L'Arche

L'Arche Bognor Regis Bethany

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
L'Arche Bethany is a residential care home providing personal care to six people at the time of the inspection. The service can support up to six people.

People's experience of using this service and what we found
Right Support- People were not always supported to have the maximum possible independence, choice or control over their own lives. People did not have outcome focused support plans. Some practices restricted people's independence and choice. People told us they were not supported to pursue their interests or achieve aspirations and goals. One person told us this was "Annoying" because they couldn't choose what they wanted to do. People did not receive support in an environment that was well maintained, well equipped or well furnished. Staff and visitors to the service told us the poor condition of the environment and furnishing was long standing. One said, "It's been like this for years, we just get used to it". People told us they were not able to decorate their rooms or the communal areas.

There were enough staff to keep people safe. Staff enabled people to access specialist health support in the community.

Right Care - People's care and support plans did not reflect people's individual needs and aspirations. People's care and support did not consistently focus on their quality of life or follow best practice. There was a failure to assess risks people might face and people were not encouraged or enabled to take positive risks. People were not provided with opportunities to try new activities tailored to them that enhanced and enriched their lives. We observed that people participated in group activities facilitated by L'Arche rather than pursuing their own individual interests or seeking opportunities for volunteering or employment. The provider had not fully considered people's needs and wishes in the planning and deployment of staff.

People could communicate with staff and understand information given to them because staff understood their individual communication needs. Throughout the inspection we observed people communicating effectively with staff using Makaton sign language, pictorial prompts and verbal speech.

Right culture- People were not supported to lead inclusive and empowered lives. There was a failure to identify and mitigate institutionalised practices and risks associated with closed cultures. People could not be assured of receiving support based on transparency, respect and inclusivity. People shared their home with staff who lived alongside them. People told us they did not choose the staff who shared their home.

There was a strong emphasis on meeting people's spiritual needs and valuing people as members of the L'Arche community.

Rating at last inspection
The last rating for this service was good (published 27 September 2018)

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

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture. This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to protecting people from avoidable harm, restrictive practices, safe care and treatment, medicines, staff skills and knowledge, person centred care and the management of the service. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

L'Arche Bognor Regis Bethany

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two Inspectors carried out the inspection.

Service and service type
L'Arche Bethany is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. L'Arche Bethany is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke and communicated with six people who used the service and four relatives about their experience of the care provided. People who used the service who were unable to talk with us used different ways of communicating including using Makaton sign language and their body language.

We spoke with eight members of staff including care staff, deputy manager, manager, community leader and housing coordinator. We reviewed a range of records. This included six people's care records and three medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not kept safe from avoidable harm and abuse. Staff were not knowledgeable about or committed about deploying techniques that promoted the reduction in restrictive practice.
- For example; We observed a person being denied their TV remote control throughout the day despite asking for it and this was causing them anxiety. The person told us on numerous occasions "[staff name] has it in the office". Staff including managers, told us on several occasions and in front of the person staff were looking for the remote control as the person had lost it. One staff said to the person "You have lost it again haven't you". This was found to be an incorrect and dishonest account as we later learnt that staff kept the persons remote control in the locked managers office. It was found by the CQC inspector amongst prescribed medicine in the locked office along with the TV remote control for the lounge.
- We addressed this with the community leader who told us the person had capacity to agree to staff holding their remote control and this was in place as a behaviour strategy. We asked to see evidence of this agreement and the behaviour strategy. The community leader and manager were unable to provide this and informed us these were not in place. The person told us they would prefer to keep the remote control in their bedroom. Positive solutions to this had not been sought and the person was denied access to the remote control.
- Staff had training on how to recognise and report abuse. This had not been effective in recognizing unlawful and restrictive practices as a form of abuse. We spoke to the community leader who said they would take immediate action to address the concerns we had raised.

