Society of the Sacred Heart

Duchesne House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 and 17 November 2017 and was unannounced.

Duchesne House is a Catholic care home, providing personal care to sisters of the Society of the Sacred Heart religious order, in the London Borough of Wandsworth. The home is registered to for 22 people some of whom may have dementia. At the time of the inspection there were 13 people using the service.

The service was last inspected on 10 November 2015 and was rated 'Good'.

The service had a registered manager in place. 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.

People were not always supported by staff that had undergone regular training to effectively meet their needs. Training in some mandatory areas was not up to date. We shared our concerns with the registered manager who took action to address our concerns. We were satisfied with the action taken by the registered manager.

People received their medicines as prescribed. Records management of medicines was not always accurate. We shared our concerns with the registered manager. After the inspection the registered manager put systems and processes in place to address our concerns. We were satisfied with the action taken.

People continued to be protected against the risk of harm, abuse and identified risks. The service had embedded systems and process in place that gave staff clear guidance on how to mitigate identified risks. Staff were aware of how to identify, report and escalate suspected abuse. Staff received safeguarding training.

People were supported by sufficient numbers of staff to keep them safe. Rotas were flexible to ensure people's changing needs were reflected in staffing levels.

People were protected against the risk of cross contamination because the service had implemented systems and processes to ensure infection control was managed safely.

People are supported to have maximum choice and control of their lives and staff do support them in the least restrictive way possible; the policies and systems in the service do support this practice. Staff had an adequate understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's dietary needs and requirements were met. People continued to be supported to make healthy choices and were given access to a wide range of healthcare professionals.

The service ensured people's needs were being met by the design and adaption of the premises. Changes to the environment were done in consultation with people as far as practicably possible.

People continued to be treated with compassion and kindness. The service employed Pastoral officers to ensure people's spiritual and emotional needs were catered to. People had their right to privacy and dignity maintained. The service placed emphasis on ensuring people's end of life care was delivered in a way they chose. People receiving end of life care were treated with the upmost dignity and kindness.

Staff supported people to make decisions about their care and support. People were given information in a manner they understood to enable them to make decisions. People were able to raise their concerns and complaints, systems in place ensured those who may find it difficult to speak up, had a voice.

People received person centred care that was tailored to their needs. People were encouraged to be involved in the development of their care plans, which were reviewed regularly to reflect their changing needs.

People views about the service continued to be sought through regular house meetings, keyworker sessions and pastoral discussions. Issues identified through feedback received was then acted on in a timely manner.

People received care and support from a service that actively encouraged partnership working with other healthcare professionals. A healthcare professional told us any recommendations given to the service were implemented into the delivery of care.

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 remains Good.

Is the service effective?

Requires Improvement

The service requires improvement. People did not always receive care and support from staff that had up-to-date training.

People's consent to care and treatment was sought prior to the delivery of care. Staff delivered care in line with legislation.

People were supported to access sufficient amounts to eat and drink that met their dietary requirements.

People were encouraged to make healthy decisions about their health and wellbeing and had access to a wide range of healthcare professionals.

The adaption of the service took into consideration the needs of people.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Duchesne 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and 17 November 2017 and was unannounced.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we gathered information we held about the service, for example information from members of the public, healthcare professionals and notifications. Statutory notifications are information about important events which the service is required to tell us about by law. We used this information to plan the inspection.

During the inspection we spoke with seven sisters of the sacred heart (people), seven staff members, one health care professional, the registered manager and the provincial. A provincial is an officer who ensures that orders are properly carried out. We reviewed five care plans, five medicine administration records, two staff files and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "Safe, what a strange question to ask me. Of course I feel safe, why wouldn't I?" A healthcare professional told us, "I believe [people] are safe here, as they are well looked after by staff."

People received their medicines as prescribed. Although people received their medicines correctly, we identified medicine administration records (MAR)s did not always contain the correct balance of remaining medicines. We raised our concerns with the registered manager who subsequent to the inspection sent us an action plan detailing, daily audits and checks to be carried out to ensure medicines were managed in line with good practice. We were satisfied with the action taken by the provider.

