L'Arche

L'Arche Bognor Regis Zacchaeus

Inspection report

36-37 Servite Close
Bognor Regis
West Sussex
PO21 2DE

Tel: 01243828532
Website: www.larche.org.uk

Date of inspection visit:
22 February 2016
24 February 2016

Date of publication:
12 April 2016

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 22 February and 24 February 2016. The inspection was unannounced.

L'Arche Bognor Regis Zacchaeus provides accommodation for persons who require personal care for up to five people with a learning disability or autism. At the time of our inspection there were four people living at the service. We refer to L'Arche Bognor Regis Zacchaeus as Zacchaeus House in the body of this report.

It is a condition of the provider's registration that a registered manager be in post at this location.. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered provider are also '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 registered manager had left in December 2015.
The provider had notified the Care Quality Commission of this and had started the process of correctly de-registering that person. The service was being managed day to day by a house leader, who was supported by a director. The director told us the registered manager position was being advertised and recruited for. Due to not having a registered manager in place at the time of our visit this has limited the "well led" domain to requires improvement. .

L'Arche originated in France in 1964 and is now an international movement that builds faith based communities with people with learning disabilities. Zacchaeus House is a large property, with bedrooms on the ground and first floors. There is one communal lounge and an open planned kitchen/diner. There is a garden to the rear of the service with an outdoor hut which is used for people to relax in and do activities. Zacchaeus House 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 Zacchaeus House 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 of the facilities.

Staff worked positively with community professionals such as learning disability nurses, psychologists and speech and language therapists to ensure that people's needs were met. Changes and recommendations by

professionals were clearly communicated to people who lived at Zacchaeus House in an easy to read format which helped them to understand the advice given.

People were protected against avoidable harm and abuse. Good systems were in place for reporting accidents and incidents and the service was responsive to people's individual needs.

Staff completed an induction course based on nationally recognised standards and spent time working with experienced staff before they were allowed to support people unsupervised. This ensured they had the appropriate knowledge and skills to support people effectively. Records showed that the provider's required staff training was up to date. This training was refreshed regularly to enable and ensure staff had retained and updated the skills and knowledge required to support people effectively. Staff told us that they felt supported and had received training to enable them to understand about the needs of the people they care for.

There were sufficient numbers of staff on duty to keep people safe and to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting was employed.

People received their medicines safely, administered by staff that had completed safe management of medicines training and had their competency assessed annually by the house leader. Staff were able to tell us about people's different medicines and why they were prescribed, together with any potential side effects.

People who used the service expressed satisfaction with their care and felt confident that staff understood their needs.
Staff were kind and caring. People who lived at the service were allocated key workers and we observed trusting friendships between people who lived in the service and staff members.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been submitted for three people in the service. All three applications were in the process of review and authorisation.

People were supported to maintain a healthy balanced diet through the provision of nutritious food and drink by staff who understood their dietary preferences. We observed communal mealtimes where people and staff ate together. Where people had been identified to be at risk of choking staff supported them discreetly to minimise such risks, while protecting them from harm and promoting their dignity

We looked at care records and found good standards of person centred care planning. Records showed that people who lived at the service were assessed against risk on an individual basis. Care plans represented people's needs, preferences and life stories to enable staff to fully understand people's needs and wishes. There were three incidences of risk assessments not being fully completed for falls, epilepsy and a caffeine addiction, however staff told us they knew how to support these individuals and were able to explain this in detail

People who lived at the service and staff were invited to weekly meetings. People were encouraged to engage in the running of the service and involvement was clearly a key principle of care at the service.

The service was responsive to people's individual needs. The good level of person centred care meant that people could lead independent lifestyles, maintain relationships and be fully involved in the local community.

The service had robust systems in place for monitoring the quality of care and support. The auditing systems showed that the house leader was responsive to the needs of people who lived at the service.

Some areas of the environment were tired looking and in need of refurbishment. The house leader showed us maintenance plans which detailed improvements to be made and these were on going. This included the décor of two hallways and two upstairs bathrooms.

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.

Identified risks associated with people's care were assessed and plans developed to mitigate such risks.

Staff had a good understanding of safeguarding. Staff knew what to look for and how to report any incidents both internally and externally.

Recruitment processes ensured staff were safe to work with people at risk and the provider had ensured appropriate staffing levels were in place to meet people's needs.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received training as required to ensure that they were able to meet people's needs effectively.

