Nazareth Care Charitable Trust

Nazareth House - East Finchley

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 1 and 2 December 2014. When we last inspected the home on 4 September 2013 we found no breaches of the regulations we looked at.

Nazareth House is a residential home that provides accommodation and nursing with personal care for up to 84 older people with physical ill health or learning disabilities. The home is run by a charitable trust connected to the Catholic church. The home has two floors and each person had their own bedroom, some with an ensuite bathroom. People share a communal lounge, dining area and bathrooms. Located in East Finchley in the London Borough of Barnet, the service has a garden, activities rooms and a church where daily Mass occurred. At the time of our inspection 64 people lived there.

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

Summary of findings

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.

Most people said they were safe at the service and some people said staff were kind and listened to their needs.

Medicines were not always stored appropriately. Although systems were in place for returning medicines, these were not always followed. Staff did not always understand the medicines they were dispensing. People were at risk of inappropriate or unsafe care through the unsafe use and management of medicines.

Risk assessments and care plans were completed by the service, however staff did not always understand the risks associated with people's support as these were not always clearly documented. People and relatives we spoke with said they had not been involved in planning and reviewing their own or their relative's care.

Staff had not been supported by the service as they had received regular supervision, appraisals and training. Therefore staff may not have had the correct skills to care for people at the service.

Although people's capacity to understand and make decision about their support had been assessed, we could see no evidence that best interests meetings had occurred with people who knew and understood the person when necessary.

People were supported by staff to access health care professionals and details of these meetings were recorded in people's care records.

Staff were aware of people's likes and dislikes and treated them with dignity and respect.

People knew how to complain and said they knew the registered manager. However, most relatives we spoke with did not know who the registered manager was and said they would like to better understand the complaints process at the home.

Although systems were in place to monitor the quality of the service, we saw these were not effective. They had not picked up on problems that we observed during the inspection such as medicines being incorrectly stored.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The home was not always safe. Medicines were not always stored safely and dispensed by staff who had the skills and knowledge to do so.

People may not have been safe as not all staff understood safeguarding and their responsibilities in keeping people safe.

Although the service monitored staffing to ensure there were enough staff to meet people's individual and changing needs, some people told us there were not enough staff with the correct skills and knowledge to support them.

People had individual risk plans, however these were not fully understood by staff which left people at risk of receiving unsafe support.

Is the service effective?

Requires improvement

The service was not always effective. People were not always supported by staff who were appropriately trained and supported in their work.

Staff supported people to access other healthcare professionals to ensure their healthcare needs were met.

People were able to choose the food they ate and staff supported them to eat and drink. People were assessed and supported to maintain good nutrition.

Staff did not always understand the requirements of the Mental Capacity Act 2005. People had capacity assessments where needed but these had not been completed with the support of relatives or independent advocates to ensure the person was represented and decisions made in their best interests.

Is the service caring?

Requires improvement

The service was not always caring. Although we saw staff being patient, kind and compassionate, they sometimes spoke about people they cared for in a negative way.

Staff supported people to maintain relationships with friends and families within and outside the service.

Is the service responsive?

Requires improvement

The service was not always responsive. People did not always receive personalised care that met their needs.

People and their relatives were not always involved in planning and reviewing their care.

The provider sought feedback from people who used the service and their representatives yearly.

Summary of findings

People knew how to complain and were aware who the registered manager was. Most relatives did not know who the registered manager and deputy manager were should they wish to make a complaint.

Is the service well-led?

Requires improvement 

The service was not always well-led. The provider did not always have effective systems for reviewing services. They had not identified the concerns we found and their audits of medicines had not resulted in safe medicines practices.

The provider sought feedback from people who used the service and their representatives however this had not occurred in 2014 by the time of our visit.

Accidents and incidents were reviewed and the service encouraged learning from these.

Nazareth House - East Finchley

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 1 and 2 December 2014 and was unannounced.

The inspection was conducted by a single 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. Their area of expertise was in the care of older people.

Before the inspection we reviewed all of the information we held about the service including notifications the provider must send to us about important events.

During the inspection we spoke with 10 people who used the service, eight care workers, the activities coordinator, the chef, one of the deputy managers, the registered manager and the regional manager for London, as well as nine relatives. 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.

We reviewed the care and support records for 10 people and looked at staff personnel files for nine care workers. We also reviewed records relating to the management of the service such as emergency plans and records, policies and procedures, records of checks and audits undertaken, medicines records, staff and resident meeting minutes and equipment and premises maintenance records.

