L'Arche

L'Arche Bognor Regis Bethany

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 14 and 15 August 2018 and was unannounced.

L'Arche Bethany provides care and support for up to six people with a learning disability and other complex needs, including autism and mental health issues. At the time of this inspection there were six people living at the home, all of whom were able to communicate verbally and independently.

L'Arche Bethany is a large three storey house. Rooms were of single occupancy. Communal areas included a large sitting room and a kitchen with a sitting area. The kitchen had access to a conservatory which was being used as a dining /activity room, overlooking an accessible garden to the rear of the property.

L'Arche originated in France in 1964 and is now an international movement that builds faith-based communities with people with learning disabilities. L'Arche Bethany is part of an ecumenical, meaning all inclusive, Christian community which welcomes people of all faiths and those who have none. The community has a cycle of events throughout the year that provide a focus for spiritual development. These include an annual pilgrimage, monthly community gatherings, days of reflection and occasional retreats and gatherings. People who live and receive a service at L'Arche Bethany are known as 'core members' and staff as 'assistants'. Due to the philosophy of L'Arche that people with disabilities live in a community, most assistants live in the service alongside core members, sharing all the facilities.

At the last inspection on 31 January 2017 we found the service was in breach of two regulations. The provider had failed to notify us of incidents which they were required to do as set out in regulations. We made a requirement notice regarding this and the provider sent us an action plan of how they would be addressing this. Since the inspection of 31January 2017 the Commission have been notified of those incidents defined by the regulations as needing to be reported to us. This regulation is now met.

At the last inspection of 31 January 2017 we found the provider had not ensured the home was adequately cleaned and hygienic. We made a requirement notice regarding this and the provider sent us an action plan of how they would be addressing this. At this inspection we found the home was clean and hygienic and there were no offensive odours. This regulation is now met.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At this inspection we identified some of the actions and decisions regarding the care of people were not always recorded. We have made a recommendation about this.

Staff had a good awareness of their responsibilities to protect people in their care and for reporting any concerns. People said they received a good standard of care.
Risks to people were assessed and care plans included details of measures to counter these risks.

Sufficient numbers of staff were employed to meet people's needs. Staff recruitment procedures ensured only staff who were suitable to work in a care setting were employed.

Medicines were safely managed.

The home is a converted residential dwelling. The premises were safe and well maintained.

There were systems to review people's care and when incidents or accidents had occurred.

People's health and social care needs were comprehensively assessed and arrangements made to monitor and treat health care needs.

Staff had access to a range of training courses including nationally recognised qualifications in care. Staff were also supported with supervision and their performance was monitored by regular appraisals.

People were provided with varied and nutritious meals. There was a choice of food at each meal and people said they liked the food.

Staff supported people to make their own decisions and to have as much control about their lives as possible. Staff were trained in the Mental Capacity Act 2005 (MCA) and in the Deprivation of Liberty Safeguards (DoLS). The provider liaised with relevant local authorities to seek their advice if there was an issue regarding someone's capacity.

There was a culture of inclusion where people and their relatives were involved and consulted about care and the service provision. There was a family ethos and a sense of community at the home.

People received person centred care which was responsive to their needs. Care plans reflected people's needs and preferences. People benefitted from a range of educational, social and recreational activities both within the home and in the wider community. This helped promote people's life skills and independence. People's communication needs were assessed and staff were skilled when interacting with people. Information was provided to people in a format they could more easily understand.

People, relatives and staff were able to contribute to decision making in the home. A relative described how they were involved in decisions and that a good dialogue and working relationship with the registered manager and staff helped ensure any issues were resolved. There were a number of audits and quality assurance checks regarding the safety and quality of the services, including seeking the views of people who lived at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had a good awareness of the need to protect people in their care.

People were supported to access the community and other activities within a system of assessment and measures to keep the person safe.

Sufficient numbers of staff were provided to meet people's needs.

Medicines were safely managed.

The home was found to be clean and hygienic.

Incident and accidents to people were reviewed and appropriate action taken.

Is the service effective?

Good

The service was effective.

The provider had good links with organisations to ensure current guidelines and legislation were followed.

Staff were trained and supervised and knew people well.

People were supported to eat and drink enough. There was a choice of nutritious food.

Health care needs were met and the provider worked with health care services to ensure people got the correct treatment.

The premises were homely and suitable for the people who lived there.

People were fully consulted about their care and the provider followed procedures where people did not have capacity to consent to their care as set out in the MCA.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness. The culture of the service valued people and promoted people's rights and independence.

