The Sons of Divine Providence

St John's

Inspection report

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31 October 2017

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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?	Good

Summary of findings

Overall summary

This was an unannounced inspection that took place on 24 and 31 October 2017.

The home provides personal care and accommodation for up to six people with learning disabilities. It is located in the Teddington area.

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

At the last inspection on 2 and 7 September 2015 the home met all the key questions and was rated good in each with an overall good rating.

Relatives spoke on behalf of people with limited verbal communication. People enjoyed living at St John's and were happy there. They liked how staff provided them with care and support. People were enabled to make their own choices and these included activities with people going to and coming back from them during our visit. The activities they pursued were varied and took place at home and in the community. The home was a safe place to live and work and there was a welcoming, friendly atmosphere. People's interaction with staff and each other was positive throughout our visit.

The home's records were up to date and covered all aspects of the care and support people were provided with. People's care plans were individualised to them and contained comprehensive information that was regularly reviewed. This enabled staff to carry out their duties efficiently and professionally. Staff encouraged people to discuss their health needs with them and people had access to GP's and other community based health professionals. People were supported to choose healthy and balanced diets that also met their likes, dislikes and preferences, whilst protecting them from nutrition and hydration associated risks. They said they were happy with the choice and quality of meals provided.

People were well supported, familiar with the staff that supported them and staff were fully aware of people's needs, routines and preferences. Relatives told us that staff worked well as a team and provided them with updated information as required. Staff had appropriate skills and provided care and support in a professional, friendly and supportive way that was focussed on people and their individual needs. The staff were well trained and made themselves accessible to people and their relatives. Staff said they enjoyed working at the home and that the organisation was a good one to work for. They received good training, support and there were opportunities for career advancement.

People said the management team and provider were approachable, responsive, encouraged feedback and consistently monitored and assessed the quality of the service provided.

The health care professional that we contacted was satisfied with the support that the home provided 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? 'The service remains Good.'	**Good**
Is the service effective? 'The service remains Good.'	**Good**
Is the service caring? 'The service remains Good.'	**Good**
Is the service responsive? 'The service remains Good.'	**Good**
Is the service well-led? 'The service remains Good.'	**Good**

St John's

Detailed findings

Background to this inspection

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

This was an unannounced inspection and took place on 24 and 31 October 2017.

The inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During the inspection, we spoke with five people, three care staff and the registered manager. We also contacted six relatives, three of whom responded and two health care professionals one of whom responded. There were six people living at the home.

During our visit we observed care and support, was shown around the home and checked records, policies and procedures and maintenance and quality assurance systems. We also looked at the personal care and support plans for three people and two staff files.

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

Good

Is the service safe?

Our findings

People's body language and happy, smiling faces showed us they enjoyed and felt safe living at St John's. Relatives told us that they thought the home was a safe place for people to live and staff thought it was a safe place to work. One person said, "I'm happy." This indicated that they felt safe in the home's environment. A relative said, "St John's is ideal." Another relative told us, "The accommodation is excellent with everyone on the ground floor and the home is always clean."

Staff understood what constituted abuse and what to do if they encountered it. They were provided with policies and procedures regarding abuse and had received induction and refresher training that enabled them to protect people from abuse and harm safely. Their responses to our questions followed the provider's policies and procedures.

Staff were aware of how to raise a safeguarding alert, the circumstances under which this should happen and had received appropriate training. Safeguarding alerts were appropriately reported, investigated and recorded. There was no current safeguarding activity. There was also information about keeping safe available to people living at the home.

The staff recruitment process was thorough and staff records demonstrated that it was followed. The process included scenario based interview questions to identify prospective staff's skills and knowledge of learning disabilities. References were obtained and Disclosure and Barring service (DBS) security checks carried out prior to starting in post. DBS is a criminal record check employers undertake to make safer recruitment decisions. There was also a six month probationary period with a review. If there were gaps in the knowledge of prospective staff, the organisation decided if they could provide this knowledge, within the induction training and the person was employed.

Staff told us and their rota confirmed that staffing levels were enough to meet people's needs. The staffing levels during our visit enabled people's needs to be met and the activities they had chosen to be pursued safely. A staff member said, "There are very good staffing levels and we have the time to give people the support they need."

People had risk assessments that enabled them to take acceptable risks and enjoy their lives in a safe way. The risk assessments included their health, daily living and social activities. Risks were reviewed regularly and updated as people's needs and interests changed. Staff shared information regarding risks to individuals including any behavioural issues during shift handovers, monthly staff meetings and if they occurred during a shift. Staff told us they knew people living at the home very well, were able to identify situations where people may be at risk or in discomfort and took action to minimise the risk and reduce discomfort.

The home kept accident and incident records and there was a whistle-blowing procedure that staff said they would use if required. There were general risk assessments for the house and equipment used that were reviewed and updated. Equipment was regularly serviced and maintained. The home was clean and well

furnished.

Medicine was safely administered, regularly audited, appropriately stored and disposed of, when required. We checked people's medicine records and found that they were fully completed and up to date. Staff were trained to administer medicine and this training was regularly updated.

