Care Quality Commission

Lifeways Community Care Limited

Lifeways Community Care (Taunton)

Inspection report

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31 August 2023
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19 September 2023
21 September 2023

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Lifeways Community Care (Taunton) is a supported living service providing personal care to people with learning disabilities and autistic people living in their own homes. People were supported over 13 different properties with some people living in self-contained flats and others living in single or shared accommodation. Not everyone who used the service received personal care.

CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection there were 34 people receiving personal care.

The service is also registered to provide domiciliary care services. At the time of the inspection the service was not providing domiciliary care services.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support:
People were not always supported to have maximum choice and control of their lives; the policies and systems in the service to support this were not effective.

Where people lacked capacity to make decisions, the provider failed to follow the Mental Capacity Act (MCA) 2005 code of practice. Restrictions were placed on people without considering the principles of the MCA and there was not always clear evidence that the restrictions were in the person's best interest. Not all options were considered when looking at the least restrictive option for people. Some practices restricted people's independence and choice, and breached their human rights.

People received their medicines from trained staff. However, improvements were needed to ensure guidance and administration records were accurate and up to date. Staff enabled people to access specialist health and social care support within the community.

The service completed assessments prior to people receiving a service, with care plans completed from the assessments. Care records viewed throughout the inspection were of mixed quality and were not always up to date.

Right Care:
People were not always protected from the risk of harm as staff did not always have all of the information needed to meet people's needs safely. Incidents were documented, however follow up processes and incident analysis needed improving to ensure people were given the appropriate support after an incident.

Recruitment processes were not always robust, and concerns were raised regarding staffing levels. Staffing levels were based on the needs of the people living at the supported living settings. The service was currently using agency staff to ensure safe staffing levels.

Staff received training in safeguarding vulnerable adults. Staff spoken with said they would be confident to report any concerns.

Right Culture:
There was lack of management oversight and reliable systems to inform the management of the quality of care people were receiving.

The culture within the service was not always positive. Staff did not always complete records about people in a dignified and respectful way, and improvements were needed to ensure people were involved in decisions about their care.

Staff did not always receive appropriate training and people were supported by staff who did not always understand best practice in relation to the wide range of strengths, impairments, or sensitivities people with a learning disability and/or autistic people may have. This meant people did not always receive empowering care that was tailored to their needs.

Most relatives were positive about the service their loved ones received and felt involved. Where concerns were raised, these were discussed with the registered manager.

The registered manager was open and honest throughout the inspection, accepted the shortfalls found and immediately sought to rectify them.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 4 July 2023, and this is the first inspection. Prior to the service becoming registered with us, the service was operating and being managed from another of the provider's registered locations.

Why we inspected
The inspection was prompted in part due to concerns received about the culture of the service and how people who experienced emotional distress were supported by staff. A decision was made for us to inspect and examine those risks. Initially we completed a targeted inspection. Due to concerns identified during the targeted inspection, we changed our approach and completed a comprehensive inspection.

Enforcement
We have identified breaches in relation to governance, staffing, dignity and respect, consent, safeguarding, medicines, and risk management at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Lifeways Community Care (Taunton)

Detailed findings

Background to this inspection

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

This was initially a targeted inspection to check a concern we had regarding the culture of the service, and how people who experienced emotional distress were supported by staff. Due to concerns identified we changed our approach and completed a comprehensive inspection.

Inspection team
The inspection was carried out by 3 inspectors, a regulatory officer, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in 13 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 31 August 2023 and ended on 29 September 2023. We visited the location's office on 31 August, 5 and 19 September 2023.

What we did before the inspection
We reviewed information we held about the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited 5 of the supported living settings, and met 13 people using the service. We spoke with 8 members of care staff, the registered manager, 4 service managers and 2 team leaders.

We looked at a sample of records relating to people's individual care and records relating to the running of the service. This included 12 people's care records, a sample of medication administration records and a variety of records relating to the management of the service, including a sample of accident and incident forms, staff debrief forms, training records, recruitment files, policies, and procedures.