The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from abuse and improper treatment. This was a breach of regulation 13 (safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The service worked with other agencies when concerns had been identified. These had been reported appropriately and action had been taken in a timely way to ensure people's immediate safety. The provider had been transparent about reporting concerns and worked with people and other agencies to mitigate the risk of the concern being repeated.
- People and those who matter to them told us they felt the service was safe. People told us they knew when and how to raise a safeguarding concern. People told us they would tell staff if they were not happy or were worried about something. One person said, "I would tell [staff name] if staff hurt me because they shouldn't do that". Another person said they would call the police if their money was stolen. Relatives told us they had no concerns about their loved one's safety. One relative said "[Name] is well looked after and

has never expressed any concern".

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● The service failed to keep people safe by sharing of information about risks. People did not have specific support or risk management plans for health concerns and staff knowledge about how to support people safely was inconsistent. Some risks associated with medical conditions such as seizures, diabetes, allergies and food intolerances had not been considered or shared. This meant people could not be assured of receiving appropriate support or that staff would recognise the signs of their health deteriorating and the action to take.

● Information from medical professionals was not reflected in people's support plans. For example, specific guidance from a healthcare professional to ensure a person's safety whilst eating had not been shared. At lunch time we observed the persons meal that was not in line with this guidance. We made the manager aware of our concerns and they took immediate action to prepare the meal in a way that was safe for the person to eat. We observed that it was not explained to the person why their meal had been taken away from them.

● People's care records did not ensure they received the help and support they needed. This was because staff failed to keep accurate, complete and up-to-date records. For example, a known trigger for a person having a seizure was not reflected with their support plan. Another person's care plan did not reflect their significant respiratory condition, or the risks associated with this. Where the hospital had recorded a drug allergy for a person their care passport recorded no known adverse reactions to medicines. We spoke to staff about these risks and their knowledge was inconsistent. This meant people could not be assured of receiving consistent and appropriate support to keep safe.

● The safety of the living environment was not well managed. The first day of our inspection was unannounced and, on our arrival, the front door was wide open and remained open throughout the day. We were told by people and staff this was usual practice. The house was on a busy road with a constant flow of passing cars and pedestrians. Consideration had not been given to the risks associated with intruders or the safety of staff and people or their possessions.

● We observed damaged flooring on the stairs and in the kitchen that was a potential trip hazard. A new stair carpet had been ordered although the hole in the current one had not been made safe. We spoke with the manager, community leader and housing coordinator about our concerns and were provided with assurances the areas would be addressed and made safe.

● People could not be assured that accidents and incidents would be investigated appropriately. Processes for manager oversight of accidents and incidents was not effective. Since March 2022 there had been six incident and accidents reported by staff. None of these had the managers part completed or signed and there was no evidence of manager oversight, investigation or trends analysis.

● For example, one person had recently fallen towards the bottom of the stairs. Staff had recorded the cause of the fall as tiredness. At inspection there was a hole in the stairs carpet and the person told us this was the area they had fallen. The lack of management oversight and investigation meant we could not be assured that all potential causes of the fall had been considered such as a seizure or environmental factors.

The provider had failed to do all that is reasonably practicable to mitigate risks. Care and treatment were not provided in a safe way. Risks to the health and safety and wellbeing of people had not been assessed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the community leader about the lack of accurate and up to date information in people's care plans and the absence of risk management plans. They provided assurances that all care records would be reviewed over the next six weeks to ensure they reflected up to date and person-centred information. Where

there were known risks, risk management plans would be implemented as a priority.

● Staff raised concerns and recorded incidents and near misses and this helped keep people safe. As a direct result of staff reporting improvements had been made to the way the service operates and the care people receive. For example, staff had received additional training to address some concerns about medicine errors and handover between shift changes was introduced to improve communication.

Using medicines safely

● People were not supported by staff who followed safe medicine systems and processes. We were not assured the processes in place to dispose of waste medicines were robust. Medicines held in the medicine's fridge were several months out of date. It is acknowledged these medicines were no longer being administered to people however staff and managers were unaware these were out of date until we showed them. We identified an extremely large quantity of medicines for disposal in a locked hall cupboard. These dated back to 2021 and were not logged. This left them open to potential misappropriation. The manager and community leader told us they were not aware of these medicines but would ensure action was taken to dispose of them appropriately.

