L'Arche

L'Arche Kent Faith House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

L'Arche Faith House is a service for up to five people with learning disabilities and autism. The service is a in a residential area of Canterbury. There is a main house where four people live and an annexe for one person to live with support. L'Arche is a Christian based charity that supports people of all faiths and none in their services. There were five people living at the service when we inspected.

L'Arche Faith House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

L'Arche Kent Faith House provides accommodation and personal care. The philosophy of L'Arche is that people with disabilities live in a community. Therefore, some staff members also live in the home. The accommodation is over two floors, with some bedrooms on the ground floor and some upstairs. There is a communal lounge and a large dining room/activities room and a garden to the rear of the home. L'Arche Kent Faith House was previously registered with a different address and was rated as Require Improvement in December 2015.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality monitoring systems had not consistently brought about prompt changes to practice where risks had been identified. We found that some temperature checks had not taken place as per the registered provider's procedures and some food left in the fridge was out of date. The issue of meat temperatures not being recorded had been highlighted in an audit but prompt action had not been taken to check shortfalls had been corrected.

People were kept safe from abuse and harm and staff knew how to report suspicions around abuse. There were sufficient numbers of staff deployed to meet people's needs and ensure their safety.

People received their medicines when they needed them from staff who had been trained and competency checked. Staff understood the best practice procedures for reducing the risk of infection; and audits were carried out to ensure the environment was clean and safe. The service used incidents, accidents and near misses to learn from mistakes and drive improvements.

People had effective assessments prior to a service being offered. This meant that care outcomes were

planned for and staff understood what support each person required. Staff were trained in key areas and had the skills and knowledge to carry out their roles. Staff had been supervised effectively by their manager and their performance appraised. People were supported to receive enough to eat and drink and staff used nationally recognised guidance to ensure people had a balanced diet.

The service worked in collaboration with other professionals such as psychologists and people's GPs to ensure care was effectively delivered. People maintained good health and had access to health and social care professionals. Environments were risk assessed to ensure people were safe and met people's individual needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful and the least restrictive option.

Staff treated people with kindness and compassion. Staff knew people's needs well and people told us they liked their staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and staff encouraged people to be as independent as safely possible.

People received a person centred service that was supportive of their needs. People's needs were fully assessed and care plans ensured that personal details were carried through to care delivery. There was a complaints policy and form, including an accessible format available to people. Complaints were used to improve the service delivered to people.

There was an open, inclusive and empowering culture that was implemented by effective leadership from the management team. People and staff spoke of a person centred culture that was empowering. The management team understood their regulatory responsibilities.

People, their families and staff members were involved in the running of the service. There was a culture of learning from best practice and of working collaboratively with other professionals and health providers to ensure partnership working resulted in good outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of their role and responsibilities in relation to safeguarding people.

Risks had been managed safely and had been mitigated by effective assessments.

There were enough staff deployed to meet people's needs and they had been recruited safely.

People's medicines were managed safely and people had medicines when they needed them.

Staff understood the importance of infection control measures and supported people in a way that protected them from infection.

Lessons were learned and improvements made as a result.

Is the service effective?

Good

The service was effective.

People's needs were met in line with best practice and legislation.

Staff had the training and support required to carry out their roles.

People were supported to have a balanced diet which met their needs.

People were supported to access medical professionals as required and any advice was followed.

Staff used a range of systems which promoted effective communication and ensured people's needs were met.

The premises were well maintained and met people's needs.

Staff asked for consent for people before supporting them and understood the principles of the Mental Capacity Act. (2005)

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well and treated them with kindness and compassion.

Staff used a variety of communication tools to support people to express their views.

People were supported in a way which promoted their dignity and privacy.

Is the service responsive?

Good

People's needs were assessed, recorded and reviewed.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems for assessing, monitoring and developing the quality of the service had not resulted in prompt changes to mitigate risks.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

Staff, people and their relatives had been involved in the running of the service.

The service continuously learned and improved, and implemented positive changes.

The service worked effectively in partnership with other agencies.

L'Arche Kent Faith House

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 6 March 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted local safeguarding and social work teams and looked at notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury.

During the inspection we spent time with people who live at the service. We spoke with the registered manager, senior carer, and two assistants. After the inspection we received feedback from two relatives. We looked at three people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

Good

Is the service safe?