An Expert by Experience spoke with 6 relatives about their family member's experience of the care provided, and following the visits a regulatory officer spoke to a further 4 care staff and 1 team leader over the telephone.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated 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; Assessing risk, safety monitoring and management

- People were at risk of avoidable harm as staff did not always have all of the information needed to meet people's needs safely.
- Some people could become anxious, leading to incidents, which could cause harm to themselves or to others. Measures were not always put in place to reduce the re-occurrence of any incidents. An unexpected significant incident occurred that required staff to use unplanned physical intervention. Following this incident, a risk assessment was not completed for 8 weeks, a positive behaviour support plan was not implemented for 10 weeks, and training required to enable staff to support this person safely, was not delivered to staff for 3 months. During this time, another significant incident occurred which required staff to use unplanned physical intervention again. This was because staff did not have the right information or training to guide them as to any actions they should take to keep this person, themselves, and others safe.
- One staff member told us this person's trips out of the home had been restricted. Another staff member told us this person was not being supported outside of the house due to a lack of staff training and the subsequent risk to themselves and to others. This restriction placed both the person and staff at significant risk, and was also a breach of this person's human rights.
- The provider recognised that this person's current and changing needs could not be safely met within the person's current home. The staff team were doing their best but factors, such as the environment, made it very difficult to provide safe and effective support.
- We viewed various records across the supported living settings. We found care plans, risk assessments and positive behaviour support plans were not always being followed. These records detailed specific training staff needed to enable them to support people safely. Service managers confirmed not all staff had received this training.
- The provider did not always consider less restrictive options before limiting people's freedom. For 1 person, who lived in their own home, the kitchen was locked at all times. We observed they were not able to use their kitchen even if staff were present. We were told there were some risks to this person in relation to the kitchen, however, a risk assessment identifying the specific risks was not in place. We were unclear when the restriction had last been reviewed, and if any less restrictive options had been considered. During the inspection, restrictions were reviewed, with less restrictive measures implemented enabling the person to use their kitchen safely.

The provider had failed to adequately assess, monitor, and manage risks to service users' health and safety which placed people at an increased risk of avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and most people's relatives raised no concerns in relation to safety. One relative raised concerns about the safety of their loved one. This was discussed with the registered manager who advised this had been reported to the local authority safeguarding board.
● Staff had training on how to recognise and report abuse and they knew how to apply it. Comments included, "I would report harming in any way to ensure the safety of the service user, any form of abuse financial, bruising etc" and "If there was an issue I couldn't go to [service manager] with, I would call safeguarding direct, people in danger, if something doing wrong within the company I would also follow the whistleblowing policy."

Learning lessons when things go wrong
● Accidents and incidents were documented by staff, although we were not always assured there was clear management oversight or action taken to reduce the risk of an incident happening again.
● During the inspection, a staff member made us aware of a significant incident where unplanned restraint was used, which the registered manager told us they were unaware of. The provider had an electronic system in place to record incidents. Daily management of the supported living settings was completed by service managers. Service managers were required to input incidents within their settings onto the system to enable oversight from the registered manager. We found not all incident forms, viewed within settings, had been entered onto the electronic system.
● The electronic system analysed incidents and identified some trends. The system did not identify all trends, for example if incidents were happening with a certain member of staff. The registered manager told us when they were aware of an incident or concern, they looked for other trends not identified by the system, although this was not recorded.
● Staff did not always receive debriefs following an incident, and when they did these were not always prompt. Following 1 significant incident, staff involved did not receive a debrief for 7 weeks. This meant potential opportunities to learn lessons quickly when things went wrong, were lost.

The provider failed to have systems in place to learn from incidents and improve the safety of the care provided. This contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager shared a clear procedure that had been implemented to ensure effective management of incidents. The registered manager also arranged refresher training for service managers on recording accidents and incidents onto the electronic system.
● There was evidence lessons were learnt across the organisation, and learning from significant incidents was shared between services.