People were supported to maintain good health and had regular contact with health care professionals.

People had sufficient to eat and drink and were encouraged to eat a healthy diet.

The service had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures and staff were provided with training. The legislation was being followed to ensure people's consent was lawfully obtained and their rights protected.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took time to speak and listen to people. Staff acknowledged people's

privacy.

People were consulted about their care and had opportunities to maintain and develop their independence.

Is the service responsive?

Good

The service was responsive.

People received care which was personalised and responsive to their needs.

There were structured and meaningful activities for people .

Care plans identified the support people needed and their preferences were clearly recorded to ensure they received person-centred care.

People told us that any concerns raised with the service were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was well-led. However there was no registered manager in post at the time of our inspection which is a ratings limiter for this domain.

The provider sought the views of people, relatives, staff and professionals regarding the quality of the service and to check if improvements needed to be made.

There was an open culture at the service and staff told us they would not hesitate to raise any concerns.

There were a number of systems for checking and auditing the safety and quality of the service.

L'Arche Bognor Regis Zacchaeus

Detailed findings

Background to this inspection

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

This inspection took place on 22 February and 24 February 2016. The inspection was unannounced. One inspector undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.
We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law. We used all this information to decide which areas to focus on during the inspection.

We spoke with four people who lived at the service. Staff members helped the inspector to understand each person's communication abilities which enabled engagement with people who lived at the service. We observed a team meeting and how staff interacted with people who used the service. We spoke with three care staff, the deputy manager, the house leader and the director.

We viewed three people's care records, which included their daily notes, care plans and medication administration records (MAR). We also looked at a wide range of records including the personnel records of four staff members. We looked at the individual supervision records, appraisals and training certificates

within these files.
We looked at the provider's policies and procedures and other records relating to the management of the service, such as staff rotas between 08 February to 21 February 2016, health and safety audits, medicine management audits, infection control audits, emergency contingency plans and minutes of staff meetings.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The service was last inspected on 07 January 2014 when no concerns were identified.

Good

Our findings

People told us they were happy and content at Zacchaeus House, where they were supported by staff they could trust, who made them feel safe. One person told us, "The staff look after me," another person told us, "they listen to me when something is worrying me."

Staff had completed the provider's required safeguarding training and had access to guidance to help them identify abuse and respond appropriately if it occurred. Staff were able to explain their role and responsibility to protect people. The provider's training schedule and staff files confirmed that staff safeguarding training was up to date. Staff were aware of the provider's policies to protect people, and were able to describe the procedure to raise concerns internally and externally when required. Posters in the service reminded staff of their responsibility to protect people from abuse. People were protected from abuse because staff were trained and understood the actions required to keep people safe.

There had been seven incidents since our last inspection, which had been referred to the local safeguarding authority. These incidents had been reported, recorded and investigated in accordance with the provider's safeguarding policies and local authority guidance. The house leader had reviewed people's risk assessments and behaviour management plans and implemented changes to ensure people were safe and the risk of a future recurrence was reduced.
There were three incidents where the risk assessments lacked information around falls, epilepsy and caffeine addiction. The staff knew of these risks and knew how to keep people safe but this was not entirely reflected in the person's risk assessments. We brought this to the attention of the house leader at the time of our visit who rectified this before our visit concluded. The house leader showed evidence that they had also contacted the falls prevention team in West Sussex for additional support and advice. The house leader had also liaised with a social worker to ensure all was being done to mitigate risks relating to one person's health condition. In addition, the provider had arranged for staff to receive additional specific training in relation to understanding this person's medical condition. Other risks specific to each person had been identified, assessed, and actions taken to protect them. Risks to people had been assessed in relation to their mobility, social activities and eating and drinking. People's care plans noted what support, people needed to keep safe, for example in relation to safety awareness and completing activities, such as swimming and going out independently.. These risk assessments also detailed the required staffing ratio at different times and for specific activities to ensure the safety of people, staff and others.

Staff were able to demonstrate their knowledge of individual risk assessments and how they supported people in accordance with their risk management plans. For example one person when upset was at risk of

hurting others. The risk assessment detailed what the triggers could be, who was at risk, how to support the person safely and what known diversions to use to help de-escalate the behaviour. Another person was at risk of choking. They had an eating care plan and risk assessment which ensured food was cut up and the person was not left alone during meal times. We observed staff support this person safely in accordance with their risk assessments and care plans. Risks affecting people's health and welfare were understood and managed safely by staff.