● Staff did not ensure effective processes to assess and provide the support people needed to take their medicines safely. For example, we observed a person in the dining room was administered a very large tablet after their breakfast. This was prescribed three times every day after food. The person was struggling to swallow it and began coughing. Staff said "Oh, is it stuck again?". Another said, "He always does that it's normal". The person coughed for several minutes and was very red in the face. The person said, "This always happens" and described the tablet as, "Difficult to take", "Nasty", and "Tasted awful". Consideration had not been given to exploring if the medicine was available in another form. The person told us that if they could have the medicine in a way that was easier it would be "better, yes please". The manager provided assurances the GP surgery would be contacted about prescribing instructions for the tablet or having it in another form.

● People could not be assured of a person-centred approach to medicines management. We observed medicines being administered openly in communal areas and in front of others. There had been a failure to consider the risk of increased seizure activity for a person whose medicines to manage their epilepsy were being reduced. Protocols were not in place for people who required medicines to be administered 'as and when required'(PRN) such as pain relief or laxatives. There were no clear guidelines as to when these should be considered and administered. People told us staff would know if they needed medicines. One person said, "They know when I'm not feeling well". Another said, "I can ask for tablets".

The provider had failed to ensure the safe and proper management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff who administered medicines were fully trained and had undertaken competency assessments. Medicine administration records (MAR) were completed accurately. Medicines were counted after they had been administered and this had been effective at reducing medicine errors.

● People had been supported by staff, families and medical professionals to reduce excessive use of medicines. Where appropriate the positive behaviour support (PBS) team also provided support. Positive behaviour support (PBS) is a person-centred approach to supporting a person with a learning disability.

Preventing and controlling infection

● The service did not always use effective infection, prevention and control measures to keep people safe. This was because some areas of the environment and furnishings were hard to sanitise effectively due to

their poor condition or state of repair.
●The service did not prompt safety through the layout of the premises. Due to the poor condition of the environment and some furnishings safety not ways implemented effectively. We made the manager aware of our concerns.
● Staff demonstrated hygiene practices in line with national guidance and there was clear signage and advice about hand washing.
● The service's infection prevention and control policy was up to date.
● The service prevented visitors from catching and spreading infections.
● The service followed shielding and social distancing rules.
● The service admitting people safely to the service.
● Staff used personal protective equipment (PPE) effectively and safely.
● The service tested for infection in people using the service and staff.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
● The service supported visits for people living in the home in line with current guidance.

Staffing and recruitment
● Staff and people consistently told us staffing was a barrier to being able to undertake person centred activities. People told us they were not able to undertake activities they enjoyed such as swimming. Staff told us there were not enough staff to drive the minibus and this prevented them from going further than places they could walk to as a group. We observed staffing was not always deployed to take account of people's activity needs or preferences. This included where people had additional 1-1 funding for staff.
● For example, where the local authority funded a person to have an additional 1-1 support for two mornings a week, staff told us, and the rota evidenced that staffing was not increased to provide this. At inspection the person's four hours of 1-1 time was provided from the existing staffing allocation and the person walked to a group activity with everyone else in the house. At the activity the person stood by the front door until staff suggested a walk which they accepted. On return to the house all staff were involved in preparing lunch. We observed the person was not provided with any support or encouragement to prepare their own meal.
●The service covered gaps on the rota with agency staff and safe staffing levels were maintained. The service was actively recruiting staff and people were involved in the interview process. A person told us they were looking forward to interviewing potential new staff later that day and was going to plan the questions they wanted to ask the candidates.
● Staff recruitment and induction processes promoted safety. Safe recruitment checks were undertaken on all staff including bank staff to ensure they were safe to work at the service.
● People shared their home with some 'live-in' staff. These staff were mainly recruited from overseas and lived alongside people sharing communal facilities as well as mealtimes, activities and spiritual reflection. This was in line with the L'Arche ethos of sharing lives and valuing diversity. We asked people if they were involved in choosing these staff and how they felt about them living in their home. People told us they were not involved in the interview and did not have any choice about who shared their home. People where happy to share their home with live-in staff. One said, "I don't mind them, they are nice". Another said, "It's alright", and "They tell us when a new one is coming".