Our findings

There were effective systems and processes in place to help keep people safe from abuse. One person told us, "I'm safe living here because it is a safe environment and a safe area." One relative commented, "My Son is most definitely safe. Faith House is the first place that they have not got lost in the community and this is a big issue. [Faith House] have more carers and they engaged [name] more so they feel a part of the L'Arche community, and that keeps [name] safe." In the 12 months before our inspection there had been three safeguarding referrals made to the local safeguarding adults team.

Each safeguarding referral had been made appropriately and in a timely manner. Where an incident occurred, that was a possible safeguarding alert, they were sent directly to the registered manager who reviewed them and then reported correctly. The registered provider had a safeguarding policy in place, which referenced the local authority safeguarding adults policy and protocol, and gave a link to the most recent copy. The registered provider's policy was up to date and included key information, such as guidance on responding to allegations of abuse. There was also a separate reporting policy that referenced the duty of candour. Duty of candour is a commitment for healthcare professionals to be honest with people and their families when things go wrong. The local authority safeguarding officer had visited the service to attend a team meeting to speak about safeguarding and ensure that staff members knew how to report concerns. Staff had received training in safeguarding and were knowledgeable in the possible signs of abuse and how to report any concerns they may have about people.

Risks to people were assessed and managed safely without restricting people's freedom. People had individual risk assessments to mitigate any potential hazards they may face. Where people had behaviours that others may find challenging, these had been assessed and plans to help staff manage potential conflict had been made. Each personal risk assessment looked at a specific risk, proactive and reactive ways to manage the risk and any other actions that could be tried. There was a focus on how to reduce the potential hazard without restricting people's freedom. For example, one person who rode a bike had a risk assessment as this was an activity they used to enjoy. Risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. The fire risk assessment was effective and up to date. Fire drills were happening and records showed that this included night time drills when staffing levels were lower. Staff were aware that each person had a personal emergency evacuation plan (PEEP) for the risk level associated with evacuating people safely in the event of a fire. A PEEP gives details of the support each person would need to leave the service in the event of an emergency such as a fire.

There were sufficient staff deployed to meet people's needs and to keep them safe. The services staffing rota changed from week to week based on the different activities that people engaged with and their social plans. There was a mixture of live- in staff and permanent staff employed at the service to provide flexible coverage to meet people's needs and keep them safe. The service had a minimum staffing level of two staff to five people and on most days had a higher level of staffing on the rota to support people to attend activities and learning opportunities. We checked the rota for the two weeks preceding our inspection and found that the levels of staff identified by the registered manager to keep people safe had been provided.

Staff and people's relatives told us there were enough staff on shift. One staff said, " There are enough staff on shift; we never have less than two staff and that keeps people safe." One relative commented, "There are always plenty of staff and we've called in at odd times and there's always people there." On the day of our inspection we saw one person was being supported outside the service by an activities assistant.

Safe recruitment processes had been followed and recruitment systems were robust. Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. References had been taken up before staff members were appointed and were obtained from the most recent employer where possible.

There were safe medicines administration systems and people received their medicines when required. The service used a monitored dosage system where tablets arrived from the pharmacy pre-packed and in separate compartments for each dosage time of the day. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted correctly. MAR charts had been signed to indicate that people had been given their medicines. Medicines were stored in a lockable cabinet with different areas of the cabinet for different people's medicines to reduce the risk of errors. One person had been assessed to manage their own medicines and had been supported safely to do this. People had been supported to have regular reviews of their medicines and were supported to attend GP appointments to ensure that any changes in medicines were understood and transferred to their care plans. Staff had been trained in the safe administration of medicines and had their competency checked to ensure they were safe to give people their medicines in practice.

People were being kept safe against the risk of infections by the prevention and control of infection hazards. Infection control training had been provided for all staff and there was an infection control lead in the service. There were cleaning rotas in place which staff had followed and the service was clean. There was an infection control policy that covered key areas, such as effective hand washing, cleaning procedures and who to report any outbreaks of infection to.

Lessons had been learned when things went wrong in the service. Any accidents or incidents had been recorded and investigated appropriately. The registered manager had followed up every incident, reviewed them for learning points and had reported on incidents every month to the registered provider. We saw that lessons had been learned. For example, following one incident the registered manager had found out the underlying cause for the incident and arranged a meeting between parties involved. This produced a successful resolution to the problem. We spoke to one relative involved in the incident and were told they were very happy with the way the incident was handled by the registered manager. Staff had then discussed the incident and the successful resolution at a staff meeting to ensure that all staff knew how to ensure there was no repeat of the incident.

Good

Is the service effective?