If people displayed behaviours which may challenge, these were monitored and where required referred to health professionals. Guidance and advice provided was followed by staff. This ensured risks to people associated with their behaviours were managed safely. One person had a 'signalling plan' which gave clear details about how the person presented when they were relaxed, agitated and displaying behaviours which challenged. Each section detailed how staff should respond. During our inspection we observed sensitive interventions by staff that recognised triggers for behaviours which may challenge, ensuring that people's dignity and human rights were protected.

People could access their money at any time and were supported by staff to ensure they were not subject to financial abuse. During the inspection we observed staff supported people to manage their finances and protected them from the risk of financial abuse by adhering to the provider's recording processes. The finances had recently been audited by the house leader who had identified signature gaps which staff should have completed; this was raised in the team meeting as a concern and the policy for supporting people's finances was reinforced. The gaps identified by the house leader did not have an impact on the people living at the service but the audit had been used to improve this practice in future.

Equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electric safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Fire equipment such as emergency lighting, extinguishers and alarms, were tested regularly by the provider's maintenance engineer to ensure they were in good working order. We found, due to the age of the building that some areas of the environment were tired looking and in need of refurbishment. The house leader showed us maintenance plans which showed improvements to be made and these were on going. This included the décor of two hallways and two upstairs bathrooms.

Daily staffing needs were analysed by the house leader. This ensured there were always sufficient numbers of staff with the necessary experience and skills to support people safely. Staff told us there was always enough staff to respond immediately when people required support, which we observed in practice. If more staff were needed due to unforeseen circumstances, such as staff illness, they were provided from another service. The house leader told us wherever possible they used the same staff, which improved the consistency of care. Rotas confirmed there was always staff deployed in accordance with the staffing needs assessed to ensure there were sufficient staff to meet people's needs safely.

Staff had undergone pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicant's conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Prospective staff underwent a practical assessment and role related interview before being appointed. People were safe as they were cared for by sufficient staff whose suitability for their role had been assessed by the provider.

People received their medicines safely, administered by staff that had completed safe management of medicines training and had their competency assessed annually by the house leader. Staff told us about

people's different medicines and why they were prescribed, together with any potential side effects. People's preferred method of taking their medicines, and any risks associated with their medicines, were documented. We looked through everyone's medication administration records (MAR).They included a picture of each person, any known allergies and any special administration instructions. The MAR forms were appropriately completed and records confirmed that people received their medicines as prescribed. Where people took medicines 'As required' there was guidance for staff about their use. These are medicines which people take only when needed. The provider had a protocol in place for the safe use of homely remedies. These are 'over the counter' medicines to treat minor illnesses like headaches and colds.

Medicines were stored safely and securely. Temperatures of the storage facilities were checked and recorded daily to ensure that medicines were stored within specified limits to remain effective. Staff knew the temperature range within which the medicines people had prescribed remained effective. People's medicines were managed safely in accordance with current legislation and guidance.

Good

Our findings

People spoke positively about staff. People told us, "Staff are encouraging" "and "I can do the things I want." Another person told us, "There is nothing wrong with here."

Staff had completed an induction course based on nationally recognised standards and spent time working with experienced staff before they were allowed to support people unsupervised. This ensured they had the appropriate knowledge and skills to support people effectively. Staff told us their induction programme gave them the skills and confidence to carry out their role effectively. The house leader was in the process of linking the induction process to the new Care Certificate. The Care Certificate sets out learning outcomes, competencies and standards of care that care workers are expected to achieve nationally. New staff completed monthly support meetings with the house leader during their induction programme which was separate to their support and supervisions. These ensured they had received the appropriate training and preparation for working with people in the service.

Records showed that the provider's mandatory training for staff was up to date, including topics such as safeguarding people from abuse, moving and handling, health and safety, fire safety, food hygiene and infection control. This ensured staff understood how to meet people's support and care needs.
Training was refreshed regularly to enable staff to retain and update the skills and knowledge required to support people effectively. Where necessary the provider had enabled further staff training to meet the specific needs of the people they supported, including autism, learning disabilities, person centred planning, fluids and nutrition, communication and managing challenging behaviour.