People were involved in decisions about their care. People's privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed. Care plans were of a good standard and reflected person-centred care. People were supported to attend a range of social, recreational, occupational and educational activities.

People and their relatives were consulted and involved in decisions including when they wished to raise a concern.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records regarding care and audits of medicines were not always recorded.

The home had an open culture where people and relatives were fully involved in decisions and the running of the home.

There was a system of audits of the quality and safety of the service which included seeking the views of people, their families and health and social care professionals.

The provider had good links with organisations to ensure people received coordinated care.

L'Arche Bognor Regis Bethany

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 August 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people and to one visiting relative. We spoke with two care staff, the deputy manager, the registered manager and the provider's area manager whose job title was Care and Support Coordinator. We spent time observing the care and support people received in communal areas of the home.

We looked at the care plans and associated records for four people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents reports, records of medicines administered to people and records relating to complaints.

Good

Is the service safe?

Our findings

At the last inspection of 31 January 2017, we found the premises were not always clean and hygienic. Adequate procedures regarding the prevention of infection were not always followed. We made a requirement notice for this. The provider sent us an action plan of how this was to be addressed. At this inspection we found the home was clean and hygienic. There were regular checks to show communal areas were cleaned. Bathrooms and toilets were clean. Notices were displayed about the importance of handwashing. Staff were trained in infection control. We judged this requirement was now met.

People told us they received a good standard of care and were safely supported by staff. For example, one person said, "There's always staff available. You can ask for help." Another person said, "I am looked after properly." Staff were trained in the principles of safeguarding and knew what to do if they had a concern about someone's welfare.

People told us staff supported them to access community facilities and that staff helped ensure they were safe doing this. Each person's care records included risk assessments for activities such as going out, the risk of falling, completing tasks in the kitchen and behaviour needs. The benefits of people taking risks was recorded to a good standard along with measures to protect the person.

Checks were made on equipment by suitably qualified persons such as the fire safety equipment, fire alarms, electrical appliances and electrical wiring. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water and the water temperature was checked. First floor windows had restrictors so people could not fall or jump out. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. The staff were trained in fire safety and the alarms and emergency lighting were tested as required. There were contingency plans in place in the event of a fire or need to evacuate the premises. The provider used a contractor to check the water system for Legionella.

Staffing levels were provided on the assessed need of the support each person required. These staffing levels were organised on a rota so that individual staff were assigned to support people at specific times. For example, the rota included details of the support and times a person needed care and support alongside the name of the staff member who would be doing this. Staff told us the duty roster was well organised so each staff member knew what they were doing. The staff rotas, and, discussion with the registered manager, confirmed three staff were on duty when people were present in the home such as in the morning and evening. Night time staffing consisted of 'sleep in' staff who people could ask for assistance from when they needed it. People who lived at the home had been assessed as being able to do this as they were relatively able. Staff told us they considered there were enough staff to meet people's needs and to help them attend community events. Some people were funded to have one to one support with a staff member for specific activities.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff

to work with people in a care setting.

Medicines were safely managed. Records and medicines stocks showed people were supported to take their medicines as prescribed. The temperature of the medicines fridge was monitored. However, the air temperature of room where medicines were stored was not monitored. This was discussed with the registered manager who was unaware this needed to be done and confirmed this was would be implemented. We noted one person's medicine dosage had been amended by the GP via telephone conversation. There was a record of the telephone call but it did not give the name of the GP and there was no follow up written confirmation from the GP about this. The registered manager agreed this needed to be done. We have also referred to this in the Well-Led section regarding the maintenance of records.

Records and discussion with the registered manager showed people's needs were reviewed when changes occurred or incidents occurred. This involved communication and liaison with other health and social care professionals.

Good

Is the service effective?

Our findings

The staff and management had links with organisations and agencies regarding current legislation and guidance for providing effective care to people. This included receiving updates from organisations such as the British Institute for Learning Disabilities (BILD) and Learning Disability England. There were good links with the local authority for learning and discussion about the care of people. The provider had a national team which updated staff and managers on care procedures. The provider also followed guidance regarding the Equality Act which staff were trained in. This included training in supporting people's rights to have personal and sexual relationships.

Staff had the skills and knowledge to provide effective care. People and their relatives said staff supported them well. For example, one person's relative said, "The staff are universally brilliant." The same relative said the staff worked well with them to ensure care needs were met.