Our findings

People's needs were assessed and their care was planned to ensure their needs were met. There were assessments of people's needs prior to a service being provided. The last person to move to the service had moved at the end of December 2016. During their move there was extensive contact between the service and the person's previous care home. An assessment form had been completed that looked at the person's disability and support needs in relation to any disabilities or protected characteristics they may have. The registered manager invited the manager of the person's old care home to the service to discuss if they could meet their needs and an application form had been completed. There was a series of visits organised that included the person, their family and their staff team. During these visits a holistic picture of the persons need was built up. The registered manager also visited the person in their previous care home and obtained copies of their care plan, risk assessments and health plans and contacted the funding authority for copies of relevant paperwork. Technology had been used to enhance the delivery of effective care and to promote people's independence. People had access to electronic tablets that they used to plan their day and read accessible documents. People were using these tablets to aid their communication and to let staff know what they wanted.

Staff members had appropriate skills, knowledge and experience to deliver effective support to people. One person said, "The staff know how to look after me and they know what to do." One relative commented, "The staff absolutely know how to look my Son. Not long after they moved in there was a big meeting where I went and did a presentation on their condition and all the staff were there. I'm organising a conference on [person's condition] and L'Arche are going to do a presentation on caring for someone with it." Staff members had formal supervision as well as observed supervision with their line manager or a more senior manager. Supervision in care settings is a process whereby through regular, structured meetings with a supervisor, care staff can develop their understanding and improve their practice. Staff received a range of core training courses related to subjects such as safeguarding and fire safety. In addition to core training there was a scheme run by the registered provider called 'formation training' that covered courses in additional areas such as managing stress. For new staff there was a first year formation training programme that included courses such as 'Makaton' and 'causes of challenging behaviour'. Makaton is a language programme using signs and symbols to help with a learning disability to communicate. The Care Certificate was in place for all new staff to complete to ensure their induction was effective and they had a good grounding in care and support. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care services are expected to uphold.

People received enough food and drink to meet their needs and maintain good health. One relative told us, "We monitor [name's] weight every month to make sure there's no loss or gain: most of the food is homemade. We have tried the food and it's like the food I cook. There are lots of foreign foods that people get to try as staff come from abroad and it's absolutely delicious." Where there were risks to people with complex needs in relation to their eating and drinking they had been identified and managed. One person was at risk of choking and had been referred to and seen by a speech and language therapist (SaLT). The SaLT had put special guidelines in place around how the person's food and drink should be prepared and these had been signed by all staff. People were able to choose a menu at a weekly house meeting and there

were picture cards available to assist people to choose their favourite meals. People received a balanced and nutritious diet. There were resources for staff to use to engage people in making decisions about their diet. There was a copy of the Department of Health 'eatwell plate' which served as a guide for obtaining the correct balance between different food groups.

Staff worked together to ensure that people received a consistent and person-centred support when they moved from or were referred to the service. One person who previously lived at the service had moved to a supported living scheme run by the registered provider. The registered provider had a team of staff that worked across Faith House and the supported living services so the person was not isolated and had the support of staff they knew well. Faith House had given copies of the person's support plans to the new team so that there was consistency of support and staff from Faith House had supported the person at first to help them to settle in their new home.

People had been supported to live healthy lives and had access to health and social care professionals. Records confirmed that people had access to a GP, dentist and an optician and could attend appointments when required. Care plans demonstrated that a wide range of professionals were involved in people's care. For example, one person had seen their GP seven times in the past 12 months. In addition to this they had seen a district nurse, dentist, chiropodist, and optician. People were being weighed every month to check they were a healthy weight. When people were unwell staff completed sickness sheets to record the nature of the illness, the person's temperature, any medicines or medical treatment given, and food and fluid intake. People who required it had continence records completed to track bowel movements or urine output. People had health action plans in large print and accessible picture format to help them to understand their health needs. People had hospital passports that were written in the first person and consistent with information in their care plans. A hospital passport is a resource for people with learning disabilities or autism who might need hospital treatment. People's mental health was monitored through effective care planning and review, and people who required it received sympathetic and appropriate care.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People's right to make decisions was promoted and the principles of the MCA were adhered to. Where complex decisions were made the service had completed an MCA assessment and where capacity was found to be lacking a best interest meeting was held involving key people in the person's life, such as social workers and family members. There were details for people with a lasting power of attorney. A lasting power of attorney is a legal document which names an attorney who can make decisions on another person's behalf. The registered provider had an effective MCA policy and there was information about capacity displayed on a staff noticeboard. Staff understood the MCA and were focused on supporting people to make their own decisions as frequently as possible. One staff member told us, "People can make their own decisions. There are DoLS to make sure we aren't making choices for people. People who can't talk still can make choices, for example they can choose from pictures we show such as different restaurants, and pick the one they want to eat at."