Most staff had received an annual appraisal and the house leader had scheduled the remainder to be completed in the first quarter of 2016. All staff had received monthly support and supervisions. Supervision records identified staff concerns and aspirations, and briefly outlined any agreed action plans. Supervisions provided staff with the opportunity to communicate any problems and suggest ways in which the service could improve. Staff told us that the house leader, deputy manager and provider encouraged staff to speak with them and were willing to listen to their views. In addition to this, staff participated in an informal monthly meeting to discuss their wellbeing. Staff received effective supervision, appraisal, training and support to carry out their roles and responsibilities.

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. Records confirmed that staff had completed training in the MCA and staff demonstrated an understanding of the principles of the MCA and described how they supported people to make decisions.

We observed staff communicating with people using the methods detailed in their care plans. Staff were unhurried when talking with people, who were always given time to consider their decisions. People told us that staff always spoke with them to gain their consent before providing any care or support. It was clear from people's records that relatives and health and social care professionals involved them in all decisions relating to people's care and support.

People had a communication care plan, which recorded how information should be communicated to them and how to involve them in decisions. Where people required support to make a decision this identified who to consult about decisions made in their best interests such as an advocate and social worker. Where people had been assessed as lacking the capacity to consent to their care, decisions had been made in their best interest, which involved staff, relevant health professionals, their families and advocates. Where required best interest decisions had been made in accordance with current legislation and guidance. For example the use of a monitoring aid at night for a person with epilepsy was being used. This was also being reviewed at the time of our visit, to ensure this was the most least restrictive option.

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 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. DoLS applications had been submitted for three people in the service. All three applications were in the process of review and authorisation.

Records demonstrated that relatives were invited to and attended care reviews and the house leader had ensured they had a chance to consider all significant decisions, even if they could not attend meetings in person.

People were supported to have enough to eat and drink and were provided with a balanced, healthy diet. People were encouraged and supported to prepare their own meals, snacks and drinks in accordance with their eating and drinking plans. If staff identified concerns for people's well-being they were referred to the dietician and speech and language therapist. We observed communal mealtimes where people and staff ate together. People were provided with appropriate support to eat at their own pace. Where people had been identified to be at risk of choking staff supported them discreetly to minimise such risks, protecting them from harm and promoting their dignity.

Staff were aware of people's health needs, and recognised when they were unwell. Staff understood the impact of health appointments on people's anxieties, and worked with health professionals to address people's health needs without causing them distress. People were supported to maintain good health through regular check-ups with their GP, optician and dentist.
People's records contained essential information about them which may be required in the event of an emergency, for instance if they required support from external health professionals. These were referred to as 'hospital passports.' At the time of our inspection the house leader and deputy manager were in the process of updating these records. Information included people's means of communication, medicines, known allergies and the support they required. This ensured health professionals would have the required information in order to be able to support people in line with their needs and preferences.

Each person had a health plan which documented their health appointments and reviews, and advice and guidance from health professionals. For example one person had a fall at the beginning of January 2016, staff immediately identified that there might be a health problem and arranged a GP appointment. Staff then implemented the advice and guidance provided by the GP. This demonstrated that health issues or concerns identified by staff were raised with and addressed by health professionals promptly.

Good

Our findings

People told us the staff were always friendly and treated them with kindness. During the inspection staff responded to people with patience and understanding, following people's preferred communication and behaviour care plans. One person told us, "The staff are kind." Another person said, "The staff are nice to me."

There was a supportive family atmosphere at Zacchaeus House, where people and staff shared a mutual respect and understanding. During the inspection we observed staff readily provided support to people before it was requested. Staff were attentive and responded promptly to people's needs. We observed people becoming worried and anxious who were immediately supported by staff offering reassurance and compassion.

Staff understood triggers that could potentially upset and distress people and took action to prevent these situations from occurring and supporting people's well-being. For example one person became anxious due to losing a coin. We observed staff comfort the person and provide an explanation as to where it might be. The staff provided another coin to the person who appeared satisfied with this. Staff then encouraged the person to engage in an activity they enjoyed to reduce their anxiety further.