Using medicines safely
● People's medicines were not always administered safely.
● Some people were prescribed 'as required' medicines (PRNs). Protocols for the PRNs were in place, although within 1 setting these had not been reviewed since being written in 2020. One person's medication administration record (MAR) did not include all of their PRNs. It was also not clear if medicines were PRN, as the medicines label and PRN protocol detailed different administration instructions.
● Clear guidance for 1 person on when to administer emergency medicine was not always available. The persons care plan, medicine protocol and the label on the medicine all detailed different administration instructions.
● One person was prescribed medicines covertly. This had been agreed by the person's GP in 2018. Although we had been told this had been reviewed, there was no evidence of this. The person's MAR stated this medicine should not be chewed, however staff informed us the medicine was added to the person's food.

Staff were unable to provide any evidence of the medicine being suitable to be mixed with food or that this would not affect the medicines integrity.

The provider failed to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a medicine administration policy in place, and staff involved in medicine administration were trained and had their competencies assessed to administer medicines.
● The provider ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The provider was mindful of the principles of STOMP (stopping over-medication of people with a learning disability, autism, or both) and ensured people's medicines were reviewed by prescribers in line with these principles.

Staffing and recruitment
● The provider did not always follow safe recruitment processes to ensure staff were suitable to work with vulnerable people. The provider had recently carried out an audit and had identified this. At the time of the inspection they were completing improved recruitment checks retrospectively.
● The provider conducted Disclosure and Barring Service (DBS) checks before new staff started working. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.
● We received mixed feedback about staffing levels. Relatives told us, "I am happy, or was, but there are not enough staff, and that's the crux of it" and "They could help more with cooking, as [relative] does here when I'm making cakes. But they haven't got the time to do that. There's a car and [relative] loves to go out in that, but they're short-staffed."
● This was discussed with the registered manager who was aware that commissioned hours were not always being met. Assurances were provided that current staffing levels were safe, and commissioners were aware they were not always delivering people's assessed staffing hours.

Preventing and controlling infection
● We were assured that the provider's infection prevention and control policy was up to date.
● Staff received training and had access to appropriate personal protective equipment (PPE) to prevent the spread of infection.
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. Two flats within 2 of the settings were not clean. We discussed this with the service managers who explained the plans in place to address this.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection of this newly registered service. This key question has been rated requires improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People's rights were not fully protected because the correct procedures had not always been followed where people lacked capacity to make decisions for themselves.
- Mental capacity assessments and best interest decisions had not always been completed when needed to determine if people were able to make decisions. This meant the provider had not ensured people's consent was being sought in accordance with the MCA.
- The provider had not followed best practice when assessing mental capacity and best interest decision making. Some assessments contained generic information and did not indicate what opportunities were attempted to try and engage the person in decision making. People also had their capacity assessed for numerous decisions within 1 day. For example, 1 person had their capacity assessed for 5 separate decisions on the same day. The service manager agreed this was too much information for the person to try to understand and decide upon on the same day.
- Records did not always detail what other options were considered or which option was the least restrictive.
- Not all service managers, who had completed mental capacity assessments, told us they had received training to support them to undertake these assessments. During the inspection, the registered manager told us they had nominated service managers to undertake further training. Following the inspection, the

registered manager confirmed all staff had completed mental capacity training, and also told us other support was available to offer guidance where required should service managers request this.
● Some staff we spoke with did not always understand the principles of the MCA. Restrictions were identified during the inspection and not all staff spoken with identified these as restrictive practices. For example, 1 staff member didn't recognise the use of a monitoring device or 24 hour staff support could be considered restrictions under the MCA.

The provider had failed to ensure processes were in place to ensure consent to care and treatment was sought in line with law and guidance. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appropriate DoLS applications had not been made to the Court of Protection when required.
● We reviewed people's records and found they detailed a number of restrictive practices. These restrictions had not been authorised by the Court of Protection, and there was no other legal basis or framework in place to support their use. This was a breach of people's human rights.
● Within supported living settings, the Local Authority (LA) are required to make these applications. In some instances, the LA had been made aware of the need for applications to be made to the Court of Protection, although it was not clear whether applications had been made. Following the inspection, the registered manager told us the provider used an electronic system to provide oversight and review the application status, with service managers in the process of inputting the information required for each person to ensure effective oversight.
● When advice was given from the LA regarding the process of applying for a DoLS, staff did not always follow this. Within 1 of the settings emails had been sent to the LA seeking advice regarding the DoLS application process. Advice for applying was given by the LA, which was not followed. In other instances there was no evidence the process had been considered.

