how he had started this activity with staff support, but had eventually moved towards attending independently.

Another person we spoke with enjoyed swimming and took part in this activity regularly. She told us, "I like keeping fit. I'm doing 17 lengths now!" This person also took part in voluntary work at a local shop, with a view to working towards paid employment. The plan of care for one person, who used the service read, 'I like listening to Asian music and I like to go to bed at 10pm.' This demonstrated a person centred approach to care and support.

A one page profile provided staff with a clear overview of the support people needed and what they enjoyed doing. Records showed that people were supported to be involved in community life. For example, some people attended Mencap, clubs or day centres, whilst others enjoyed eating out or gardening. Day trips were also arranged to places of interest, such as knowsley safari park and the Coronation street set. This helped those who used the service to maintain their interests and to enjoy life.

One person we spoke with eagerly described one of his favourite leisure activities. He said, "Every Friday I go trampolining. I can do a front flip in the air and am just about learning how to do a back flip. One of my support workers comes with me." Another person told us, "I went to the pictures the other day. I also went to Monkey Forest with the Manager. We paid extra to feed the monkeys. It was out of this world feeding the monkeys."

A Service User's Guide and a detailed complaints policy was available at the agency office, which together outlined the services and facilities available and the correct procedure to follow, should people feel the need to make a complaint. However, these documents which were also contained within the support plans at the agency office needed to be exchanged in line with the updated master copies.

Good

Is the service well-led?

Our findings

People we spoke with felt the service was well organised. One person commented, "They [the staff] make sure I do all my activities and they make sure I am not late for them." Another said, "I've been in the office plenty of times. Before I moved into this house I used to have a job in the office. I used to make them brews and help with the photocopying and the shredding." And a third told us, "I don't think I'd find anywhere as good as this. My family is really happy. My mum can settle knowing I am OK."

Staff we spoke with told us that they felt well supported by the manager of the Lifeways (Chorley). One of them said, "He is really approachable and down to earth."

We were aware of some recent restructuring developments within Lifeways Community Care. The registered manager told us that the Manchester and St Helens services had been reallocated to different areas, which had created a reduction of approximately 3000 hours. He explained the changes which had been made and how these had affected the service, including the appointment of a deputy area manager. He told us that the new arrangement was neater and more manageable in terms of numbers and areas. The registered manager told us that he had autonomy to increase staffing levels without having this decision approved, if the need for additional staff arose. The improvements we noted since the last inspection were significant.

Members of staff we spoke with felt there was now a consistent team in place, which enhanced person centred care and the quality of service provided.

Records showed that a robust and structured system was in place for assessing and monitoring the quality of service provided. The organisation engaged an external company to undertake satisfaction surveys. Recent individual returns were seen and, in general the responses were positive. The registered manager had begun to collate salient comments onto an action plan. We saw an action plan entitled 'Driving up Quality', which was devised using the latest CQC report, internal audit results, satisfaction surveys and monthly reports. In addition, meetings took place with the organisations quality manager on a three monthly basis.

One service manager advised that weekly managers meetings took place during which managers had the opportunity to discuss service developments and review any adverse incidents, such as accidents. This helped to ensure learning could be cascaded throughout the teams. Another service manager confirmed they had received training in management and leadership and were satisfied with the resources provided, for example resources for staffing. We saw the latest minutes from the last two service managers meetings, which covered topics, such as, training, quality survey results, accidents and incidents, use of agency staff, CQC reports and action plans.

Local operational meetings were also held every week, which were chaired by area managers and all service managers were expected to attend. One service manager explained that following the last inspection all staff were invited to meet with senior managers to discuss the issues. He said, "Management were honest and open. Our views were invited about how we could improve."

Records showed that team meetings for each group of staff were held regularly. These covered areas, such as whistle-blowing, confidentiality, updates about service users, best practice and changes in the management structure. This helped to enable staff members to discuss specific topics within an open forum and to ensure all relevant information was disseminated to the staff team.

Meetings were also held for those who used the service and people were encouraged to participate. These meetings covered areas, such as places to visit, things to do, new items needed, what makes us happy and what we don't like.

Evidence was available to demonstrate that the quality management team conducted an audit every twelve months within each property, following which relevant action plans were developed in relation to any shortfalls identified. Each service manager completed a monthly workbook, which was a checklist that looked at how a variety of areas were being managed, such as safeguarding concerns, health and safety incidents, accidents and complaints. These were submitted to Head Office every month.

There had been two formal written compliments received from January 2016 to the date of the inspection. A number of verbal compliments had been made but these were not formally recorded, so a piece of work was underway with service managers to ensure such compliments were captured.

A range of quality checks, including water temperatures, smoke alarms, support planning, medicine management, fire safety, menu plans and finances were carried out on a monthly basis by the management team.

A wide range of detailed audits were carried out in line with CQC domains. A national audit team was also in place for additional support. The audits were scored and equated to the current CQC ratings. Each audit generated an action plan, which was discussed with the relevant service manager. We were told that the registered manager was able to instigate a random service audit, should concerns be raised. Otherwise audits were conducted on a rolling annual programme, so that each location would be audited annually, or as intelligence dictated. There was an additional layer of scrutiny in place, as audits were also reviewed by departments, such as learning and development, quality, regional operation directorate and health and safety.

A service users' guide and a wide range of policies and procedures were in place at the agency office, which were current and covered areas, such as dignity and respect, health and safety, moving and handling, infection control, the Mental Capacity Act, safeguarding adults and children. Lifeways policies and procedures were also available on line.

All staff we spoke with felt well supported by the managers of the service and confirmed access to twenty four hour on call whenever it was needed. Since our inspection the registered manager has informed us of progress he has made as a result of our feedback and recommendations made, which is considered to be good practice.