

L'Arche

# L'Arche Kent The Rainbow

## Inspection report

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### Ratings

<b>Overall rating for this service</b>	<b>Requires improvement</b> 
Is the service safe?	<b>Requires improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires improvement</b> 

### Overall summary

The inspection was carried out on 23 and 24 November 2015 and was unannounced. At the previous inspection in October 2013, we found that there were no breaches of legal requirements.

L'Arche Kent The Rainbow provides accommodation and personal care for up to six adults with a learning disability and there were five people living there at the time of the inspection. The philosophy of L'Arche is that people with disabilities live in a community. Therefore, some staff members also live in the home. The accommodation is

over two floors, with one bedroom on the ground floor and the other bedrooms on the first floor. There are two communal lounges, a dining room and a garden to the rear of the home. .

The home was run by 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. However, the locality leader and not the registered

# Summary of findings

manager were in day to day charge of the home. The locality leader was present at the home on a daily basis, organised staff rotas and training and was available to people who used the service and their relatives. The locality leader was responsible for managing the service and also part of the companies supported living scheme.

Assessments of risks to people's safety and welfare had been carried out. However, some aspects of a persons' daily life, such as the risks when they were out in the community, or swimming, had not been reviewed to ensure they contained up to date guidance for staff. There were clear guidelines in place for staff to follow for people whose behaviours may challenge themselves or other people. However, one of these guidelines directed to staff to lift a person off the floor which is potentially dangerous to the person and staff involved and against the person's wishes.

Quality assurance systems were not effective. Shortfalls in risk assessments and had not been identified and action had not been taken to address shortfalls in care records which had been identified six months ago. The service was not proactive in gaining the views of relatives and stakeholders of the service. This meant that there was not a culture of continuous improvement in the home.

The home was managed on a day to day basis by a person who was not registered with the Commission to do so. The registered manager was office based, acted as a senior manager and only visited the home every two weeks. We have made a recommendation in relation to the day to day management of the service.

Health and safety checks were effective in ensuring that the environment was safe and that equipment was in good working order. The service carried out regular fire drills and checks of firefighting equipment to ensure it was in good working order. However, visitors to the home did not always sign the visitors book, and no visitors signed the book when they left the home. Therefore, there would not be accurate records of who was in the home in the event of a fire.

Medicines were managed appropriately and staff received medicines training yearly. An area to consider for improvement is for staff to have their competency in giving medicines checked on a regular basis by staff who have received training in how to do so, in addition to yearly medication training.

Clear and comprehensive guidance was in place for staff about how to recognise and respond to abuse and staff knew how to put it into practice. Accidents and incidents were recorded and any learning from these events had been incorporated into people's assessments of risk, in order to help keep them safe.

People's health and dietary needs had been assessed and clear guidance was in place for staff to follow, to ensure that their specific health care needs were met. Staff were knowledgeable about people's health care and dietary needs and the service liaised with a number of health professionals as appropriate.

Comprehensive checks were carried out on all staff at the home, to ensure that they were fit and suitable for their role. Staffing levels were flexible and reflected people's assessed needs.

New staff received a comprehensive induction, which included shadowing more senior staff. Staff were trained in areas necessary to their roles and staff had completed some additional specialist training to make sure that they had the right knowledge and skills to meet people's needs effectively.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Staff showed that they understood their responsibilities under the Mental Capacity Act 2005. DoLS applications had been made for people who lived in the home to ensure that people were not deprived of their liberty unnecessarily.

Good positive relationships had developed with staff who treated people with kindness and compassion. Relatives were extremely positive about the kind, caring and supportive relationships that had developed between staff and people. Visiting professionals commented on the calm atmosphere in the home and enjoyed spending time at the service. Staff communicated with people using a variety of different methods to help them understand and respond to people's individual needs and choices. People led active, busy lives and were fully involved in community life with L'Arche and the wider community.

Relatives said they had no complaints and would recommend the service as it integrated people into life in the L'Arche and wider community. Professionals said they enjoyed spending time at the home as it was calm and

# Summary of findings

peaceful and one professional said they would place a relative at the home if they needed the care the service provided. Staff were aware of the aims and values of the service to treat people who used the service as equals.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Potential risks to people's safety and welfare had not always been assessed and monitored.