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

● People who were new to the service could not be assured that their needs and choices had been effectively communicated and planned for. For example, important information about a person's very specific health and behaviour support needs related to food had not been included within their support plan. The person was observed having periods of high anxiety and frustration during the inspection and received inconsistent responses from staff. Guidance had not been provided to staff to enable them to understand the persons genetic condition and how this impacted on their daily life. There was a lack of information to reflect how person wanted to be supported to maintain their own wellbeing.

● Support plans and assessments were not robustly reviewed to ensure they contained accurate and up to date information. For example, a person who had diabetes did not have this reflected within their support plan which recorded they were 'able to eat anything'. We observed the person having a carbohydrate rich meal of rice and they had two slices of staff birthday cake. Following their meal, the person was given prescribed medicine to manage their diabetes.

●People with epilepsy did not have support or risk management plans in place. It is acknowledged that people's seizures were rare however, some staff were unable to describe people's individual support needs or how their seizures presented. This meant people could not be assured of receiving safe, consistent and appropriate support to manage their health and well-being.

● People were not provided with opportunities to be involved in planning, shopping and cooking their own meals in their preferred way. People told us staff planned and cooked their meals for them. One person told us they liked macaroni cheese but said this was never on the menu. A person told us they had helped to make a staff birthday cake but apart from that they were not encouraged to help in the kitchen. We observed breakfast and lunch being prepared for people without their involvement. Teaching plans were not in place to support people to develop skills in preparing or cooking their own meals and snacks. We observed people being supported to make drinks.

● One person's support plan said they liked to help with the supermarket shopping, and this was supported by a picture of a shopping trolley full of food. During the inspection we observed the weekly shop being put away by staff. We asked the person if they had been shopping and they said "No". Staff told us the shopping was ordered online and delivered. One staff said, "It's easier and safer this way and we wouldn't have the staff or transport to go to the shop". Consideration had not been given to seeking a solution that enabled the person to participate in food shopping shop at the supermarket which is something they enjoyed.

● People told us they were unsure if they had been involved in reviewing their support plans. Relatives told us they were not involved in the planning and reviewing of their loved one's care. Where care plans had been

reviewed this was evidenced by the date being crossed out and a new date added. There was no evidence of people's outcomes, achievements or new aspirations being reflected or planned for.

The provider had failed to ensure people received person centred care that that was appropriate to their needs and reflected their personal preferences. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● For a person with a food intolerance food was provided that was in line with their specific need. One person had been supported with healthy eating which had resulted in weight loss and increased mobility. People told us their meals were good, comments included "Staff are good cooks". Another said, "I like the food here". People had access to drinks and told us they had plenty to eat.
● People were assessed to ensure there was enough staffing for their needs to be met. An assessment of need before a person moved into the service showed there was a need for additional staffing at night to meet the person's well-being and personal care needs. The funding was provided by the local authority and a review of the person's care notes showed this was effective at providing the person with reassurance and support throughout the night. The person told us "[Name] helps me when I'm upset".

Staff support: induction, training, skills and experience
● People were not supported by staff who had received relevant training to meet their bespoke needs. Some people had very specific medical and genetic conditions that impacted on their day to day life including the way they behaved and the support they required. We asked staff about these and their knowledge was limited and inconsistent. Staff had not been provided with the skills, knowledge or training to meet people's specific needs. This meant people could not be assured of receiving care and support to help them achieve the best quality of life.
● The provider had an induction programme for staff to prepare them for their role. We were provided with the most up to date record of staff induction and training dated May 2022. This showed that four staff inductions were overdue for completion. Of these, two were overdue by more than 12 months. The provider was addressing this and where staff mandatory training was not up to date.
● Staff received inconsistent support. Formal supervision and appraisal were not provided in line with the providers policy. Staff said they had not received supervision in a long while due to the absence of a manager. They told us they had received occasional informal support from the deputy manager in the form of a general wellbeing check rather than supervision and were able to speak to the community leader.