Inadequate

Is the service safe?

Our findings

Some people told us they received their medicines on time. One person said, "The staff look after my medicines and they always give it to me on time." Another person did not have the same experience and said, "Staff do not understand the importance of my medicines been given to me on time, I very rarely get them on time, this causes me discomfort for the remainder of the day." They went on to say, "The staff do not understand why I'm taking these medicines, if they did they would make sure they were on time." During the inspection we looked at how the service's medicines were ordered, stored and dispensed. We found that the service was not always appropriately recording and keeping medicines safely.

In the room where the service stored their medicines, we saw that staff had not been recording the temperature of the room during the last month. When they had recorded the temperature it had been over the recommended temperature five times during October and no action had been taken. Staff we spoke with were unaware what to do should this occur. The service did not have a suitable process for ensuring that medicines were consistently stored at or below the correct temperature, so medicines may not have been safe to use.

Staff did not always understand the medicines they were giving to people and possible side effects. We saw on one floor that eight sets of eye drops that were kept in the fridge had not been labelled with the date they were opened. Therefore these medicines may not have been safe to use. We reviewed medicine administration records (MAR). These had been completed by staff. However, we noted that when people were on as-required eye drops for dry eyes we saw no evidence that staff had asked people if they required these as it had not been recorded people had been asked and refused. One person told us, "I need eye drops but the care staff never remind me that I have them, the drops help with my dry eyes." Staff we spoke with did not know what the different eye drops were for and were not confident giving eye drops and eye ointment. They were unsure if this had been provided in their medicines training. Therefore people were at risk of not receiving medicines when they needed them or medicines being administered by staff who were not trained or confident.

The home stored controlled drugs, however both of the cupboards in which these drugs were stored did not meet the legal requirements. This had been noted at the last inspection in September 2013. We spoke with the registered manager who showed us evidence that new cupboards had been ordered. We reviewed the controlled drugs and records kept at the home and saw that often staff had not been signing the book correctly. They had not been recording when medicine was received or returned to the pharmacy when it was no longer needed. Therefore there was a risk that controlled drugs were unaccounted for. We reviewed the returns book and medicine arriving at the home and found evidence of these medicines arriving and leaving the service. Some staff we spoke with were unaware they should have been recording in the controlled drug book when medicine arrived or was returned to the pharmacy.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with 10 people who used the service. Eight people told us they felt safe. Comments included, "I'm perfectly safe here", and "This is a very safe place". However, two people said they did not feel safe. One person said, "I do not feel safe here at all," and another said, "I'm not safe at night". We saw that some staff were kind and listened to people. However, staff did not always understand risks to people, although they had read people's risk assessments. We saw they understood if someone was at risk of falling and how to reduce this happening. However, when people had more complex needs staff did not fully understand their roles in reducing the risk. For example, ensuring people received pain-relieving medicine on time before moving and handling, to reduce the person's pain. The eight risk assessments we looked at did not explain in enough detail to allow staff to fully understand the risk. We saw for all lifting and handling risk assessments, it was not always evident how many people were needed to support the person, the equipment needed such as size of sling, and the needs of the person. All the people we spoke with had not had input into the development of their risk assessments. Therefore, people were at risk of receiving inappropriate or unsafe care due to staff not understanding people's risks fully.

The registered manager and staff told us that after a recent investigation, the service now had extra checks in place to

Is the service safe?

support people who may be at risk of pressure ulcers. For example, checking special equipment such as mattresses were set at the correct level daily, and contacting the tissue viability nurse (TVN) and the registered manager or deputy with any concerns. Staff we spoke with knew which people at the home were receiving support from the TVN. However, staff we spoke with did not fully understand what signs may suggest that someone was at risk of developing a pressure ulcer and when to notify the registered manager and the TVN. Therefore, people may have been at unnecessary risk of developing pressure ulcers.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service completed risk assessments such as Waterlow assessments (assessing the risk of getting a pressure sore) and the Malnutritional Universal Screening Tool (MUST) which records people's weight and height to assess the risk of people experiencing malnutrition. These were up to date. We reviewed other documents such as turning charts for people who were at risk of developing a pressure ulcer or had an ulcer; these were fully completed.