The provider had failed to ensure care was provided to people in a way that ensured people were not unlawfully deprived of their liberty. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills, and experience
● The provider had not ensured staff received appropriate training to meet people's needs.
● The provider had an induction programme in place. This included a number of courses to enable staff to meet the needs of the people they support including learning disability, autism, and mental health awareness. We were told after the induction there was no requirement for staff to update this training. Therefore, we were not assured staff were kept up to date with best practice guidance.
● Staff told us they had not always received adequate training to support people who experienced emotional distress. Service managers also told us not all staff had received the training required to support people who required the use of physical intervention using the safest and least restrictive methods. This meant people were at risk of harm and unlawful restraint because some staff had not received the specialist training they required.
● Some people used sign language to enable them to communicate. Staff told us they had not received training in this to support them within their role and aid communication. After the inspection, the registered manager told us Makaton (a form of sign language) training had been sought for staff.
● Many of the training courses were completed online. Some staff we spoke with told us they found it more difficult to learn or retain information through this form of learning.
● The management team raised concerns regarding the induction they received when starting within their management role. We were told they completed limited training, and most of their learning for the role was

from other managers. Although managers raised concerns about their induction and felt they had received limited training for their role as manager, following the inspection the registered manager provided evidence of some manager level training, along with confirmation that supervisions, team meetings and organisational live learning opportunities are completed to offer information, support, and guidance to service managers.
● Staff received support in the form of continual supervision and team meetings, however this differed across the settings. Evidence was not always available to show when team meetings had been completed, who had attended or what had been discussed.

The provider failed to ensure staff were sufficiently trained and competent. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● People were supported by staff who had received an induction which included shadowing other colleagues and completion of the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● The registered manager told us the provider held a 'colleague council' with staff where a team representative could attend and discuss any concerns their team may have.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care needs had been assessed and support plans had been created to guide staff on how best to meet people's needs. The care plans identified people's individual needs and preferences.
● People's records also contained a 'Me at a Glance/Essential information' and 'My everyday routines' sheet to enable staff to support the person in the way they wished to be supported.

Supporting people to eat and drink enough to maintain a balanced diet
● People's support files contained information on diet and nutrition. Staff encouraged people to eat a healthy and balanced diet.
● People were involved in choosing their food, shopping, and planning their meals.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's health was promoted and supported. People were referred to health care professionals where necessary to support their wellbeing and help them to live healthy lives. People's files described input from other services, including dentists and opticians.
● People were supported to attend annual health checks, and had a 'hospital passport' which gave key information about how the person was to be supported if they went into hospital.

Requires Improvement

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always referred to in a respectful way when staff recorded information about them. We found language used in some people's records to be disrespectful. For example, 1 record stated a person was requesting breakfast but was told they had to wait. Another record stated an incident occurred due to the person "not getting their own way," and 1 person's care plan stated "I can be very demanding at times."
- Staff received training in dignity and respect, and equality and diversity as part of their induction training. The registered manager told us there was no requirement for staff to update this training once completed. Following the inspection, the registered manager told us all staff had been reassigned equality and diversity training to undertake. The registered manager also told us all staff will be completing documentation training.
- Some staff told us people were supported in a way that supported their independence. Comments included, "Independence is a big thing, experiencing new things and always pushing to better people" and "We support and promote independence, respecting what people can do."
- Most relatives were positive about the caring nature of the service provided to their loved one. Comments included, "There were a lot of issues, but now the care is brilliant. They really care about [relative]", "They are all kind and caring" and "The staff do support [relative], even if [relative] is having a bad day they talk to [relative], offer a cup of tea. They've learnt when to leave [relative] and when to stay with [relative]. They know [relative]."