Staff told us they took pride in the caring values of the service. One staff member said, "I love spending time with the core members living here, speaking to them, they have personality and spark". Another staff member told us, "I really like communicating with our core members, arranging and doing activities, interacting with them." The deputy manager told us, "I am passionate about working with the people here. I care about them and their families, making sure they have a life." We observed these values demonstrated during our inspection and found staff to be committed, patient and caring towards people living at Zacchaeus House.

Staff told us that it was important for all people living at Zacchaeus House to feel safe and secure with staff supporting them, due to their personal anxieties. Staff spoke passionately about people's needs and the daily challenges they faced. Without exception staff were able to tell us about the personal histories and preferences of each individual at Zacchaeus House.

People respected others living in the service, who they regarded as their friends. We observed one person greet another person on their return from an activity, the person helped them take their coat off and encouraged the person to the lounge to sit with them, and this was well received from the person returning

from their activity. The person had limited communication but demonstrated a beaming smile. Once they were settled in the lounge the person encouraged staff to consider getting a drink for the person, who they referred to as their "special friend."

People took pride in completing household tasks and had a daily rota for housekeeping. During the inspection staff praised people for completing daily tasks and provided constant encouragement while doing them.

People had their own activity schedules which showed what they were doing, when and with whom. This ensured that people were informed about who would be supporting them during the day to reduce their anxieties. Staff gave people time to communicate their wishes and did not rush them. Although people were encouraged to take part in scheduled activities they were able to exercise their right of choice and to decide when they had had enough.

Staff told us that they had completed shadow shifts prior to their selection where their compatibility to people and their needs had been assessed. New members of staff told us they had been supported by other staff to develop their relationships with people. People experienced positive relationships with staff who worked as a team to develop people's trust and confidence.

People's rooms were personalised to reflect their tastes, preferences and interests. Photographs of families and activities were displayed in the service to remind people of events and others important to them. This ensured that relationships were maintained to promote people's wellbeing.

Staff were aware of items of particular importance to people, which were available when people wanted them. Staff sensitively supported one person while they were watching their favourite television programme. We observed staff ensured the person had their favourite photo which the person normally carried around with them, which the person meticulously positioned to provide further comfort and reassurance.

People were supported by thoughtful staff that treated them with dignity, privacy and respect. Staff told us, "We keep doors closed, when we do personal care routines. If we need to have a private discussion about something health related, we ensure core members don't hear." Another staff member said, "We always ask their permission before entering their room, when supporting around personal care we ensure the person is comfortable, offer reassurance physically and mentally." The deputy manager told us, "We always knock first, ensure the person answers before entering their room, and leaving at the appropriate times we are not needed." The deputy manager gave an example of a person who needs support with their hair in the bath but once this was done the person can be left to finish their bath independently. The person's care plan stated "[Name] prepares himself in the bathroom with a closed door; you can tell him that you will help him to wash his hair. It will take some time, but when he is ready and in the bath you knock on the door and ask if he is ready to wash his hair. [Name] can do most steps himself, but needs verbal prompting with following the steps." There was also a pictorial, personalised step by step guide for this person.

Good

Our findings

Records sampled showed that people were involved in developing their care and care plans, which were personalised and detailed daily routines specific to each person.

The care plans documented comprehensive details about people's life story, their preferences interests and aspirations. Each care plan for a person attending church was personalised, all four individuals attended a different church of their preference each Sunday. The care plan detailed if the person went on their own or if they preferred to be supported by a member of staff. One care plan on how to support a person with Communion needed clarification so the house leader amended the care plan before our inspection concluded.

Each person had a communication plan. This provided staff with information about how people communicated and their level of understanding. Care plans and risk assessments were completed and agreed with individuals, relatives and advocates, where appropriate. A person whose relative had passed away and a detailed bereavement plan to detail additional support the person needed. The house leader had contacted the local authority for bereavement counselling to be provided and this had been arranged and followed by staff.

The house leader reviewed people's needs and risk assessments regularly to ensure that their changing needs were met. Care plans were reviewed monthly by designated staff. These monthly reviews informed the team of outcomes from reviews with professionals whose input was being used such as speech and language therapists, occupational health therapists and neurologists.