Four people at the home told us there were enough staff to meet their needs. One person said, "Attentive staff; will be better when we have the new nursing station. Staff will be more visible." Another told us, "Staff are available when I need help." However, four people said their needs were not met due to staff not being available when needed. One person said, "I press my buzzer at night and no one comes to help me." Another said, "I ring my bell for help, staff come, switch it off and say they will be back, but I have to ring again as they do not come back. Then I get upset at the staff and they get upset with me." Another person said, "I press the bell and no one comes, at night I have to shout and shout for help." We pressed this person's call bell and no staff responded. We reported this to the registered manager and maintenance staff. Later we were told the call bell had been put in the incorrect socket. We were unsure how long this person had not had a call bell that worked. We spoke with the registered manager who had a plan in place to prevent this happening again.

People told us they could not get help quickly at night and in the morning when everyone was getting up. One person told us staff were rushed in the morning, adding, "Staff are sometimes not kind in the morning, they roll me and push me about as they are rushing. It's painful for me and I get upset." We saw the service monitored people's dependency levels and the registered manager believed there was sufficient staff to meet people's needs. Staff we spoke with did not agree and said more staff were needed in the morning when people needed to get up and washed and during the night to meet people's increasing care needs. The provider had been using agency staff, however we saw that the registered manager had recently employed more permanent staff. She told us this would help with continuity of care for people, however we were not assured that this change would be sustained and would result in more positive experiences for people and staff.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Effective recruitment procedures were in place to ensure that staff employed were suitable to work at the service. We reviewed nine staff recruitment records which showed that checks were undertaken before staff began work and robust recruitment, selection and employment processes were in place. Staff records showed staff had criminal record checks, two written references, evidence of the right to work in the UK, proof of identity, and full employment history.

We saw the service premises were being refurbished. This included new dining rooms, lounges, medicine rooms and bedrooms with ensuite facilities. This work had been ongoing for some time. People said sometimes it was difficult to cope with the noise, but when they saw the improvements it was worth it. We noted in the lounges that had not yet been refurbished people were sitting in seats that were worn, not supportive and did not protect people's pressure areas. We spoke with the registered manager and the regional director who confirmed that new furniture had been ordered for all lounges.

The service was protected from foreseeable risks. This included a business contingency plan which set out how those risks would be managed and an emergency evacuation plan.

Requires improvement

Is the service effective?

Our findings

Two people told us that staff were "nice". Three people told us that staff were training to support their changing needs. One person said, "I think the staff are trained, well I see them having training sessions." However the remaining five did not think staff had the correct training. One person said, "I do not think they have the expertise and knowledge to care for me." Another said, "They do not understand my illness and how to manage it."

Staff told us they received training. However, they all said they would like more on understanding people's specific physical needs such as pain management and epilepsy. Staff told us they had completed training on moving and handling, infection control, fire and safeguarding. When we reviewed staff training records, we saw three staff had received some training in 2014 such as safeguarding and infection control. We saw that provider's mandatory training for all staff included fire safety, moving and handling, and food hygiene. The provider's policy stated staff should receive a minimum of three training days a year. We saw staff had not undertaken the mandatory training in line with the provider's policy. We saw during the inspection that staff struggled to support people who were able to explain their needs clearly and how they would like these needs to be met. Staff did not have the skills and training to manage people's different needs at the home effectively.

The registered manager told us that supervision had not been happening at the service prior to her arrival in June 2014. She told us staff were now starting to receive supervision, and regular staff meetings were occurring for day and night staff. Of the nine staff files we reviewed, we saw that only one person had received supervision in 2014. However, four of the staff we spoke with confirmed they had received supervision. We saw that the registered manager was providing group supervision, however most staff had not been involved in these. None of the staff had received an appraisal in 2014. The registered manager confirmed this and said she had plans to ensure all staff would receive appraisals from April 2015. We reviewed the staff meeting minutes which included discussions about pressure care, activities and care plans. We saw that not all staff attended these meetings. We reviewed the provider's Staff Supervision Policy and saw that the registered manager was responsible for ensuring supervision occurs for every member of staff bi- monthly. It went on to say that the four main objectives of supervision are: maintaining high quality service delivery, staff development, staff support, and ensuring compliance with adult social care policies and procedures. Therefore the provider was not following its own policy and not ensuring that staff were supported to enable them to deliver care safely and to a high standard.