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

- People were not always involved in decisions regarding their care. 'My support records' were completed for each person supported by the organisation. We were told that in some instances these were completed by the individual themselves. These records contained a section to be completed with the individual at the end of the month to review progress, and gather people's thoughts and feelings about the past month. These were not completed consistently across the settings. We fed this back to the registered manager who said they would discuss this with service managers at their next meeting.
- The provider completed a people, family, and carers survey in 2021/2022. The surveys viewed contained comments from people and families that the provider could do better. During the inspection the registered manager was unable to tell us if a number of the comments had been acted on, and whether people had been informed about what had changed as a result of their comments. For example, 1 person stated "I don't like my support as early as 9am on certain days." Following the inspection the registered manager told us outstanding actions from the satisfaction survey had been added to the service's action plan.

● The registered manager told us people within some settings were involved in recruiting their own staff. The registered manager advised this is something she is discussing with service managers to complete within other settings.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● The provider was not always responsive to people's changing needs as detailed within the safe section of this report.
● People's care records were of a mixed quality. We viewed many records across different settings supported by the provider and although they were detailed and person centred, we found some people's care records had not recently been reviewed. For example, 1 persons support plan had not been reviewed since 31 July 2021.
● Care plans included information on how to support people in a number of areas such as personal hygiene, dressing and nutrition. This included information on how the person wanted staff to support them.

Improving care quality in response to complaints or concerns
● Systems in place to manage informal complaints were not always effective. We saw 1 example of where a concern was raised by a person in July 2023. This had not been acknowledged or responded to. We discussed this with the registered manager who responded to this concern during the inspection.
● The provider had processes in place to act on any formal complaints. We viewed 1 complaint received. The complaint had been resolved and the complainant had been provided with an outcome letter.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication needs were clearly detailed in their support plan. People had communication plans and we observed different tools being used to enable people to effectively communicate.
● Comments from relatives included, "They interact with [relative], and I notice when I go over they get down and talk to [relative] at [relatives] level if [relative is] in the armchair" and "The carers interact with them which us really good."

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's relationships which were important to them were encouraged. Staff supported people to keep in touch with and visit family members. One relative told us, "Every couple of months they bring [relative] down and [relative] seemed alright."

- During the inspection we observed people being supported to participate in social and leisure interests. We observed people going to the pub, out for lunch, and to the beach. People's support plans included a section on community and social activities. People were involved in planning their weekly activities.
- We received mixed feedback from families regarding leisure interests. Comments included, "[Relative] goes out 3 to 4 times a week, [relative] can say on the day and they organise it" and "I'd like them to do more than just go for a coffee with [relative]. I wanted them to go swimming with [relative] for over a year, but nothing's been discussed."

End of life care and support

- The service was not providing palliative or end of life care at the time of inspection.
- Systems and processes were in place to support people at this time of their life if this was needed. We were told that conversations with family members regarding these arrangements had taken place.

Requires Improvement

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not always a positive culture within the service. Records received by CQC prior and during the inspection did not always demonstrate staff recorded information about people in a dignified and respectful way.
● Lack of training and understanding of current best practice when supporting people with a learning disability had a negative impact on some people. For example, the restrictive practices being used and the poor application or understanding of the Mental Capacity Act (MCA), including not following the MCA and DoLS Codes of Practice. This meant people did not always lead inclusive and empowering lives.
● The management team told us the visions and values of the service were to provide person centred care, promote independence and always push to 'better people'. Although a number of staff echoed the visions and values, other staff told us they were there to "Keep them all calm really, make sure they have their medication at right time and that they are clean and presentable." This did not demonstrate a person centred approach.
● Relatives raised some concerns about the culture of the service which we asked the provider to investigate.