Keyworkers updated people's needs and risk assessments monthly. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. The nature of the service provided meant that people's needs changed frequently and care plans were also reviewed whenever a change was required. Where any concerns or changes were identified these were immediately addressed by the management team. Each care plan contained a record of any changes to the person's health or behaviour and the resulting changes to their risk assessments. This ensured staff provided care that was consistent but flexible to meet people's changing needs. For example a person who was at risk of falls needed to be reminded to take it slowly and use their walking stick. The person attended regular meetings with the neurological team and GP; any action points from those meetings were reflected in the care plans.

Each person had a care plan to set their own goals and learning objectives and record how they wanted to

be supported. Staff talked knowledgably about the people they supported and took account of their changing views and preferences. For example a person who had a detailed activity plan that started at 8am Monday to Friday, who was known on occasions not to sleep well in the night, had alternative options if they woke up later. This ensured the person did not become anxious, worried and overtired.

We observed one handover at the beginning of a shift where the incoming staff team were updated on any relevant information. Detailed information was provided about people's health and different moods, together with the potential risks and impact on planned daily activities. For example, one person had not drunk enough during the day. A plan was agreed on who would ensure the person was encouraged to drink more that afternoon and evening. We observed the person was offered drinks that afternoon with different choices. Significant events were also recorded in a communication book, which staff signed daily to show they had read all entries since their last shift for example GP appointments and dentist appointments.

Staff told us they had been taught a recognised system for supporting people to manage behaviour which may challenge others, which training records confirmed. We observed positive behaviour management and sensitive interventions throughout our inspection, which ensured people, were treated with respect and their human rights were protected.

People had activity plans which had different entries throughout the day. This ensured people were offered a range of varied and stimulating activities every day. We reviewed each person's activity schedule which had been tailored to meet their personal interests and pursuits.
Photographs of people taken while doing the activities on each of their plans had been used to develop the person's life story. Detailed risk assessments were in place to ensure activities such as bowling and using public transport were pursued as safely as possible.

People with a learning disability had reasonable adjustments made to make sure they received support to promote their independence and freedom of choice. The service had good links with the local community. Staff were proactive and made sure that people were able to maintain relationships that mattered to them. One person had been encouraged and supported to participate in work experience at the local library. This was a volunteer role, supporting the librarians. This work experience had come to an end at the time of our visit but the house leader told us other options were being explored with the person to start work again in the Bognor area. This was documented in the person's records from a meeting with their advocate and key worker.

People were supported to maintain relationships with people who were important to them, and to develop new ones, which prevented them becoming socially isolated. People were supported to keep in contact with their family and friends. Each type of contact, whether it was meeting each other, talking on the phone or by email had been clearly documented in people's records.

People had access to information on how to make a complaint, which was provided in an accessible format to meet their needs. Over the past 12 months there had been a number of formal complaints about the service from a concerned relative. The records demonstrated the house leader and director had responded promptly and taken steps to address the issues raised. These issues were still being explored at the time of our visit.
Other complaints from relatives were clearly documented, responded to without delay and detailed the complainants' satisfaction with the action the provider had taken.
Staff knew the complaints procedure but told us they dealt with small concerns as soon as they arose to prevent them escalating. This was observed during a team meeting at the time of our visit, which were held every Monday.

The house leader and staff were responsive to people's concerns. People at Zacchaeus House met with the staffing team weekly to discuss actions from the house diary, complaints, menu choices and activities. Records showed that one person was concerned about the temperature of the lounge, that it was occasionally too cold. In response the room temperature checking form was implemented to make sure the heating system was correctly working and checking the room temperature in the lounge to make sure the person was warm enough.

Requires Improvement

Our findings

It is part of the registration condition of this service to have a registered manager. The registered manager for the service had not been in post since December 2015 and was in the process of de-registering. The provider had started the recruitment process to fill this position. Due to not having a registered manager in place at the time of our visit this has limited the "well-led" domain rating to requires improvement.

The provider's mission statement 'Is to nurture communities of faith in which relationships can be mutually transformed and can flourish. It is to enable people to take part in L'Arche community activities and society. It's to be open and outward looking, activity engaging with those around them and responsive to changing needs and circumstances'.

People living at Zacchaeus House told us staff had created trusting and supportive relationships with them, that they felt safe and that Zacchaeus House was their home.

People told us staff understood their needs and feelings which made them feel valued. Staff were able to tell us about the values of the provider and we observed staff followed these in practice. Records demonstrated that people and their relatives were able to express their views freely. Without exception staff told us the house leader and deputy manager were approachable and supportive. Staff told us they enjoyed working at Zacchaeus House and the house leader was always available if required.