Staff told us they received training which equipped them to carry out their role. For example, staff said they felt supported and that they could suggest training courses to enhance their skills which they were then able to attend. Newly appointed staff completed an induction which included enrolment on the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Staff confirmed the induction prepared them for their role. The induction involved an assessment of the staff member's competency to work unsupervised. People were involved in giving feedback on the performance of each staff member following their induction and on an ongoing basis. This reflected a service which was open, transparent and valued what people said.

Training was a combination of online and face to face classroom style courses. Staff completed training in subjects considered mandatory to their role. These included health and safety, moving and handling, safeguarding procedures, the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), dementia care and infection control. Staff who handled medicines completed training in this which involved an observational assessment of their competency to do this safely. Staff were supported to complete nationally recognised qualifications in care such as the National Vocational Qualification (NVQ) or Diploma in Health and Social Care at levels 2 and above. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The registered manger was qualified in the Diploma level 5 in leadership and management and the deputy manager was completing this course. Staff told us there were weekly discussions about relevant topics and one staff member said this had recently included sexuality and people.

Staff received regular supervision and appraisal of their work. Supervisors were trained in staff supervision. Records of staff supervision were maintained. There was an open culture where staff said they were comfortable raising any concerns of questions.

People were supported to eat and drink enough, and to have a balanced diet. People said there was a

choice of food and that they were consulted about meals at the weekly house meetings. Meals were planned and people had opportunities to help prepare food to develop their cooking skills. People's nutritional needs were assessed and recorded. People's weight was monitored to check they were not losing or gaining too much weight. Specialist diets were catered for. The registered manager said recent changes had been made regarding meals. People now ate with people and staff from the next-door home also run by L'Arche, which helped create a sense of community. We took part in the main lunch time meal. People were able to eat independently and the meal was healthy and nutritious.

Each person's care records showed there was a comprehensive assessment of health care needs. These demonstrated people's eyesight, teeth, hearing and foot care were regularly checked by health care professionals. Where people had specific health care needs these were recorded and included details of how staff should manage conditions such as asthma and mental health conditions. More specialist health care assessments were arranged where needed, such as, with a dietitian, gastroenterologist and psychiatrist. People confirmed they were supported by staff to attend health care appointments.

Each person had their own bedroom with their own personal belongings. People told us they were involved in discussions about the environment such as when redecoration was planned so their views were taken account of. There was ample living space in a ground floor lounge and in the kitchen and dining area. People also had access to gardens at the front and rear of the home. One part of the garden was used to grow vegetables which people were involved in with staff support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's records showed they were fully involved in decisions about their care and had agreed to their care plan. Staff received training in the MCA and had a good understanding of the principles of the legislation. There were no people who were subject to a DoLS authorisation. A DoLS application had been made for each person. The registered manger said they followed the advice of the relevant local authority when making a DoLS application. We noted the provider had made an application for one person to be on a DoLS but had not completed a capacity assessment. The registered manager said this was advised by the relevant DoLS team. The registered manager and Care Coordinator described in detail their assessment and the reasons why they had made an application for a DoLS. This was not recorded and is referred to in the Well-Led section of this report where we have made a recommendation regarding records.

Good

Is the service caring?

Our findings

People were supported by kind and friendly staff in family type environment. People confirmed they got on well with staff. For example, one person said, "The staff are quite nice and friendly. We get on well and like a family in this community." Another person said staff were "kind and gentle." Staff also described the service as having a friendly, family ethos. For example, one staff member said, "Everyone is close. There are good bonds, like a big family. People are treated as family members. We listen to what they want." We observed people and staff got on well together. People were comfortable approaching and talking to staff. There was a good rapport between people and staff with lots of joking and laughter. We observed staff had a good knowledge of people and how to communicate with them.

The philosophy of the provider emphasised valuing 'the gifts that each individual brings to others.' The provider told us in their PIR that this approach 'fostered a culture of compassion, commitment and concern for the people we support.' These values were evident during the inspection of the service.

Care records showed people were fully consulted about their care and that their views and preferences were reflected in how they were supported. The care records were individualised and showed person centred care was provided. Each person had a keyworker who was a named staff member with a main responsibility for coordinating their care. People confirmed they had regular meetings with their keyworker when they could discuss any issues they had. Records of these meetings were maintained. The care records showed people were supported in a way which promoted their independence. For example, care plans gave details of the way staff should support people with their personal care so that their independence was maintained. People were also supported to develop life skills and independence by college courses, employment and in tasks within the home. Emotional and psychological needs were assessed and care plans gave details of how staff should support people when their mood or behaviour changed.

People had their own bedroom which promoted their privacy. Each bedroom door had a lock so people could be private and secure. A relative said they could visit when they wanted and were always made to feel welcome.