Comprehensive checks were carried out on staff before they started to work at the home and staffing was flexible to meet people's assessed needs.

Staff were trained in how to administer medicines safely, but their competency in this area had not been regularly checked.

Requires improvement



### Is the service effective?

The service was effective.

People's health care needs were assessed and they had access to healthcare professionals when needed.

People's dietary needs were taken into consideration when providing people with meals. Meal times were managed effectively to make sure that people had an enjoyable experience and were as independent as possible.

Staff were trained to ensure that they had the skills and knowledge to meet people's individual needs. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and how to act in people's best interests.

Good



### Is the service caring?

The service was caring.

Staff knew people well and communicated with them in a kind and relaxed manner.

Good supportive relationships had been developed between the staff and people who lived in the home. Some staff and people lived together and shared their lives on a daily basis.

People were supported to maintain their dignity and privacy and were treated as equals with staff members.

Good



### Is the service responsive?

The service was responsive.

Staff were knowledgeable about people's support needs, interests and preferences, in order to provide personalised care.

People were offered a range of diverse and individual activities in the home and the local and wider community and had many opportunities to take part in community life.

Good



# Summary of findings

Relatives said if they raised a concern, that they were listened to and their comments were acted on.

## Is the service well-led?

The service was not always well-led.

Quality assurance and monitoring systems were not robust as they had not identified some shortfalls. Where the service had identified shortfalls, there was a delay in responding to them.

The registered manager was not in day to day control of the service. The locality manager managed the service and led by example.

Staff were aware of the aims and values of the service and put them into practice.

**Requires improvement**



# L'Arche Kent The Rainbow

## 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 checked 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 over two days, on 23 and 24 November 2015 and was unannounced. One inspector carried out the inspection.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR within the set time scale. Before the inspection, we looked at information about the registration of the agency and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

People varied in their ability to tell us about their experience of living in the home. Some people were able to talk to us and other people had limited verbal

communicated and/or communicated by Makaton. Makaton is a language programme using signs and symbols to help people to communicate. We talked with five people, joined some people for breakfast, and observed staff helping people throughout the day, including preparing food and drink. We spoke to the locality leader, deputy locality manager four staff, and a director of L'Arche. We spoke with staff about the care needs of two people who lived at the home, spoke with these people, looked at their care plans and observed how staff supported them. This was to track how people's care was planned and delivered.

During the inspection we spoke with an aromatherapist who was a regular visitor to the home. After the inspection we received feedback from a physiotherapist, and a representative from the local authority who commissions services at the home. We spoke with the relatives of three people who live in the home and one person's foster carer who remains actively involved in their life.

During the inspection we viewed a number of records including three care plans, three staff recruitment records, the staff training programme, staff rota, medicine records, environment and health and safety records, risk assessments, menus and audits and safeguarding, whistle blowing, disciplinary, medicines and complaints policies.

# Is the service safe?

## Our findings

Relatives told us that The Rainbow was a safe place to live. One relative told us, “He is safe. We are 100 per cent happy that is why we placed him there.” another said, “She is very happy living there and that makes us happy. She is safe and well looked after”. Relatives all commented on the staff changes at the home. Comments included, “Staff are great but I never know who I am going to see. New staff affects my relative, but only for a day or two, as if they are nice, they get along ok”. “Staff are always changing. The whole staff team has recently changed, but my relative takes it on the chin. Sometimes it is an advantage as my relative likes new faces, but at other times when they make friends it is a sad for them when they leave”; “Staff changes a lot. We were concerned about this, but it has not affected him at all although he is not good with changes”.