Staff told us they felt they were part of a team where their contribution was valued. Staff told us they took pride in the caring values of the service. Staff told us it was a privilege to be part of the mission of L'Arche. We observed these values demonstrated in practice by staff during the provision of care and support to people.

Staff told us they were encouraged to express their views about the service and support being provided to people, which records confirmed. A new staff member told us they were impressed with the management team who encouraged all staff to share a joint responsibility to continually improve the service. People and staff told us told us they felt they could raise concerns with the house leader and that they would be supported. We spoke with a staff member who had raised a grievance with the house leader. The staff member told us they had been well supported by the house leader who took prompt action to deal with the concerns raised. We observed this was fully discussed during the team meeting and the issue resolved amicably. The minutes from the team meeting addressed the negative feedback received by a staff member and demonstrated how the house leader was going to make improvements. The house leader apologised to the staff member for the misunderstanding. This demonstrated the provider encouraged and demonstrated

an open and honest culture, where they took responsibility for things that happened at Zacchaeus House.

The house leader understood their 'duty of candour' responsibilities. The 'duty of candour' is the professional duty imposed on services to be open and honest when things go wrong. The house leader and deputy manager were able to describe under what circumstances they would follow the procedures.

We reviewed staff rotas which demonstrated the house leader and deputy manager worked shifts alongside staff, which enabled them to build positive relationships with people and staff. During periods when there was unforeseen staff absence, for example due to illness, the management increased their direct support of people. On the day of our inspection the house leader and deputy manager were providing "hands on" care and support to people.

The provider had established an effective system to assess and monitor the quality of care people received and to ensure people's positive lifestyles were maintained and improved. The house leader and designated staff completed audits of medicine administration, health and safety, fire and infection control. These were used to improve the quality and safety of the service, although no outstanding issues had been identified from recent audits.

The provider's satisfaction questionnaires were completed annually and quality assurance audits were completed monthly. The annual survey of staff and people's views was sent out in December 2015 and the results had not yet been received or analysed. The annual survey of relatives' views was sent out in January 2016. The results had not yet been analysed but two of the four relatives' feedback included, 'Very grateful for all the care that [name] receives. Don't hesitate to contact me regarding any problems that might occur with [name], be it health matters or otherwise.' Another relative included, 'I think L'Arche is a wonderful community and [name] thinks so too. Those caring for him are extraordinarily patient and kind, and I am full of admiration for them. Thank you so much to everyone for looking after [name] so well'.

The quality of care people received was continually assessed to ensure it was maintained and where required improved. The house leader and deputy manager produced a weekly report for the provider identifying all significant issues and action taken by staff at the service. The house leader also completed a more detailed monthly quality monitoring report which identified all areas for improvement and required learning from incidents. These reports also identified the progress made in relation to issues identified in the preceding monthly report. Examples of what the house leader had identified as an area for improvement from their audit in January 2016, was to ensure daily records completed by staff each shift included how people's action plans for working towards goals were being documented. The house leader felt this was an area where more detail could be added. Another area of improvement the house leader had identified was that communication passports could be in a more accessible format. We saw documentation that referrals to the community speech and language team had been made since this audit and a meeting had taken place to discuss communication passports.

Staff immediately logged all accidents and incidents, which were reviewed daily by the house leader and deputy manager. This ensured the provider identified trends and managed actions to reduce the risk of repeated incidents.

During our inspection we observed the director, house leader and deputy manager engage with staff and positively manage them. We observed a person being supported with an escalating health issue and staff required guidance regarding the administration of their prescribed medicine. The team leader provided clear instructions to staff in relation to the administration of the person's prescribed medicines, which staff then implemented. The house leader provided clear leadership and guidance to ensure people were

supported safely, while promoting their independence. This was evident when one person began to display behaviour which may challenge in relation to making a drink. The house leader calmly explained to the person what to do next and how staff would support them to resolve the problem, which reassured the person and reduced their anxiety.

Records accurately reflected people's needs and were up to date. Other records relating to the management of the service such as audit records and health and safety maintenance records were accurate and up-to date. People's and staff records were stored securely, protecting their confidential information from unauthorised access but remained accessible to authorised staff. Processes were in place to protect staff and people's confidential information.