This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with had little understanding of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty safeguards (DoLS). However, staff were aware of signs that would suggest someone was being abused. They were also able to tell who they would report this to at the service, however were unsure of who else they could report this to, such as the local authority and CQC. The registered manager was aware of her responsibility in assessing people who may be deprived of their liberty and the scope of the DoLS.

We saw that one person was receiving medicines covertly (medicines hidden in food or drink). This person had been assessed as not having capacity to refuse medicines by a GP in September 2013, however we could see no evidence that relatives, staff or an independent advocate had been involved in a best interests meeting. The mental capacity assessment form had not recorded why this decision had been made. We could find no information relating to this decision in this person's care records. Staff we spoke with said this person sometimes did not take their medicines. We saw that in the 10 care records we reviewed, people had capacity assessments completed, however these assessments were all identical and did not explain why the decision needed to be made and why and who had been involved in making this decision and dates for review. Therefore when people were identified as lacking capacity, best interest meetings did not occur with people who knew and understood the person using the service so that least restrictive decisions that respected the person's identity could be agreed.

Requires improvement

Is the service effective?

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed lunch in two dining rooms. All the people we spoke with were happy with the quality of the food. One person said, "The food is very good, no excellent." We saw that staff encouraged people to drink throughout the day and night. Juice and water jugs were available in people's bedrooms. Records we reviewed showed staff recorded people's fluid intake where needed.

We saw the food was hot and well presented on the plate. Fresh vegetables and fruit were available at meal times as was a choice of drink. Staff we spoke with knew people's likes and dislikes. The chef made himself available during meal times to seek feedback and support people if they did not like what was available. We saw one person requested fish and this was cooked by the chef.

We met with the chef who told us he had recently began working in the service and had started to find out people's likes and dislikes so he could tailor the menus to meet the needs of the people. Some people needed a special diet due to health needs. Staff and the chef understood these people's diets and care records we reviewed showed that speech and language therapists had been involved where needed to assist with safer nutritional support and to reduce the risk of choking.

We saw the kitchen was clean and food was stored appropriately in the cupboards and fridges. We reviewed how food was ordered and saw that the chef had flexibility and this allowed him to get food when it was in season. The kitchen had a first aid kit, which was in date and was monitored by the chef. This helped ensure that food was safely stored and prepared.

When people saw health professionals this was recoded in their care records. People told us they had access to the GP either at the service or going to the GP practice which was nearby. Relatives we spoke with did not understand when the GP came to the service and how their relatives or themselves could access the service should they need to discuss their relative's care. Therefore relatives may not have been involved in important health decisions. The registered manager told us that the home had access to nurse practitioners from Barnet who were able to prescribe medicines and Intravenous fluids (IV) fluids which helped reduce admissions to hospital. People told us and records confirmed that other professionals supported people at the home, these included district nurses, tissue viability nurses, opticians and chiropodists. We saw that referrals had been made to professionals but these had not always been made promptly. The registered manager was working with staff to ensure when people needs changed referrals were made to the relevant professionals. This would ensure people had access to health care professionals when they needed it.

Requires improvement

Is the service caring?

Our findings

Six people we spoke with told us staff at Nazareth House sometimes looked after them well. Comments we received included, "[Staff] are all so good, they look after me so well and are kind and caring." However four others said, "Staff are sometimes not kind", "Staff are not caring" and "Some staff are ok, but not the night staff".

We reviewed people's care records and it was not evident that people were involved in planning their care. Six people told us they had not been asked to be involved. One person said, "No one has ever asked for my input into my care plan or risk assessment, but I would like to be involved in writing these." Another said, "No one has asked me to involved, but it they had I would tell them to write down I like my back scrubbed." Relatives said they had never seen a care plan or been invited to a care review. One person told us, "My relative has been in the home for several years and I have never been invited to a review, or been shown a care plan, I have no idea what is happening with their care."

Care records we reviewed had some history about people before they came to the service, such as the jobs they used to do, information on family and friends and hobbies they had. Not all staff we spoke with were aware of people's histories. This may have helped staff to engage more effectively with people if they understood more about their life before they came to the service.