Risks to people’s personal safety and in their home environment had been assessed. However, this did not include an assessment of whether it was safe for one person to keep a prescribed cream in their own room. There was a potential risk that this person may use the cream inappropriately and may suffer harm as a result. [MS1]Each potential risk was identified together with the appropriate action that staff needed to take. This included potential risks when people were undertaking household activities, personal care, when they were out in the community and in relation to their health. For people who may require support with their mobility, detailed guidance was in place identifying the specific equipment and steps that staff needed to take to keep them and the person safe. However, risk assessment were not all regularly reviewed to ensure they were up to date. For one person who had a specific health care need, assessments of risk in relation to when they were out in the community and also travelling by taxi had not been reviewed since October 2014 and in relation to the risks when they were swimming had not been reviewed since February 2013. Therefore, it could not be assured they contained accurate guidance to staff to keep people safe.

For people whose behaviour challenged themselves or others, a behavioural support plan was in place. This set out what the behaviours were; in which situations they were more likely to occur; what to do to minimise the occurrence; and how staff should appropriately respond to the behaviour. For one person, their support plan was

dated August 2015 and a referral had been to the psychology team to gain further guidance for staff and support for the person. However, for another person, their support plan was not dated so it was not clear when it had been devised or if it had been reviewed. The guidance stated that the person may lie on the floor and refuse to move when they were either inside their home or out in the community. The advice was that staff should ask another member of staff to help them lift them, which is potentially unsafe for the person and staff involved.

This lack of monitoring of risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The inspector was not asked to sign the visitor’s book on either of the two days that they visited the service. The locality manager showed the inspector the visitors book, but it did not contain the names of the professionals who had visited the home on one of the days of the inspection. There was only space in the visitors book to date and record the time when the person entered the home, and not when they left the home. Therefore, staff would not be aware who was in the home in the event of a fire staff.

This lack of effective systems to know which people were in the home in the event of a fire was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

An external audit of medicines management in the home had been undertaken prior to our inspection visit. A number of recommendations had been made including staff receiving refresher training in the administration of medicines on an annual basis and their competency being checked by senior staff. Staff had all been informed about the need to redo on-line training in the administration of medicines and the majority of staff had undertaken this training. However, although the locality manager often worked alongside staff and observed them giving medicines to people, their competency had not been formally checked and recorded by a member of staff who had been trained in how to do so. This is an area for improvement.

The service had a medicines policy which set out the services roles and responsibilities with regards to ordering, storing and administering medicines. Staff training in how to administer medicines consisted of on-line training and practical training from more experienced staff. Information

## Is the service safe?

about what each person's medicines were for was contained in each person's health action plan. Medication administration records (MAR) were clearly and accurately completed to show that people had been given their medicines as prescribed by their doctor. Where people had been prescribed pain relief which needed to be taken 'when required' (PRN), staff recorded the reason that the medication had been given.

The service had a safeguarding policy which set out the different types of abuse and the signs to look for to indicate that abuse could have taken place. The safeguarding policy indicated that staff should also refer to the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway', and the service had a copy. The Multi-agency policy contains guidance for staff and managers on how to protect and act on any allegations of abuse. Staff demonstrated they knew how to recognise different forms of abuse and that they knew people well. They said they would raise a concern to the locality manager if a person presented any behaviour that was unusual, so that the cause could be investigated further. The phone numbers for people's care managers who worked for the local authority were available to staff, so there would be no delay in reporting any serious concerns and so keep people safe. Staff also demonstrated that they knew how to "blow the whistle". This is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

Staff knew to report and record any accidents or incidents to the locality manager. Accidents were recorded together with the any action that was taken as a result of the event. The locality manager reported these events to the registered manager who in turn shared them with the company directors and governing committee to check for patterns and trends to address and learn from any mistakes. When an incident had taken place, the person's risk assessment had been updated and feedback had been given to staff about what they needed to do to minimise the risk of a similar incident occurring. The service had a continuity plan in place which set out how the service would continue to support people if they were affected by a short term disaster or loss of their home. There was a grab file containing important information about people's support needs, so that staff would be able to continue to support people if they had to move out of their home.

A nominated person responsible for health and safety carried out monthly health and safety checks of the environment undertaking visual checks of all areas inside and outside the home. These checks were then signed off by the locality leader. There were effective systems in place for ensuring that electrical and gas appliances at the home were safe and that the home took action to prevent Legionella. Checks on fire prevention and firefighting equipment were made to ensure it was in good working order, and regular fire drills were undertaken so staff and people knew what action to take in the event of a fire. Each person had a personal emergency evacuation plan (PEEP), which set out their specific physical and emotional requirements to ensure that they were safely evacuated from the home in the event of a fire.