People continued to be protected against the risk of harm and abuse. Staff were able to clearly demonstrate sufficient knowledge on how to identify, report and escalate suspected abuse. Staff confirmed they would inform the registered manager of any suspected abuse and if they felt this wasn't being address appropriately would contact more senior staff or relevant external agencies for support and guidance. Staff confirmed they received safeguarding training.

People were supported against identified risks. People were supported and encouraged to take risks and these were monitored and managed to ensure people remained safe whilst maintaining their independence. Records confirmed risk management plans were in place which gave staff guidance on how to mitigate risks and action taken to minimise future risks. Risk management plans included, for example, medicines, mobility, food, fire and reticence in reporting problems. Risk management plans contained the activity, hazard, likelihood of the hazard occurring and measures in place to mitigate the risk. We identified all risk management plans were reviewed regularly to ensure people's changing needs were documented.

The service employed sufficient numbers of staff to ensure people's needs were met and they remained safe from harm. People told us there were adequate numbers of staff on duty to meet their needs, this was confirmed by staff. Records confirmed staff employed underwent pre-employment checks to ensure their suitability for the role. For example, staff records contained photo identification, proof of address, and a completed Disclosure and Barring Services (DBS) check. A DBS is a criminal records check employers undertake to make safe recruitment decisions. We noted during the inspection that DBS checks observed were outside of the three year good practice renewal date and informed the registered manager of our findings. The registered manager agreed to review the systems in place to ensure DBS were carried out in line with good practice.

People were protected against the risk of infection as the provider had systems and processes in place to minimise those risks. The service employed full time ancillary staff to ensure the environment was clean. Infection control plans included guidance on hand washing and supplying staff with personal protective equipment (PPE). PPE includes, aprons, gloves and other items of clothing that protect people from the spread of infection. For example, when supporting people who have open wounds or contagious conditions.

Equipment checks to ensure they were hygienic were undertaken regularly.

Requires Improvement

Is the service effective?

Our findings

People did not always receive care and support from staff that had up-to-date training to effectively meet their needs. We received mixed feedback from staff regarding the training provided. For example, one staff member told us, "I do have concerns about the training we receive. It's not up-to-date." However other staff we spoke with spoke positively about the training provided. For example, "The last training I did was safeguarding and medicines management. The training was online and sometimes can be classroom based."

During the inspection we identified that not all staff had up-to-date training. However we observed staff's knowledge and skills were sufficient to meet people's needs. We shared our concerns with the registered manager who told us, "I'm aware that some of the training needs updating. We are organising this." During the inspection the registered manager sent us the training matrix, which identified training was not current and staff were overdue in certain training, for example, Mental Capacity Act 2005, first aid and moving and handling. After the inspection the registered manager sent us an updated training matrix that showed staff were now in the process of the online e-learning training to complete all out of date training. We were satisfied with the action the registered manager had taken to address our concerns.

People received support from staff that had received a comprehensive induction to meet their needs. Staff spoke positively about the induction they received and comments such as, 'the induction was very helpful and it helped me to do my job, 'It [induction] very good'. The induction included the history of the service, the role of the keyworker, confidentiality, aims and objectives and conduct. Staff were required to successfully complete their induction before being deemed as competent to work without direct support.

People continued to receive support and guidance from staff that reflected on their working practices in order to deliver more effective care. One staff member told us, "I have a supervision every two months. I get to discuss any of the concerns I may have and talk about my work performance." Staff received regular supervisions, which reviewed staff's performance, training needs and their health and wellbeing. Where issues had been identified, an action plan was developed to ensure action was taken to address the issue.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider's policy supported this practice.

People confirmed they were offered choices about the care and support they received and that their choices were respected. Staff had an adequate understanding of the MCA and their roles and responsibilities in line with legislation. For example, one staff member told us, "We [staff members] ask for people's permission before we do anything. You have to respect people's decisions." At the time of the inspection no one was subject to a DoLS authorisation, however the registered manager was aware of the correct procedure should they feel someone's capacity was fluctuating.