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by their staff and were given emotional support when needed. One person told us, "The staff are very caring because they are nice people." Another person commented, "The staff are caring because they are understanding and know how to work with people with special needs." One relative said, "The staff are caring and it's not just a job for them. If I had found Faith House sooner I would be happy. The staff genuinely want to engage and it is a calling not a job." Staff spoke to people kindly using their preferred shortened name. When things needed to be explained to people staff sat with the person and took the time to speak in a way the person could understand. When staff entered the building, either for a visit or for the start of their shift, they sat with people and spoke with them. Staff asked questions to one person to see if they were feeling better following a recent illness, and to speak about Easter and the person's plans for the day. We observed staff sharing jokes with people, such as who was the boss in the home, and joking about where they would like to go on holiday. People enjoyed this gentle and natural conversation and there were no barriers apparent between staff members and people who lived at the service. One person was watching TV and asked their support staff for a hand massage. Staff responded by finishing what they were doing and came and supported the person with a hand massage. The person clearly enjoyed the one to one support and the sensory input from tactile interaction.

People were supported to express their views and be actively involved in making decisions about their care and support. House meetings had been held regularly and people discussed their choice of evening meals. Visitors were often invited and, for a long period, a volunteer who is a Franciscan brother had been joining weekly for a meal and house evenings to participate and enable people to discuss their faith. During house meetings Makaton signs were used to help people to express their views. Makaton is a language programme using signs and symbols to help with a learning disability to communicate.

People had limited verbal communication and often used facial expressions or small movements to express themselves. Staff understood people's communication well and responded appropriately. One person pointed across the room and staff knew that they were anxious about other persons' actions, and were able to reassure them. One person had a communication book written specifically for their needs. It contained pictorial routines so that the person could plan their day and understand what was happening next. Their communication passport described in detail what different sounds and facial expressions meant, and staff were able to describe these to us.

Peoples' independence was promoted by staff who worked in an empowering way. People were encouraged to do household jobs and to contribute to the upkeep of their living spaces. We observed staff prompting and supporting people to do their own washing up and to put their laundry in the washing machine and use the dryer. Where some people refused to engage in these tasks, staff knew when to disengage, when to try later and when to leave the person alone so as not to elevate their anxiety. One staff member told us, "We let people choose their own clothes, get dressed, encourage them to take plates to kitchen and help them to clean their own room. One person is allowed to walk to certain places on their own and they have boundaries in place to help them manage this." We spoke to one person who had been recently supported to move to more independent accommodation. They described to us the support they

received form staff at Faith House to make the move a success and to learn to be on their own at times.

People's right to privacy and dignity was respected. People felt that they were treated kindly and with respect. Staff respected people's right to privacy and ensured that all personal information was stored securely in a locked room in line with the Data Protection Act 1998. The registered provider had prepared for new changes to data protection law in order to keep peoples information safe. Staff spoke discreetly to people about any personal care issues. When people were being supported to have a bath, or to get dressed, staff ensured that doors were closed. Staff knocked on people's bedroom doors and waited for permission to enter, even when doors had been left open. Staff responded in a timely fashion to provide caring support when people were unwell or in distress. Several people had been unwell with a heavy cold in the week before our inspection. Staff had ensured that people had timely medical intervention as well as providing comfort and nurturing support.

Good

Is the service responsive?

Our findings

People received an individualised service that was tailored to their needs. One person said, "The staff support me totally differently to other people who live here." A relative commented, "One of the things they've started is finding out birthdays of family members. And I have just received mother's day flowers and card including the nickname he calls me which proves they understand him and that it is personalised." People were involved in writing their care plans and those who were able to hand signed their plans. People's support plans were individualised to their needs and contained a one page profile that listed peoples' interests, such as their favourite bands, and hobbies like going for walks. These interests had been consistently carried through all the support planning documents. Plans had been written in the first person with direct input from people and their relatives. Having plans written this way enabled staff to understand exactly what people wanted from their support and what was important to them. For example, one person loved to sing and the importance of this was made clear, with instructions on how staff could join in singing which the person enjoyed. People were involved with the review of their care plans with their key workers every three months. A key worker is a member of staff that takes a lead role in people's care. The three month reviews had looked at several areas of people's care including health, personal appearance, social and family contact and finances among other areas.