The provider had failed to ensure staff providing care or treatment had appropriate support, training supervision and appraisal as is necessary to enable them to carry out the duties they ae employed to perform. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw an email from staff to the manager requesting that supervision is reinstated. It outlined the benefits of supervision for people and staff. This was evidence that staff valued supervision as a tool for personal development related to the people they supported and as an opportunity to discuss support techniques that promoted good quality care. As a result of this the manager had booked some dates for staff supervision commencing June 2022.
● People told us they were provided with the opportunity to tell new staff about themselves and the way they wanted to be supported.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

● Staff knowledge of how to apply the principles of the MCA was limited. We observed the fridge door was locked when we arrived and there were locked food cupboards. Staff gave us various reasons for the restrictions that were in place including, for people's health and well-being, budget and to maintain food hygiene. None of the staff we spoke with considered these practices to be restrictive and had not considered these practices with regards to MCA.

● Staff failed to demonstrate best practice around supporting decision-making and best interest decision-making. One person had a DoLS in place. Where restrictions impacted this person such as access to food and equipment the service were unable to evidence a best interest's decision had been undertaken.

● Where people had capacity to make their own decisions, we were unable to see any documentation that evidenced restrictions in place had been discussed or agreed with them. People told us they were not consulted about restrictions and accepted these as a condition of living in the service. One person said, "Staff look after the food". Another said "Well, I suppose that how it is really". People told us they could ask staff for food and they had access to yoghurts in a small fridge.

The provider had failed to identify discrimination against service users on grounds of protected characteristics (as defined in the Equality Act 2010). This included the failure to identify an act intended to control and restrain which is not proportionate. This was a breach of regulation 13 (safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs

● The house did not reflect a living environment that valued the people living within in it. The environment appeared neglected and in places unsafe. The condition of the premises and equipment meant the environment was hard to keep clean and safe. People and their relatives told us they did not like the condition of the house. It was described as 'not homely' and 'poorly maintained'. People were not supported in a safe, well equipped or well-furnished environment. We have reported on this in the safe key question of this report.

● People were not included in decisions relating to the interior decoration and design of their home. People told us they were not able to decorate their rooms and we observed people's bedrooms to be dull and contained old furniture and fittings. A person told us they were not allowed to have their room decorated but if they were, they would like it painted yellow and blue. Staff told us this was because painting was the responsibility of the landlord. Furniture, furnishing and appliances within the house were old and tired. The environment did not reflect the ages, personalities and personal interests of the people living there. The manager and community leader said they were addressing the concerns we had raised. This included liaising with the landlord about property maintenance and purchasing new sofas and floor coverings. A new shower cubical had recently been fitted to support a person's mobility needs.

● People told us they liked the location of the house which was in a residential area. One people told us they liked to sit on the bench by the front door and watch the cars, another told us they liked to visit the L'Arche service next door.

Supporting people to live healthier lives, access healthcare services and support

● People were referred to health care professionals to support their wellbeing and help them to live health lives. People told us they were supported to attend regular appointments with GP's and dentists. People were supported to maintain good oral health and had access to dental products and equipment as well as regular dental check-ups.

● Records confirmed people had access to other health and social care professionals when necessary. This included speech and language therapist for advice on eating. Each person had a care passport. This helped to ensure other professionals would have the information they required if the person was admitted to hospital.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Staff were caring towards people but sometimes this inhibited people's independence and ability to be involved in decisions about how they wanted to live their lives and positive risk taking. A person who was very independent told us they were restricted from going out alone. Staff told us this was because the person might have a seizure. We did not see any documentation that evidenced this had been discussed or agreed with the person or a DoLS applied for. Records showed the person's last seizure was 2019. Guidance to keep them safe had not be reviewed since 2018 and advised the person had to be where staff could see them. Consideration had not been given to reviewing this with the person to ensure it was current and reflected the person's views and wishes.
- People were not involved in managing risks to themselves and in taking decisions about how to keep safe. For example, one person had a significant medical condition that impacted on their daily life. Self-help guidance provided by a health care professional in July 2021 to support the person to manage their condition had not been shared with them or staff and was not reflected with their care plan. The person told us "No, I don't know about that". This meant the person had been denied the opportunity to have some control over the way the way their condition impacted their daily life.
- People, and those important to them, did not take part in making decisions and planning of their care and risk assessments. Relatives told us they were not involved in the planning and reviewing of their loved one's support. One said, "We used to be involved but that's not happened for a few years now". Another told us they had not been involved in the planning of their loved one's support but felt assured it would be appropriate. There was a lack of evidence to demonstrate people's involvement in decision making or how their aspirations were planned for and incorporated into everyday life.