People continued to be encouraged to maintain a healthy diet and lifestyle. We observed the lunchtime on the first day of the inspection and identified that staff supported people appropriately. Where people required specific support to eat their meals, this was done compassionately and at a pace people preferred. People with complex dietary requirements were catered for. Those that were able to eat independently, were provided with serving dishes at their table, enabling them to help themselves. People confirmed they were offered a range of choices with the food available and they could eat either in the dining room or in their rooms. For example one person told us, "If I don't want to get up, I can have my breakfast in bed."

People were supported to make healthy choices regarding their health and wellbeing. People confirmed they had access to a wide range of healthcare professionals. For example, G.P, district nurse, dentist, optician and chiropodist. A healthcare professional confirmed, guidance given was then implemented into the delivery of care. During the two day inspection we observed three district nurses attended the service. Records confirmed what the healthcare professional told us.

People continued to be involved in the development, design and adaption of the service. At the time of the inspection the provider informed us they were due to undergo refurbishment of the service. The registered manager showed us the plans for the refurbishment which detailed consultation with people living at the service to improve the quality of the home. For example, lay out of some rooms. The renovation would include rooms being made bigger to incorporate en-suite bathrooms.

Good

Is the service caring?

Our findings

People and a healthcare professional spoke positively about the care and support they received. People confirmed they continued to receive compassionate, caring and respectful support from all staff members. One person told us, "Staff are wonderful, what else can I say." Another person said, "We [people] can't complain, the staff are very kind and helpful." A third person said, "The staff are kind and I get the care I need." A healthcare professional told us, "The staff treat people with respect and are very welcoming. I would definitely be happy if my loved one were to live here."

During the inspection we noted that people and staff had developed positive relationships, which were based on respect, empathy and encouragement. Staff knew people they supported well and were aware of their changing needs and spoke to them using their preferred name. Staff were observed interacting with people meaningfully and doing so with respect. Staff were also observed knocking on people's bedroom door before entering and gaining authorisation to do so. This meant that people's privacy and dignity was respected.

The service continued to deliver a service that embraced people's diversity and treated them as equals. The embedded culture of the service was evident through the support people were provided which enable them to follow their beliefs. The service employed pastoral care offices, who supported people spiritually and gave them additional support and guidance. People were supported to attend a daily mass which was held in the service and attended by local residents. People were encouraged to attend mass and were given space and time to pray in their rooms as they wished. People's bedrooms were personalised with items that referenced and reflected their religious beliefs.

People continued to be encouraged to share and express their views. One person told us, "We aren't made to do things but we discuss topics such as health and healthy eating and exercise." The registered manager was aware that there was a culture of people not speaking out and had devised risk assessments to ensure people were supported to raise their views. The service held regular house meetings, whereby people were encouraged to attend and develop the agenda for discussion.

People were supported to retain and enhance their independence as much as possible. People confirmed they were able to go to the shops, meals out, university and other places in the local community independently. During the inspection we observed staff encouraging people to do things for themselves as much as practicably possible. For example, when deciding what to do for the day and attending mass. Staff confirmed they offered people praise when they had attempted to do things for themselves, which in turn raised their self-esteem and self-worth. We observed staff supporting people and giving them reassurance and praise throughout the two day inspection.

Good

Is the service responsive?

Our findings

People continued to receive a service that was person centred and responsive to their individual needs. Although not everyone was certain if they had been involved in their care plans, records showed people were involved in the development and had signed their care plans. One person told us, "Everyone has a care plan, they [staff members] know what we need and they do spend time with us."

People's care plans were comprehensive and detailed people's aspirations, preferences, likes, dislikes, health, social and medical care needs. Care plans were reviewed every three months to ensure they were current and accurately reflected people's needs. For example, the review process set out goals to be achieved and by whom. Staff confirmed they read and understood the reviewed care plans to ensure they delivered up-to-date care. Where changes were made in people's care plans, these were shared with staff in a timely manner. Care plans also contained correspondence from healthcare professionals and recommendations made to enhance the delivery of care provided was then implemented.