Potential staff completed an application form which asked them to record information about their skills, experience, qualifications and past employment history, including any gaps in their employment. Applicants attended an interview and a record of this was kept at head office. If an applicant was successful identification checks, right to work in the UK, a Disclosure and Barring Service (DBS) check was undertaken and references were requested. A DBS identifies if prospective staff had a criminal record or were barred from working with children or vulnerable people. All these actions helped to ensure that only people who had been assessed as suitable, were employed to support people living at the home.

The staff rota for the service was arranged around people's individual care and support needs. One person liked to go to bed early and rise early in the morning. Therefore, one staff member was available to support this person from 6.30am with their personal care needs. Other staff were available at 8am and/or 9am depending on whether people needed support to get out early to activities. The rota was flexible so that it was arranged around people's needs. There were a minimum of two staff on duty during the day, which rose to three staff if people took part in a lot of different activities. On a Sunday there were usually more staff available so people could be supported to attend the particular place of worship of their choice. The locality manager said that they liked more staff to be around on a Sunday as this was a special day for the L'Arche community, so that many people could come together.

# Is the service effective?

## Our findings

When people were asked if staff looked after them in the right way, people responded that they did. People's relatives said that they always let them know if there were any changes in people's health or well-being. One person told us that the service had helped their relative lose weight which had improved their health. Another person told us of the extra support that staff gave their relative when they were admitted to hospital. "Staff took turns to sit with them in hospital during the day and at night time. L'Arche fought to make sure they came back to their own home and did not go to another home".

People's care plans gave written guidance about people's health needs and medical history. These were detailed and included information about people's medical conditions and what support they required from staff and other professionals to maintain their well-being. For one person there were photographs which identified to the person and staff, what physical movements they should avoid to keep themselves healthy. For people who had a history of epilepsy, there was clear guidance about how to recognise a seizure, and the specific action to take when and after they had a seizure. In addition each person had a "Health Action Plan" which focused on their health needs and the action that had been taken to assess and monitor them. This included details of people's skin care, eye care, dental care, foot care and specific medical needs. On the day of the inspection staff supported a person to attend a health care appointment and they took this health plan with them. Therefore, Health Action Plans were used as they were intended, to inform other health care professionals about people's health care needs.

A record was made of all health care appointments such as with the dentist, chiropodist, optician, speech and language therapist and physiotherapist. This included why the person needed the visit and any professional advice that was given. One person received physiotherapy support and their care plan stated that staff should prompt them to complete these exercises. A written description of these exercises was not available on the day of the inspection, and on the second day of the inspection, the locality manager confirmed that this had been requested. People had "Hospital Passports, which provided the hospital with important information about the person and their health if they should need to be admitted to hospital.

People's need in relation to food and fluids were assessed and the support they required was detailed in their plan of care. Some people required assistance to maintain a low calorie diet and other people required assistance to maintain a high calorie diet. Advice had been sought from a dietician and diet sheets had been developed. For people with a low calorie diet, photographs of the appropriate foods they could choose throughout the day were discretely available to them in the kitchen. For people who required a high calorie diet, fortified foods were used as appropriate and diet sheets included pictures of the variety of high calorie snacks they should be offered throughout the day. A record of the food that people ate together with the amount they ate was kept in their daily diary, so that their food intake could be monitored. People's weights were recorded so that prompt action could be taken to address any significant weight loss or gain.

Meal times were important social occasions at the home where staff and people came together to join in one another's company. At breakfast there was calm and relaxed atmosphere during breakfast interspersed with a lot of talking, signing and laughter, and staff let people eat at their own pace. People were encouraged to choose what they wanted to eat and to prepare their own food. Staff gave simple instructions to people such as, "You switch it on here", and "The sugar is in the pantry" and then stood back so that people could do as much as they could for themselves. Each person was allocated a day a week to cook and on this day they chose what they wanted to eat. Although the menu was not prepared in advance, it showed that people ate a balanced diet through eating a variety of home cooked, different meals.