The provider had failed to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Management staff were honest and open with us during the inspection. They exhibited caring values and spoke positively about the service. They told us they were alert to the culture of the service and spent time with staff and people discussing staff behaviours and values.
● The registered manager recognised there were areas of the service that needed to be improved and they told us they were committed to delivering this.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The service had systems in place to monitor the quality and safety of the service. However, we were not assured the current governance arrangements and oversight of the service were robust or effective in

identifying actions needed.
● At the beginning of the inspection, the registered manager told us they were yet to visit 2 of the 13 supported living settings. They advised they had visited the other settings, but due to a change in the provider's processes there were no records of this. During the inspection the registered manager was also not able to answer a number of queries relating to the settings and needed to check with the service managers. This showed systems and processes to enable the registered manager to obtain clear oversight of each setting were not effective.
● A new system and process had recently been introduced to audit settings. This included service managers auditing their settings, with the registered manager visiting to validate the information. This new process required improvement and embedding into practice to ensure audits were accurate and any improvements identified and carried out. Several governance audits completed by service managers were found to be inaccurate, and had not identified the issues found during the inspection. For example concerns with medication, training, the MCA and DoLS.
● Medication audits had been completed by service managers, but were not consistently available for all settings. The registered manager advised they had been completed but due to an office move, service managers have not been bringing required documentation into the office to ensure effective oversight.
● Financial checks and audits were not completed consistently across the settings. For example some stated 'Yes' to 'Have all staff costs been agreed and authorised' although others stated 'Non applicable' to this question. Where it stated staff costs had been agreed and authorised, the registered manager was unaware if these had been agreed through appropriate processes.
● The provider had not ensured incidents were managed well. There was a process for staff to follow, but we found incidents were not always recorded within the electronic system available to ensure effective oversight.
● We viewed many records across different settings, supported by the provider, and found they had not always been reviewed. This meant staff may not have access to the most up to date information about risks to people and how to support them safely and effectively.

The provider had failed to ensure that systems and processes were operated effectively to ensure the quality and safety of the service was assessed, monitored, and improved effectively. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was open and honest throughout the inspection, accepted the shortfalls found and immediately sought to rectify them. Following feedback from the inspection, the registered manager held a meeting with all service managers and implemented plans to rectify the concerns identified. This included a clear procedure that had been implemented to ensure effective oversight of audits and checks completed by the service managers.
● Comments from relatives included, "Over the years we've had a lot of problems with people running Lifeways, but the last few years have been great", "Since 2018 it's been brilliant. I'd hate it if people left" and "It's absolutely fine. They're lovely people, very nice. The staff are very good. No problem."
● One setting had an action plan in place following quality monitoring visits by the local authority. During the inspection the registered manager started to complete an action plan for the whole service following feedback from CQC, and a provider audit that was also being completed at the same time as the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff spoke positively about the leadership and management of the service and told us they felt supported within their role. Comments included,"[Service manager] is very supportive", "There is no-one I would trust

not to look after my relatives. We are pretty well looked after in terms of support [service manager] bends over backwards to help out" and "[service manager] is really good, it's a nice team here."

- Most families felt involved. Comments included, "If there's an issue, they'll ring me, ask my opinion. This is the most relaxed I've been for years", "We get on with the staff, and can ask questions", "I'm involved, definitely. I was very involved years ago, and am now, but don't need to be" and "We have quite strong communication and I feel comfortable if I want to make a suggestion or change something." Other comments included, "I would like to be involved a lot more. But they never call me. I have to get in touch with them" and "We had monthly appointments, therapy, but don't get that anymore. I have asked for it, but not had any answers."
- The service was currently working with local authority commissioners within one of the settings due to concerns. Quality monitoring visits carried out by the LA had identified a number of similar issues we identified during this inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure processes were in place to ensure consent to care and treatment was sought in line with law and guidance. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess, monitor, and manage risks to service users' health and safety which placed people at an increased risk of avoidable harm. The provider failed to have systems in place to learn from incidents and improve the safety of the care provided.

Regulated activity	Regulation
	The provider failed to ensure medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure care was provided to people in a way that ensured people were not unlawfully deprived of their liberty. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that systems and processes were operated effectively to ensure the quality and safety of the service was assessed, monitored and improved effectively. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were sufficiently trained and competent. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.