The health care professional that responded said they thought support that the home provided for people was safe.

Good

Is the service effective?

Our findings

People and their relatives told us they decided what care and support they received and when and how it was delivered. They told us that staff provided care and support in a friendly, enabling and appropriate way that they liked. One person said, "I'm going home for the weekend." A relative said, "My [person] needs are well met and she is always content and of a happy disposition." Another relative told us, "[person] gets on well with staff and residents and is now venturing out to Sainsbury's nearby walking there and back."

Staff received comprehensive induction and annual mandatory refresher training. Induction training was online and class room based depending on its nature. New staff also shadowed more experienced staff as part of the induction. This was to increase their knowledge of people living at St John's. The home had a training matrix that followed the Skills for Care 'Common induction standards' and identified when mandatory training was required. The training provided included challenging behaviour, medicine, food hygiene, equality and diversity and infection control. There was also access to specialist service specific training such as dementia. Staff meetings, bi-monthly supervision and annual appraisals were partly used to further identify any individual or group training needs. Staff had training and development plans on file. A member of staff told us they had received very good training.

People's care plans contained health, nutrition, diet and health action plans. These included nutritional assessments that were completed and regularly updated. Staff monitored weight charts weekly and they observed, checked and recorded the type of meals and how much people ate. This was to encourage a healthy diet and make sure people were eating properly. There was also information regarding the type of support people required at meal times. Staff told us that any health concerns were discussed with the person, their relatives and their GP as appropriate. Nutritional advice and guidance was provided by staff and there was regular communication with the local authority health care team who reviewed nutrition and hydration. Other community based healthcare professionals, such as district nurses and speech and language therapists visited. People had annual health checks and records showed that referrals were made to relevant health services when required.

People chose the meals they wanted using pictures, decided on a menu and participated in cooking. One person told us, "I've been cooking." A relative said, "The food is always good." Meals were timed to coincide with people's activities and their preferences.

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

We checked whether the service was working within the principles of the MCA and if any conditions on

authorisations to deprive a person of their liberty were being met. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider, all applications under the DoLS had been authorised, and the provider was complying with the conditions applied to the authorisation. Best interests meetings were arranged as required. Best interests meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and were recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the MCA and DoLS. Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit.

The organisation had a de-escalation policy and procedure that staff had received training in. They were also aware of what constituted lawful and unlawful restraint. Individual de-escalation guidance was contained in people's care plans if required and any behavioural issues were discussed during shift handovers and staff meetings.

The home worked closely with the local authority and had contact with organisations that provided service specific guidance and informed of local events taking place, such as Richmond Mencap.

The health care professional that responded said they thought support that the home provided for people was effective.

Good

Is the service caring?

Our findings

Staff had received training about respecting people's rights, dignity and treating them with respect. This was reflected in their respectful care practices and way they supported people which provided a relaxed, inclusive and fun environment which people enjoyed. People and their relatives said that staff treated people with kindness, dignity and respect. A relative said, "I'm impressed by the home's atmosphere, very homely." During our visit the home's atmosphere was comfortable and relaxed with people's body language reflecting this. This was mainly due to staff's calm and friendly approach to meeting people's needs. This was done in a skilful and patient way that showed us staff knew people and their needs and preferences well. Staff were warm, encouraging and approachable. Whilst people did not directly comment whether staff cared about them, there was a lot of smiling, cuddles and laughter that people clearly enjoyed. Relatives said staff were compassionate and that the care provided was of a good standard and delivered in a friendly and empowering way. This matched the staff care practices when staff were aware we were present and when they were unaware that we were observing them.

Staff received training in, recognised and put into practice people's rights to independence, equality and diversity. People were frequently consulted by staff about what they wanted to do, if they needed anything and if they had been out, what they had been doing. Staff also took time to facilitate positive interaction between people and encourage friendships and provided support in a friendly, cheerful and helpful way. One person told us, "We are all friends." A relative said, "Staff are excellent, no complaints and [relative] knows them all well."

There was a visitor's policy which stated that visitors were welcome at any time with the people's agreement.

The home had a confidentiality policy and procedure that staff said they understood, were made aware of and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook.

The health care professional that responded said they thought support that the home provided for people was caring.

Good

Is the service responsive?

Our findings

People and their relatives said they were enabled to make decisions about their care and the activities they wanted to do. Staff communicated with people in a way that people could understand. They made sure they were understood and that they understood what people were telling them. They asked what people wanted to do, where they wanted to go and who with. This included the type of activities they liked. People also discussed activities with staff during keyworker sessions and home meetings.

Staff knew what people's needs and wishes were and met them promptly. Their needs were met in a way that they enjoyed and were comfortable with. During our visit people were encouraged to give their views, opinions and make choices by staff and the registered manager. Staff made themselves available for people to discuss any wishes or concerns they might have. A relative said, "I visit regularly and [relative] is very happy there."

People were given the opportunity to make decisions and we saw that staff met peoples' needs in an appropriate and timely way. People's positive responses reflected the appropriateness of the support staff provided. If people felt they had a problem, it was resolved by staff quickly and in an appropriate way.