Relatives said that staff had the right skills and experience to care for people. They said that there were lots of new staff from different countries of origin. They said these staff had been trained and were supported by lots of experienced staff. One person told us, "There are lots of young staff around who have a lot of energy, which is good for him".

New staff completed an induction during a three month probation period. The induction included completing a work book covering the standards recommended by Skills for Care Common Induction Standards (CIS). CIS are the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised. The human resources manager was

## Is the service effective?

introducing the new care certificate for all staff as recommended by Skills for Care. Staff completed on-line training and/or face to face training during their induction period and shadowed more senior staff until they were signed off as competent by the locality leader. New staff said that they felt their induction gave them the skills and knowledge that they required to work alone.

There was an ongoing programme of training for staff which included face to face training and on-line training. These included health and safety, fire awareness, emergency first aid, safeguarding and food hygiene. Staff completed work books or answered questions and took tests to check their knowledge. Staff training was arranged and tracked by head office so they were aware of any training that needed to be completed or refreshed for each member of staff. Specialist training had been provided to staff in a variety of areas such as supporting people with behaviours that challenge, dementia, malnutrition, end of life care, stress and self-care, gentle teaching and spirituality for people with disabilities. Six out of eleven staff had completed Diploma/Qualification and Credit Framework (QCF) levels two or above in Health and Social Care. To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard.

Staff said that they felt well supported by one another and they could approach the locality leader to discuss any issues or concerns. Staff meetings were held each month where the locality leader shared information with staff team, in addition to discussing the wellbeing of each person who lived in the home. Staff were supported by regular formal supervisions with the locality manager where they discussed their practice and any concerns they may have. The locality leader had identified that staff were due an annual appraisal and had started to book them for the whole staff team. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

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 the best interests and as least restrictive as possible. Most staff had received training in the MCA and understood that everyone in the home had the capacity to make their own daily choices and decisions. They explained that some people found it easier to make a decision for themselves if they were offered a limited number of options; and that some people made their choices known by signs, facial expression or by their body language, rather than verbally.

The home had policies and procedures in place in relation to the MCA and protocols in place for arranging best interest meetings and advocacy. An advocate is an independent person who helps people to express their needs and wishes, and to weigh information and take decisions about the options available to people. Best interest meetings had been held in relation to the use of bed rails to keep a person safe and also with regards to receiving medical treatment under sedation. A social care professional told us they had attended a best interest meeting at the home. They said the meeting was well managed and the person was well supported by the staff team.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. (DoLS) concern decisions about depriving people of their liberty, so that they can be given the care and treatment they need, where there is no less restrictive way of achieving this. Some people were constantly supervised by staff to keep them safe. Because of this, applications had been applied to local authorities to grant DoLS authorisations. The applications were being considered and checked to ensure that this constant supervision was lawful.

# Is the service caring?

## Our findings

Relatives were all extremely positive about the caring atmosphere that the staff team had created in the home. They said that as people and staff lived together at Rainbow House, eating together and taking part in activities, that positive, caring relationships had developed between them. Comments included, "I am in and out frequently so I can see that staff certainly do care"; "It is very good, very caring and considerate"; and, "There is laughter and joy at the home". Relatives said that the ethos of L'Arche was good and helped to ensure that a caring and supportive environment was promoted at the service. "The ethos of L'Arche is good. It provides a kind and easy life", one relative told us. Everyone agreed that they were involved in their relatives care and were encouraged to visit at specific events provided by the service, such 'family and friends day' and the Advent service.

Relatives said that staff always treated people with dignity, compassion and kindness. They said staff respected their privacy and involved them in decisions about their care. Comments included, "It is inclusive. They discuss everything with my relative"; "Staff are considerate of my relatives dignity and always gentle with them"; and "Staff take their time with my relative. They are relaxed with them and do not rush". One person told us about a person who lived at the home, "When they return to the home, when they have been with me, they are happy and excited to go back, which is a good sign".