The registered provider was meeting the Accessible Information Standard. The Accessible Information Standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. People had accessible review documents that gave pictorial and simple word feedback to staff. One person had given positive feedback about their room, the people they lived with and the friendly attitude of staff. Questionnaires were sent out in easy read picture version for people who required it and the registered provider fed back the results of surveys to people in accessible formats. People's spiritual and social needs were reflected in their care plans and understood by staff. There were sections on peoples care plans for 'cultural issues' where people's faith was discussed and their preferences made clear. For example, one person did not want to attend church but enjoyed participating in prayer times and faith groups held within the service.

People had been supported to follow their interests and take part in a programme of activities that were socially relevant and appropriate to them. People had access to education and work opportunities as part of their activities programme. People could choose the activities they enjoyed and wanted to do, as well as indicate activities they do not enjoy or want to try. There was an activities folder setting out in accessible format which activities the registered provider runs for people. Each activity was portrayed with two photos of the event and a photo of the person running the group with a brief description. Some activities were 'production' activities: these were activities where people made crafts, or grew plants, for sale and people received back a share of any profits. The registered provider employed an activities co-ordinator who facilitated different activities such as candle making; sewing and weaving; succulent planting; dancing, and lavender bag making. One relative told us, "Going to day services was always a big problem previously and having their own activities has had a really big impact. My Son is in the happiest I've seen him in years and doesn't mind going back after home visits; for the first time in 20 years it's OK for us to drop him off."

People had been encouraged to be involved in the running of their care services and to have a voice in how the registered provider governed the organisation. This allowed people to have a direct say in how the organisation was managed and what type of care and support they received. The registered provider had two consultation groups to aid user involvement. One was for more able people and was chaired by a person with learning disabilities who lived At Faith House. We spoke to the person who told us, "I went to Liverpool for the AGM [annual general meeting] as chair of the speaking council. I listen to the group and they speak about different topics and there are representatives from different Kent communities. I attend the national meeting and feed back to the speaking group." We reviewed notes from the AGM and saw that people had spoken about three main areas: community, spirituality competence. People had discussed the importance of friendships and relationships, practiced using different communication aides and reviewed the Personal care policy. People reported they had been listened to and they had recorded that they felt that the national speaking group was valued by the leadership of the organisation.

There was also another group which was for people with learning disabilities with severe communication difficulties, to reinforce news and events through greater use of imagery and other communication tools. This had ensured that people with greater support needs around their communication had been consulted about changes and were involved in decisions about the direction of the organisation. People were able to choose a holiday and had been supported to travel abroad where appropriate; some people spoke to us about holidays they had been on and how much they had enjoyed them.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service kept a complaints file with a copy of the complaints policy, which set out the steps on how to respond to and resolve the complaint. There was a complaints form and both the form and the complaints policy made reference to the local government ombudsman if people were not happy with the complaints' resolution. There was also a guide for people on how to complain, who to complain to, what will happen when people complain, and what to do if people are not happy with the outcome. The complaints log had recorded two complaints in the past 12 months and both had been resolved appropriately and to each complainant's satisfaction. One relative told us, "Once we made a complaint and it was handled brilliantly; within a week they [registered provider] set up a meeting and addressed it with all parties and it's been fine ever since."

Requires Improvement

Is the service well-led?

Our findings

There was not a consistently effective governance framework to ensure that actions arising from quality monitoring reviews were put right in a timely manner. The registered provider had a quality assessment framework to monitor the standard of service delivered. However, any shortfalls that had been identified were not checked in good time. For example, during the inspection we checked the fridge and found four items of food that had gone past their use by date, or had been opened and labelled to be used by a date that had expired. In addition, we found that the temperature of meat had not been probed and recorded as per the registered provider's own paperwork. The registered provider had a food safety sheet that staff completed containing fridge and freezer temperatures, which food had been prepared, and the temperature of any meats cooked. The temperature charts for meat that had been cooked had not been completed for any of the records we reviewed. We spoke to the registered manager about the expired food and lack of recording of meat temperature and were told that staff sickness had impacted upon the service's ability to manage risks in the kitchen. The issue regarding temperature recording had been highlighted in an audit on 5 February 2018. Subsequent to our inspection we were informed that the team leader had raised the issue of measuring meat temperatures and food labelling and checking at a team meeting after the audit and that a new thermometer was bought. Despite this action there had been no recorded checks to ensure the issue was put right up to our inspection.

We recommend that the registered provider reviews the timescales for following up issues identified during quality audits.