The registered manager explained the procedure followed when a new person was considering moving in. The assessment process identified if people's needs could be met. Local authorities referred people and provided assessment information. The home also requested information from any previous placements. The home shared all available information with staff to identify if people's needs could initially be met. The home then carried out its own pre-admission needs assessments with the person and their relatives.

The organisation's policy and procedure stated that people, their relatives and other representatives would be fully consulted and involved in the decision-making process before moving in. They were invited to visit as many times as they wished before deciding if they wanted to live at St John's. They could stay overnight if they wished to help them make a decision. Staff told us the importance of considering people's views as well as those of relatives so that the care could be focussed on the individual. It was also important to get the views of those already living at the home. During the course of these visits the assessment information would be added to.

Written and pictorial information about the home and organisation was provided for people and their relatives and regular reviews took place to check that people's placements were working. The registered manager said that if a placement was not working alternatives would be discussed and information provided to prospective services where needs might be better met.

People's care plans were individualised, person focused and part pictorial to make them easier for people to understand. They recorded people's interests, hobbies, health and life skill needs and the support required for them to be fulfilled. They were focussed on the individual, contained people's 'social and life histories' and were live documents that were added to when new information became available. People's needs were regularly reviewed, re-assessed with them and their relatives and re-structured to meet their changing

needs. People were encouraged to take ownership of the plans and contribute to them as much or as little as they wished. They agreed goals with lead staff that were underpinned by risk assessments and daily notes confirmed that identified activities had taken place. The care provided was focussed on people as individuals and we saw staff put their person centred training into practice.

Each person had their own weekly activity planner and the home made use of local community based activities wherever possible with people choosing if they wanted to do them individually or as a group. One person said, "I'm doing drawing." Another person told us, "I go dancing on Wednesdays and I'm going to watch a scary movie on Halloween." Activities included day centres where people met their friends, college and a variety of other different things such as 'stepping out', cinema, bowling and shopping. Other activities included visiting the pub, swimming at the hydro pool, walks along the river and bus rides. People were also encouraged to do tasks at home to develop their life skills such as laundry, tidying their rooms, helping with lunch and putting the rubbish out. One person told us and staff, "I'm going to make a chocolate cake for when you come back [for the second inspection day]." The person did help to make a chocolate cake for us on the second inspection day and made us coffee. Another person was supported to have a nice relaxing guiness, after a busy day that they were clearly enjoying. There were also home based activities such as drawing and puzzles. One person told us how much they enjoyed doing puzzles and there were examples of people's artwork hanging on a wall in the kitchen. People also had regular visits to and from their relatives.

People did not comment on the complaints procedure. Their relatives said they knew about the complaints procedure and how to use it. It was provided in pictorial form for people to make it easier to understand. There was a robust system for logging, recording and investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people to make complaints or raise concerns. There were no current complaints.

The home and organisation used different methods to provide information and listen and respond to people and their relatives. There were weekly house and menu planning meetings where people could express their views and make choices. Annual questionnaires were sent to people, their relatives and staff. There were also monthly keyworker and annual care reviews that people were invited to.

The health care professional that responded said they thought support that the home provided for people was responsive.

Good

Is the service well-led?

Our findings

People's relatives said that they were made to feel comfortable by the registered manager and staff and were happy to approach them if they had any concerns. One person said, "[The registered manager] is nice." A relative told us, "They are very good and keep you informed." During our visit, the home's culture was open with the registered manager and staff listening to people's views and acting upon them.

The organisation's vision and values were clearly set out. Staff we spoke with understood them and said that they were explained during induction training and regularly revisited during staff meetings. The management and staff practices we saw reflected the organisation's stated vision and values as they went about their duties. There was a culture of supportive, clear, honest and enabling leadership.

The organisation had clear lines of communication and staff were designated with specific areas of responsibility. Staff told us the support they received from the registered manager and organisation was good. They felt suggestions they made to improve the service were listened to and given serious consideration. One staff member said, "The good thing is that they [Registered manager] chip in and it's all hands on deck." The organisation was transparent and there was a whistle-blowing procedure that staff felt confident using if they had to. They said they really enjoyed working at the home. There were regular minuted home and monthly staff meetings that enabled everyone to voice their opinion.

There was a policy and procedure in place to inform other services, such as district nurses, of relevant information should services within the community or elsewhere be required. The records showed that safeguarding alerts and accidents and incidents were fully investigated, documented and procedures followed correctly including hospital admissions. During our visit one person was admitted to hospital and arrangements were made for staff to visit them each day to re-assure and support them. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

There was a robust quality assurance system that contained performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. This enabled required improvements to be made. Areas of good practice were also recognised by the provider. Annual organisational quality audits were conducted, there were annual care development plans and monthly care services manager audit visits also took place. These included random sampling of different aspects of the care and support provided at each visit. They included checking files, records, talking to people, staff, building maintenance and budgeting. There were also daily health and safety checks that staff members took responsibility for and the registered manager checked was taking place. Shift handovers included information about each person that enabled staff coming on duty to be aware of anything they needed to know. There were also local authority contract monitoring visits.

The health care professional that responded said they thought support that the home provided for people was well led.