Professionals commented on the calm home environment. They said that there was lots of laughter, no disputes between people, that staff were very positive and friendly with people. One professional said they would like to just be able to sit in the home, as it had a calming influence. Another professional said that if they a relative who needed the type of care provided at Rainbow House, that they would be happy for them to live there.

Staff spoke with people and each other, with gentleness and kindness. The atmosphere in the home was calm and relaxed. Staff responded appropriately to people's verbal, signed and non-verbal requests. They communicated with people in a way they could understand and were patient, giving people time to make their needs known. A variety of different communication methods were used within the home. Staff communicated with some people with words and other people with words and Makaton. Some people

had their own individual sings to express themselves and staff understood what these signs meant. Symbols, photographs and pictures were also used to communicate with people. For example, the minutes of meetings were written in the same symbol format that was used throughout L'Arche. Photographs and pictures were used to inform people of their household responsibilities and of activities and tasks they had undertaken.

The home service was proactive in making sure that staff developed the skills they needed to effectively communicate with people. On the day of the inspection two staff representing the home, attended the local special needs school to learn more about how to use a computerised version of a symbols communication programme the service had purchased. The service had also contacted a speech and language therapist to obtain an iPad for one person who had limited verbal communication. This professional delivered the iPad on the day of the inspection and it enabled the person to make their needs known by referring to pictures and symbols on the device.

A specific tool was being used by the service to help staff identify when people, who had limited communication, were in pain. Each member of staff completed a series of questions about a person's body posture and facial expressions and vocal sounds when they were distressed on in pain. Then all the information was collated produce a detailed picture of how the person expressed their distress, so that staff could respond appropriately.

For people who had difficulties in building relationships with other people, a circle of support had been developed for them. This involved identifying people who could visit the person on a regular basis, take them to activities and build their social links. People were encouraged to develop and maintain friendships with people who were important to them. For example, one person had maintained contact with a member of staff who used to work at the service and visited them regularly. An ex-member of staff also visited the home socially, to continue the friendships they had developed with people whilst supporting them.

Each person's contributions were valued, their individuality and diversity was nurtured and each person was treated with equal respect and warmth. For example, when supporting a person with their breakfast, a member of staff commented on their appearance and said and singed that they were 'beautiful'. One person asked staff a lot of

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questions in succession. Staff were patient and answered the person, although they had answered some of the questions previously. At the same time, staff also involved another person in the conversation through use of signs and simple words. One person said they wanted to show a member of staff something and then went upstairs. The member of staff immediately responded by following the person as they understood the importance for this person that they saw what they wanted to show them. People's religious, ethnic and cultural needs were taken into account. People were involved in the local and wider community and were supported to attend churches of different denominations. Some people attended a group made up of people with learning disabilities, people with no disability and volunteers to explore their spirituality together.

People's private space was respected. There was a day to day practice of knocking on people's doors or asking permission before entering rooms. People were given the option of having a key to their bedroom so they could lock their door.

Advocacy services and independent mental capacity advocates (IMCA) were available to people if they were

required. An advocate is someone who supports a person to make sure their views are heard and their rights upheld. They will sometimes support people to speak for themselves and sometimes speak on their behalf.

People's ability to express their views and make decisions about their care varied. To make sure that all staff were aware of people's views and opinions these, together with their past history, were recorded in people's care plans. This enabled staff to understand people's character, interests and abilities if they were not able to verbalise them and so help to support people to make decisions in their best interests, on a day to day basis. People were involved as much as possible in records about their daily care. When staff were writing the daily notes for one person, they asked the person concerned what they should write. When another person picked up their daily notes to look at them, a member of staff read it to them, to help them understand its content. Each day staff recorded what people had done and how they were feeling and involved people as much as possible in contributing towards this record.

# Is the service responsive?

## Our findings

One person told us that they had been to the cinema and were looking forward to going shopping today. They said they were practicing a routine for the annual Advent service, which members of their family were coming to watch. Another person told us they liked to spend time in their room listening to music, but they also had someone visit them to help them with their painting. Relatives said that people were given opportunities to take part in a wide range of activities and social events. “Staff have picked up on things s/he likes to do, such as swimming, which is great”, one relative told us. Another relative said, “I am looking forward to the Advent service. You get to meet other people’s families and catch up. It is always enjoyable, even when it does not go to plan!”