Day pen profiles were also part of people's care plans. Pen profiles gave staff clear guidance on people's preferred structure and order for their day. This included, when they wanted to have personal care, where and when to have breakfast, what activities they wanted to engage in, when they wished to have time alone reflecting and praying and when they wished to go to bed. The pen profiles were reviewed regularly to ensure they reflected people's preferences.

People continued to be supported to make decisions about the care and support they received. Throughout the inspection we observed people being given choices, for example, if they wanted to participate in the planned activity or if they wanted to speak with the pastoral care officer. People's decisions were respected by staff members.

Activities available to people reflected their preferences and cultural needs. One person told us, "We do Tai Chi and I like reading. The Mobile Library comes regularly." Another person said, "We can do as much or as little as we want and I like my daily jobs, so I have enough to do." A third person told us, "We have lots of parties, we do enjoy ourselves." People were supported to access the local community, attend university lectures, go shopping, participate in flower arranging and attend Mass. The service also had three libraries people could access at any time. People's preferences were documented in their care plans and it was noted that people who preferred solitude and reflection time, were afforded this.

People continued to be supported in raising their concerns and complaints. One person told us, "I don't like complaining but if something's' wrong I tell the staff and it's usually sorted straight away." We reviewed the complaints file and found there had been no formal complaints received in the last 12 months. The service recognised that people did not always like to speak of concerns and complaints and this was identified in the risk assessments for people. Which gave staff clear guidance on supporting them with Pastoral Officers to encourage people to share their concerns.

People's preferences in reference to their end of life care were respected. One person told us, "We have to

accept that death comes to all of us. We are supported." Another person said, "We invited [Father who holds Mass] to live amongst us and he has a flat in the New House. He is a great help to us." People's care plans contained their living will which had clear reference to the type of care and support they desired when receiving end of life care. Staff had a clear understanding of people's needs and wishes. At the time of the inspection there were two people receiving palliative care. During the inspection we observed staff supporting those who were at the end stage of their lives, staff were identified as being compassionate, caring and respectful at all times.

Good

Is the service well-led?

Our findings

People, staff and a healthcare professional spoke positively about the management of the service. For example, one person told us, "Our [registered] manager is kind to us and always has her [office] door open." Another person said, "It's [the service] is managed well." A healthcare professional said, "The service really does seem alright."

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.

Staff had a clear understanding of the provider's visions and values and clearly demonstrated these throughout the inspection. One staff member told us, "The values are to maintain people's dignity, privacy and to keep people safe. It's also to ensure we support people with their religious needs." People received care, support and guidance that was person centred and reflected the provider's values.

The service notified the Care Quality Commission of safeguarding and statutory notifications in a timely manner.

The service had a very peaceful, relaxed and welcoming atmosphere where people were free to come and go as they pleased. Throughout the inspection we observed people and staff seeking guidance and support from the registered manager. People appeared to be at ease with the registered manager and staff alike. Staff described the registered manager as, 'caring', supportive' and 'approachable'.

People received support from a service that routinely reviewed the care provision through regular audits. Audits included accidents and incidents, care plans, maintenance and health and safety matters. Records confirmed where issues had been identified, regarding people's care or the health and safety of the building, these were addressed in a timely manner. We spoke with the registered manager regarding the out of date training, the registered manager was aware of the training issues identified and took action to address our concerns.

People's views on the service and care they received continued to be sought regularly. This was done in the form of house meetings, pastoral sessions, care plan reviews and general discussions. We reviewed the monthly house meeting minutes and found people were encouraged to add to the agenda, to ensure their views were discussed. Where discussions had taken place and decisions made these were then actioned by the registered manager. For example, people discussed whether they wanted television sets in their rooms.

The registered manager continued to work in partnership with other professionals to drive improvement. A healthcare professional told us, "They [the service] listens to our advice about the care provision. Staff are prompt in their response [in implementing our guidance]. Care plans detailed that consultations had taken place with architects and people to devise plans for the refurbishment of the service. People's views were

taken into consideration and actioned where possible.