The provider had failed to ensure people were enabled and supported to participate in making decisions about their care. There was a lack of collaboration with relevant people to design care and treatment that ensured people's preferences and needs were met. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were able to move freely around their home and garden. We observed some people liked to sit on a bench at the front of the house. When we arrived on the second day a person took time to speak with us and guided us how to use the bell. A member of staff who was vacuuming the hall respectfully turned it off so that the person outside was able to speak to a person in the hall. People tended to congregate in the kitchen area, and we observed this was an enjoyable and social place for people and staff to spend time together.

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

● People did not have the opportunity to try new experiences, develop new skills or gain independence. Support plans recorded people's aspirations however there was a lack of evidence to demonstrate how people were supported to achieve these. It is acknowledged that during the global pandemic there were long periods of time where government restrictions were in place. People told us this time had been boring. We were unable to see evidence that people had used this time at home to learn new skills or develop their independence.

● Staff knew when people needed their space and privacy and respected this. We observed a person whose anxiety had begun to rise towards the end of a music session at the L'Arche Hub in Bognor Regis. The person was able to explain to staff how they were feeling and needed space. Staff respect this and the person was able to walk home at a slight distance from the rest of the group. Halfway home the person said, "I'm alright now". Staff responded positively and the person began to engage in conversation for the rest of the way home.

● Staff took the time to understand people's individual communication styles and develop a rapport with them. People were observed to be at ease with staff, sharing humour and conversations. People initiated conversations with staff, and these were natural and relaxed. People told us they enjoyed spending time with staff.

● Staff supported people to maintain links with those that are important to them. During the global pandemic people had been supported to stay in touch with family and friends using telephones and video technology. People have continued to have a weekly video meeting with members of the L'Arche communities in the UK. One person told us this was important to them as they particularly like the prayer that was said during the meeting. Families told us they were able to visit the service and some people were supported to visit the family home. One relative told us they had really enjoyed being invited to lunch over Easter and spending time with their loved one which they said was important to them both.

● Staff members showed warmth and respect when interacting with people. We observed people receiving kind and compassionate care from staff who used positive, respectful language which people understood and responded well to. Staff were calm, focussed and attentive to people's emotions. People told us they were fond of the staff who supported them. Staff were described as "Funny", "Kind", Really nice", and "Helpful" by people who lived at the service. One person gave us the thumbs up sign when we spoke about the staff member who had been supporting them.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always enabled to make choices for themselves. One person told us they would like to go out in the evening but were not allowed because dinner was at 6pm. Staff told us the evening meal was important time together as a community and staffing prevented evening activities. A review of people's daily activities showed they did not go out of an evening. People told us that they had to go to bed by 10pm and staff confirmed this was encouraged to support the people's well-being. We found these practices to be restrictive and institutionalised and spoke to the manager and community leader about this.
- Staff did not routinely seek leisure activities or widening of social circles for people. People's care records prior to the pandemic failed to evidence that people had been provided a real opportunity to seek paid or voluntary employment or social activities in the local area. People had tended to go to the L'Arche workshop/ day service located in the back garden. A person told us the day service was not reopening and said they missed this as they had enjoyed the woodworking jobs and helping. Staff had not sought to find similar clubs within the local community such as the local men's shed group. This would provide the person with the opportunity to meet new people whilst participating in woodworking projects.
- People were not supported to participate in their chosen social and leisure interests on a regular basis. People consistently told us they were bored and wanted to go out and do more. One said, "I don't do very much". A person told us they wanted to go to church rather than watching it online. Another person wanted to consider joining a gym or the library. A person's support plan said they were good at swimming and enjoyed this and another person had an interest in horseracing. A relative told us they would like their loved one to visit the family home. These opportunities had not been explored.
- Rotas did not provide evidence of person-centred staffing. People and staff consistently told us there were not enough staff to do activities or to drive the minibus. The community leader told us this was due to insufficient funding for staffing and volunteers were being sought to help with this. We were not provided with assurances that the service had fully considered the planning and deployment of staff when considering people's needs and wishes and preferences.
- People, staff and managers told us that L'Arche were still restricting people's social activities as a precaution to COVID 19 although there was no longer a government requirement to do this. Risk assessments were not in place to provide any reason as to why people should not be supported to undertake activities they were asking for and enjoyed. A relative told us they felt L'Arche were being over cautious as people were able to participate in social activities when visiting families. Another family member told us they believed the service were currently using COVID19 restrictions as an excuse not to do more with their loved one. The community leader informed us that L'Arche were beginning to ease restrictions and were arranging a BBQ over the Jubilee weekend. This would be an opportunity for all the L'Arche services in