People had active lives that involved activities at home, in the L’Arche community and the local community. On both days of our inspection people were out for parts of the day and undertook activities. Activities on offer included dancing, football, singing, sewing and swimming. Some people were involved in a gardening project in which they helped grow plants which were sold to the public in Canterbury. In addition people were involved in everyday household activities and cooking. Each person had a specific responsibility such as washing up, recycling and watering the plants. People were encouraged to attend activities, but on the day of the inspection, one person had decided not to take part in their planned activity and their decision was respected. The service was supported by a number of volunteers who escorted people to their activities and place of worship and took people out shopping and to a local café.

People had been on individual holidays, such as to Scotland, Liverpool and Broadstairs. People had recently had the opportunity to go on holiday to the Greenbelt Festival. This is a festival of arts, faith and justice attended by many thousands of Christians and those from other faiths and none. There was a notice on the kitchen wall with details about a Thanksgiving service and a list was being made of all the people that people who lived at the home wanted to invite.

Relatives said they did not have any complaints about the service. One person told us, “All staff are very helpful and would put me in the right direction if I need to make a complaint”. They said when they had raised concerns in the

past, they had been responded to. One relative told us, “When I bring things up, I am listened to and they try to deal with them”; another relative told us, “They have always been open if anything has gone wrong”. Relatives said that they had good communication with the staff team and would contact them or a representative of L’Arche if they had a concern.

The complaints policy was comprehensive and stated that people could make a complaint verbally or in writing. The complaints procedure was displayed in an easy read format in the home, explaining who at L’Arche would investigate and respond to complaints. There was a photograph of each person whom the person could speak to, to help people identify the right person. Staff said that if a concern was raised they would try and address it if they were able, but if they could not that they would inform the locality leader. People were encouraged to raise any concerns as they arose and were formally asked at monthly house meetings. There was a procedure in place to record any complaint that was made about the service, together with the action that had been taken to address it.

Care plans contained guidance for staff on how to meet people’s health, social, personal and individual needs. They included guidance about people’s communication, well-being, continence, eating and drinking, health, medication and activities that they enjoyed. They were clear and detailed guidance in place about each person’s morning, weekly and evening routines and associated preferences. Each care plan had a personal profile which contained important information about the person, such as what their strengths were, when they needed support and people who were important to them, including their family tree. It was the practice of the service that people’s care needs should be reviewed every three months and a written report produced about people’s progress. This includes an overview of what people have done their social and other activities and any changes in their health. One of the three care files that we looked at did not contain a recent review and this is a suggested area for improvement.

Care plans were written using pictures and photographs to help people to understand their content. For example, they contained a number of photographs showing the person undertaking activities that they enjoyed and took part in. For one person this included photographs of the person horse-riding, swimming, dancing and going to McDonalds

## Is the service responsive?

and the library. Staff had involved people in the development of their plan of care as much as they were able and had recorded their involvement, discussion or agreement with the plan as appropriate.

# Is the service well-led?

## Our findings

Relatives said that they would recommend the service to other people. One person told us, “I would recommend it as my relative gets so much extra care and one to one support”. Another person told us, “I am always telling people about L’Arche and recommended it to one person the other day. I couldn’t wish for better”. Relatives said the service was well led although they commented there had been a number of changes in staff. There was a mixed response when relatives were asked if they were asked for their views about the service. Some people thought they were asked and others that they were only occasionally asked. However, people said that they felt able to speak up if they had something they particularly wanted to say. One professional told us that all their experiences at the service had been positive and another professional told us that the service was well run.

The service did not have effective systems in place to monitor the quality of service that it provided. The registered manager carried out an audit in May 2015. This checked aspects of the service including staff records, care plans, staff rotas, cleaning rotas, menus and checks on equipment. The audit identified that there were some shortfalls in the service, such as with staff files and maintaining equipment and these had been addressed. However, there were long and detailed notes about aspects of peoples’ care and support guidelines that required to be updated and not all these had been addressed six months later.