There was a programme of audits for health and safety, documentation and files, and the registered manager kept a key documentation register to show which documents needed updating, such as risk assessments or care plans. Audits had action plans and the registered manager had checked documents six weeks after the action plan had been written. One person told us, "I think the house is well run. The manager makes sure they [staff] understand how to look after people." One staff member said, "The managers are professional and efficient but very nice. They are very approachable and responsive and have the answer straight away."

There was an open and inclusive culture in the service. The service was person centred and each person was supported according to their own needs and the service achieved good outcomes for people. The registered provider produced a new mandate every four years: the current mandate focused on leadership, faith, service and growth. These values were incorporated in to Faith House by the registered manager and reviewed every year in a workplace review. We reviewed the latest annual appraisal and saw that plans to develop a network of churches and faith groups, and to organise a community gathering event, had been achieved.

There was a registered manager employed at the service and they had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. The registered manager was responsible for four services based in Canterbury and visited the service at least weekly. There was a 'locality manager' based in each service that reported to the registered manager and the registered

manager was in daily contact with locality managers. The registered manager knew people well and people were at ease speaking to the registered manager. The registered manager kept an overview of the service and where necessary had challenged staff members on day to day practice when supporting people. The registered manager was supervised by a director from the registered provider and had regular meetings and updates with the registered provider.

The registered manager was aware of the challenges facing the service and showed us solutions to recruitment issues currently being experienced. The service used some live-in staff and had been recruited from the UK and the EU. The registered manager had ensured that the right mix of people had been recruited who shared the organisations values. Recruitment had ensured that the organisation promoted equality and inclusion within its workforce by adhering to their equality and diversity policy when recruiting staff and promoting equality of opportunity for potential staff applying for work.

The registered manager and the registered provider were aware of their responsibility to comply with the CQC registration requirements. The registered provider had effective oversight of the management of the service and completed audits and checks as well as offering supervision and guidance to the registered manager. The registered manager had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. We saw that any incidents that had met the threshold for Duty of Candour had been reported correctly.

The registered manager was given good support from their line manager who supervised and appraised their performance and oversaw quality monitoring with the registered manager. The registered manager also met the nominated individual, with other managers, every six months for a three day work session looking at updates, sharing good practice at a local and national level. The registered manager told us that they had incorporated the use of electronic communication aides in to the service for some people after using them at the most recent meeting. The service had robust arrangements to ensure the security, sharing and integrity of confidential data, in line with data security standards. The registered provider had a national data protection team and was aware of imminent changes to data protection law. All documents sent via e-mail were from secure email accounts and password protected, and paper copies of documents were kept locked securely in the service.

People, their families and staff members were involved in the service and regular feedback was sought through questionnaires. Staff were involved through staff meetings held every two weeks. Each staff member had a key client and the meeting is used to discuss ways to help develop the person. Staff were able to make suggestions to improve the running of the service and one staff member suggested an improved way to support a person who was collecting excessive amounts of recycling waste in their room. People's friends and relatives were welcomed to the service and there was a family and friends day once a year where visitors can come for a meal and meet the director. There was a newsletter sent to families every three months and one person was regularly supported to video call their relative abroad.

The service was continuously learning and improving, and learning was shared with staff members. One relative told us, "They are very, very good and [name's] condition is very difficult to care for and once they got to know him it's been brilliant. If I email I get a response and if it's an issue I get a phone call as well as an email." There was a service development plan with goals that were being worked towards and achieved. There was a mentoring programme available for new staff where they were paired with a more experienced staff member. There were also away days for staff called 'days of reflection' where staff in similar groups,

such as first year staff, can meet up and spend time together. Information from incidents and compliments had been used to improve the quality of the service delivered. We reviewed one incident where the registered manager had given feedback in a team meeting around how to support a person following one incident. After the meeting the registered manager had ensured that risk assessments were reviewed to reduce the risk of the incident reoccurring.

The registered manager had a good working relationship with the local health and social work teams. The registered manager had regular contact with care managers and the local social work team. Speech and language therapy services had been involved and had assessed one person and a referral had been made to the local psychology services for another person. When there had been several low level incidents the service worked with the local safeguarding adults team to deal with them in one professionals meeting and the issues were resolved. The service worked closely with the local primary health teams and had close ties to the local doctor's surgery. The service had been sharing appropriate information with other relevant agencies for the benefit of people who use the service. The registered manager told us that information was only shared on a need to know basis and when staff work across different services they are trained not to use the names of people in other services.