Bognor Regis to get together.

The provider had failed to ensure people received person centred care that was appropriate to their needs and reflected their personal preferences and interests. This is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's support plans recorded what people could do for themselves and levels of independence. One person's relative told us their loved one had pictorial prompts about how they wanted to be supported on their bedroom wall which they considered to be helpful.
● People told us they were looking forward to the annual L'Arche pilgrimage walk. The walk has been adapted this year to include walks to other L'Arche houses to enable people who moved into L'Arche services during lockdown to get to know each other. People have also been involved in the L'Arche film club. This is project organised by L'Arche where people made a film about their life and experiences. The community leader told us this has been shared throughout the L'Arche community worldwide through a locked online video channel.
● People told us about activities they undertook when they visited family. A person told us they had enjoyed spending time with their friend, visiting the Brighton Pavilion and a zoo. A person who was particularly interested in cars was going to The Festival of Speed in a few weeks' time and they told us they were really looking forward to this.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Information was routinely provided to people in a way they could read or understand. We observed information around the service in pictorial formats, although this did not always reflect up to date information. For example, the pictorial rota for staff did not reflect the staff that were on duty on both inspection days.
● People had their communication methods recorded in their support plans. This ensured people were able to make their needs known. Throughout the inspection we observed people engaging in conversations with staff who were fully proficient in each person's unique communication needs. The provider ensured training was available to ensure people's communication needs were met.
● We observed throughout the inspection people engaged with staff using many different communication methods including body language. A person's positive behaviour support plan (PBS) plan provided clear guidance on how to communicate with the person in different situations and we observed these in practice with positive outcomes.

Improving care quality in response to complaints or concerns
● People, and those important to them could raise complaints easily and staff supported them to do so. People knew how to make a complaint if they wanted to. A person told us they would tell the manager if they had a complaint another said they would tell staff.
● Complaints were recorded and responded to in line with the organisations policies and procedures. Relatives told us that any concerns they had, had been dealt with swiftly and professionally. Investigations into complaints were thorough and improvements had been made as a result of learning from reviews. The provider shared learning with staff to ensure improvements were sustained.