In order to establish effective monitoring of the quality of the service, it is also important to obtain, assess, and act on the views of people, relatives, and stakeholders. The views of people who lived in the home were regularly sought through monthly house meetings and reviews. The audit in May 2015 identified that quality questionnaires had been sent to people’s representatives and that action had been taken as a response. However, there was no evidence available to confirm that relatives had been contacted. Only one of the three care files that we looked at contained a quality questionnaire. This was very positive about the service. The other quality questionnaires were dated 2012 and 2011 and therefore it was not possible to evaluate if this was their current view about the service. One questionnaire had been received by a friend of the service, but this person was related to a member of staff and

therefore could potentially be biased. The registered manager stated in the provider information return that four compliments had been received about the service, but these could not be located during or after the inspection. People and their representatives had not been given a summary of the results of the evaluation forms they had completed. Therefore, they had not been fully involved in the process and the service had not assured people what it was doing well, and any areas it had identified that needed improvement.

The registered manager had completed a provider information return before the inspection, which set out what the service was doing well and areas for improvement. However, the locality manager was not familiar with the content of this document and not aware of one of the areas in which the service intended to make improvements.

This lack of a fully robust quality monitoring process was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The director of the service had had a meeting with people and their friends to discuss what improvements they would like made to the building. Discussion included how people would like money spent on their home, such as making some people’s rooms bigger.

Although there was a registered manager in place, there was a lack of leadership at the service and this impacted on the care people received. People and staff said if they needed advise, support or information, they would contact the locality manager who was available and visible at the service. Relatives said they would contact any member of staff who worked at the service. The complaints procedure directed people to speak to the locality or deputy locality manager, before speaking to the registered manager. Staff and relatives confirmed that they did not usually see or speak to the registered manager. The registered manager did not work at the service, and was not in day to day contact with it. They were not involved in running the service, and their role involved providing a monitoring and oversight function. They were not based at the home, and worked from the L’Arche office in Canterbury. They were also registered as manager for two other L’Arche care homes and an additional supported living scheme. The Care Quality Commission guidance on the definition of a registered manager is that, “The registered manager should be in day-to-day charge of carrying on the regulated

## Is the service well-led?

activity or activities they apply to be registered for". The guidance goes on to say that although the regulations do not prevent a person from being registered to manage than one location, the manager must have the capacity to do so.

Staff were complimentary about the locality leader, who managed the service on a day to day basis. They said that although she managed the service, she was also very much part of the team. Staff said the locality manager was approachable and supportive and there was good communication in the staff team. The locality manager led by example. In their communication with the people they demonstrated they knew people well, and when they engaged them in conversation, they moved their body position to ensure they were at the same level to make communication easier. The locality leader had a positive and relaxed manner which contributed to the atmosphere in the home.

The aims, objectives and philosophy of the home were clear and available on the company website. They were that each individual with a disability has as much to give as

to receive; that people needed a sense of belonging to L'Arche, the wider community and beyond and that "We are a Community because we believe that we all – people with learning disabilities, assistants and Community friends – have need of one another". Staff clearly understood the aims and objectives of the service which we saw were put into practice on the days of our visits. Staff said that there was good communication in the staff team and there was a positive culture. They demonstrated that they enjoyed their jobs and supporting the people in their care. Staff understood their roles and knew what was expected of them. Live-in staff had two days free a week and worked a set amount of hours each day. Live-in staff said that it was their choice if they wanted to spend time with people who lived in the home on their time off, and they often chose to do so.

**We recommend that the service seeks the relevant guidance about the roles and responsibilities of a registered manager and takes action accordingly.**

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Assessment of potential risks to people's health and safety were not all reviewed to make sure that people were protected from the risk of harm.

Regulation 12 (1) (2) (a) (b)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Premises and equipment

In the event of a fire, staff could not be assured that they knew if any visitors needed evacuating as a record was not made when they entered and left the home.

Regulation 15 (1) (d) (e)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Good governance

The provider did not have an effective system in place to identify and take action to address shortfalls in the provision of the service, nor to seek and respond to the views of relatives and stakeholders.

Regulation 17 (1) (2) (a)

This section is primarily information for the provider

## Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.