Good

Is the service responsive?

Our findings

People received responsive and person-centred care. Each person's needs were comprehensively assessed with the person. Regular reviews took place, which involved people and their relatives if appropriate. People had signed their care plans to agree the contents. The care plans reflected the person's needs and preferences such as daily routines and personal care; they were well recorded and showed attention to detail so staff had guidance on how to support people. There was a life story for each person so staff knew people's background.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. Details about people's communication needs were included in the care plans so staff knew how to find out how people wished to be supported. We observed staff knew the best way to communicate with people. Staff were also trained in communication with people who had a learning disability. The care plans and assessments were written in a format for easier understanding by the use of pictorial prompts. Equipment and notices in the home to assist people in their daily lives were provided in a format which they could use and understand.

People's social, recreational, occupational and educational needs were assessed. Arrangements were made for people to be supported with these based on their needs and preferences. People accessed community facilities such as local churches, cafes, pubs and restaurants. People said they were involved in domestic activities in the home such as cleaning and cooking. The service excelled in promoting people to have meaningful activities especially work and education. People attended college courses and attained qualifications such as in food hygiene, literacy, speaking, life skills and catering. The service had a gardening project and day centre which was also used by other people who lived in L'Arche facilities. People said they enjoyed growing vegetables, which staff supported them to do. People were supported by staff to have holidays which were partly or wholly funded by the provider.

People said they were able to raise any concerns or issues they had at the regular house meetings or with their keyworker at the monthly keyworker meetings. A relative also said there was a good dialogue with the staff and registered manager and that they were able to make suggestions as part of a joint discussions, which were then acted on. The provider had a complaints procedure, which was available in an easy read format for people. There have been no formal complaints made to the provider in the last 12 months.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of 31 January 2017, we found the provider had not always notified the Care Quality Commission of incidents such as injuries to people. We made a requirement notice for this. The provider sent us an action plan of how this was to be addressed. Since the last inspection the provider has notified us of incidents which we needed to be informed of. We judged this requirement was now met.
Some records needed to be improved as they did not reflect the actions taken by the staff. Where a GP had changed a person's medicine dosage via a telephone conversation the name of the GP was not recorded. Follow up written confirmation of the change had not been obtained from the GP. The registered manager carried out an audit of medicines, but did not record this. Where a decision to apply for a DoLS for one person was taken this was not recorded nor the reasons for the application. These omissions in recording were limited to these examples and we judged this was therefore not a breach of our regulations. However, we recommend the provider ensures these records are updated. The registered manager and Care Coordinator recognised these details needed to be recorded and committed to do this.
Care plan records were of a good standard with comprehensive details of people's support needs. Records were well maintained and secure. The provider was aware of the need to protect information on both staff and people and of the requirements of the General Data Protection Regulation (GDPR), which was effective from 25 May 2018. The provider had a staff member who had responsibility for ensuring the organisation complied with the GDPR guidance.

The culture of the service, and of the provider, was inclusive of staff, people and their relatives, who were involved in the daily running of the service and in decision making. People were involved in the staff recruitment process and gave feedback on staff performance. There were house meetings and keyworker meetings where people could give their views and contribute to decisions about the home and their daily life. Records of these meetings were maintained. The provider also involved people at a core members' council which is an advocacy group and a representative of this group also attended a national council meeting, where issues about care provision were discussed.

The views of people, their relatives and health and social care professionals were sought by a survey questionnaire. The results of these were summarised so the provider could see if any improvements needed to be made. The feedback in the survey questionnaires showed people and their families were satisfied with the standard of care. A relative told us they were able to talk to the staff and registered manager who listened and acted on what they said. This relative said of the registered manager and deputy manager, "Ana is totally brilliant, as is the deputy."

Staff demonstrated they knew the provider's philosophy of valuing people, of compassion and ensuring people received person centred care with good outcomes. Staff said they were supported in their work. Staff said they had frequent contact with the registered manager who they described a approachable and supported the with any issue they had whether work related or of a more personal nature. The service had a deputy manager and system of senior staff to coordinate daily tasks. Management staff were supported to attain qualifications in leadership and management in social care.

The provider used a number of audit checks on the quality and safety of the service provision. These included a monthly report on any specific incidents, health and safety, people's finances, staff supervision and appraisals and reviews of people's care.

There were good links with local and national organisations such as the local authority who monitored the service provision. Staff skills and knowledge were enhanced by access to training and guidance from external organisations. The staff and registered manger worked well with other agencies regarding meeting people's health care needs.