End of life care and support

- People were not receiving end of life care.
- Some people had shared their preferences as to arrangements for the end of their life including, funeral arrangements, prayers and music. This was captured in their care records.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's processes for quality assurance and audit were not robustly applied. The providers quality assurance checks had failed to identify some of the concerns we found at inspection in relation to person centred care, restrictive practices, MCA, the environment, care planning and risk management.
- For example, medicine audits were not undertaken, and this had led to the failure to identify out of date medicines or that processes for correct disposal of medicines were nor being followed in line with national best practice guidance. Information recorded on the providers monthly performance sheet recorded only the number of accidents and incidents that had occurred. There was no detail of the incident, analysis or outcome. Therefore, it was not possible to see how the service or provider used this information to drive service improvements.
- There was not a structured approach to monitoring the quality of care plans. This had led to a failure to identify care plans did not always contain enough information and guidance to ensure safe care and support. For example, there had been a failure to check information contained within professional and medical reports was accurately reflected within people's support plans. The failure to ensure care records and information relating to people's care were contemporaneous meant records could not be relied upon as an accurate record of people's care.
- Processes were not robust to protect people from harm. Systems were not in place to identify that some risks to people's health and wellbeing had not been assessed or documented. For example, quality monitoring had failed to identify the failure to implement a choking risk management plan for a person with a known choking risk. There was a failure to ensure that all reasonably practicable actions were considered and taken to mitigate risks to people. This meant the provider could not be assured people were safe.
- The provider had not ensured a robust process for assessing staff learning, areas for development or if further additional training or support was required. There was a failure to ensure staff followed best practice guidance such as Right support, right care, right culture when supporting people with learning disabilities.
- Some aspects of the care provided reflected institutionalise practices and there were restrictive practices unsupported by best interest's decision. People were not always provided with the opportunity to be involved in their care and support. This meant the provider could not be assured that staff knowledge and practice were current or that learning, reflective practice and service improvement were adopted.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This is a breach of Regulation 17 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had been without a manager between September 2021 and March 2022. The community leader told us they had been spending one day a week at the service during that time to provide management support. A new manager commenced in March 2022. They told us they planned to be registered with CQC to be the registered manager for the service.
● People, staff and visitors spoke highly of the manager and were complementary about the positive impact they had made over the last few months. People told us they were happy and the care they received was good. Staff were described as kind and caring by people and their relatives. Staff told us the manager was approachable and they felt very supported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● We received mixed feedback about communication. Some relatives told us communication from the service could be improved upon. Feedback included "I wish they would make the contact instead of relying on us to ask about things". And "Sometimes we find out things by chance, they could do better in this area". When concerns had been raised relatives felt these had been investigated appropriately. One told us "It's very rare I have a reason to complain, but on the odd occasion I have needed to raise something it's been dealt with swiftly". Relatives said they were able to speak openly to the senior team and care staff and felt there was open and honest communication in place.
● The manager understood their responsibility to be open in the event of anything going wrong. They had notified appropriate authorities and shared the outcomes with people and staff to ensure lessons were learnt. Records showed that all safeguarding concerns had been reported to the local authority and CQC in line with guidance. This is so we can be assured that events and incidents have been appropriately reported and managed.
● People told us they were looked after well during an outbreak of Covid19 in the service. Relatives told us they had been assured of their loved ones' well-being during the COVID-19 pandemic. When there had been an outbreak in the service relatives felt informed and kept up to date.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider had not sought feedback from stakeholders recently and the community leader said this was something they had planned to do over the next few months now that a new manager was in post. People told us they were involved in house meetings and were able to share ideas. For example, one person suggested planting a Rhododendron in the garden and had been able to do this a couple of weeks ago. People told us they said a prayer during these meetings, and it was nice to have everyone together including the staff.
● People had been supported to engage in the online conferences such as the Learning Disability England conference and a mindfulness conference for people with learning disabilities. This helped people to connect with other people in the country and share ideas and experiences. One person represents the house in the national L'Arche community core members council where they get to discuss topics that are important to them and help drive change within the organisation.
● The service worked in partnership with other agencies. These included healthcare services as well as local community resources. Staff were aware of the importance of working with other agencies and sought their input and advice. For example, staff had supported a person to seek advice on a personal safety matter. Records showed that staff had contacted a range of health care professionals. This enabled people's health needs to be assessed so they received the appropriate support to meet their continued needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person centred care that that was appropriate to their needs and reflected their personal preferences. The provider had failed to ensure people were enabled and supported to participate in making decisions about their care. There was a lack of collaboration with relevant people to design care and treatment that ensured people's preferences and needs were met.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that is reasonably practicable to mitigate risks. Care and treatment were not provided in a safe way. Risks to the health and safety and wellbeing of people had not been assessed. The provider had failed to ensure the safe and proper management of medicines.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's processes did not ensure the right level of scrutiny and oversight to ensure people

	were protected from abuse and improper treatment. The provider had failed to identify discrimination against service users on grounds of protected characteristics (as defined in the Equality Act 2010). This included the failure to identify an act intended to control and restrain which is not proportionate.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks.

The enforcement action we took:

Warning Notice