One person we spoke with believed they were discriminated due to their race, they said that staff did not treat them with dignity and respect by not responding to their requests for help during the day and night. We observed care given to this person and saw that staff did not always have the skills to manage their changing needs and have the time and skills to support their anxieties. We saw when the Regional Manager visited he had the time and skills to sit with this person and understand their needs and how to meet them.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff during the inspection and saw they were caring. We saw they were patient, kind and compassionate and treated people with dignity and respect. However, when we spoke with staff, they told us they were finding it difficult to connect to some people at the service who had more complex needs. They spoke about these people in a negative way, they did not understand why these people may be acting in this manner and did not reflect on ways to support and understand these people better.

Staff knew people's individual needs. We saw staff were aware of who people liked to sit next to when they were in the lounge, what drinks they liked and when they liked to go to bed. We did not see staff spend time with people, such as sitting and chatting in the lounge, they were always busy meeting people's needs. People commented on this, "It would be nice to have a chat with the staff." We saw the service had started "resident of the day". People who were resident of the day had their care records reviewed and their bedrooms deep cleaned. People we spoke with were unaware that resident of the day happened but they thought it was a good idea.

We saw that the service had access to an external advocacy service, however this was not advertised. Staff we spoke with were unaware of the advocacy service. Therefore people were not aware that a service was available to assist them if they required support to make decisions or raise concerns.

Staff knew people's like and dislikes. We saw that staff demonstrated knowledge of people and an understanding of their needs. We saw that some people were addressed by their first name while others were addressed more formally, depending on their preferences.

There was a strong religious ethos at the home and most people told us this was why they had chosen the home. People were able to attend Mass daily if they requested this. Pastoral care was offered by the nuns and priests who lived in the attached premises. People told us that the Sisters were kind and available to chat to and this comforted them.

All staff we spoke with understood how they would ensure people were treated with dignity and respect. They told us they would close doors and curtains when providing personal care and always call people by their preferred name. People and relatives confirmed this occurred.

During the inspection we saw and met with relatives who were visiting the home, they said that

Requires improvement

Is the service caring?

they were made to feel comfortable and were treated with kindness and respect by staff. This reassured them of the caring attitudes to their relatives. However relatives told us that there had been lots of staff changes and they did not know who was in charge of each unit now should they have concerns or worries.

Requires improvement

Is the service responsive?

Our findings

We saw that the service had electronic records and paper records. We saw evidence that the two systems were not always recording the same information. We saw one person's electronic record stated they had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) document. Their electronic care plan stated they were for resuscitation. Review of their paper files showed that this person had a DNACPR form. The registered manager told us that all up to date records were on the computer system. Therefore care records were sometimes not accurate. We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in people's files. All six were not completed fully, two had not been signed by the GP. All six had no information that would confirm that the person, relatives or others had discussed the order and understood what it meant. We reviewed these people's care records and saw that four people did not have a care plan that reflected the DNACPR orders. One person who had a DNAR order recorded in their care plan stated they wished to be resuscitated if the circumstance arose. We informed the registered manager of this.

The care plans we reviewed did not give enough information to assist staff to provide care, for example we saw one person who was given their medicines covertly (hidden in food and drink). The care plan did not explain how staff would manage this, for example, ask the person if they wanted the medicines, if not crush the medicines in a certain type of food or drink, and then staff to stay with this person until the medicine was fully taken. Another person who was deaf had a communication profile which stated that they needed the TV on with subtitles, to always ensure they carried a book with words and symbols to enable them to communicate, and that a pen and paper was needed to communicate their needs. This person did not have any of the above and when we highlighted this to staff they were unable to find this person's equipment to enable them to communicate. We saw this person also used sign language to communicate. We asked if staff were able to sign, but none could. Therefore this person's communication needs were not being met by the service.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had recently employed a full time activities coordinator. We saw that activities had improved at the service since she had been in post. She had plans and was supported by the registered manager to improve the activities available at the home and ensure that people were not isolated in their rooms. We saw on the day we visited that people were baking a Christmas cake with the chef and activities coordinator and, later in the day, painting. The service had a room for activities, but we were told that most people did not want to come to the room, they preferred activities to come to them. The activities coordinator told us she was getting to know people and what activities they enjoyed. She said that she had made contact with a local school whose students were coming to the home that week to sing carols. The people who lived at the home had been invited to a local school to watch their Christmas play. The activities coordinator was aware that some people were isolated in their rooms and each day she visited people in their room, hoping to build up a relationship and find out what they may like to be involved in. Some people talked about activities available they enjoyed such as exercise to music and painting. People were looking forward to the children coming to the service. One person said, "It's nice to hear the children sing." We saw that people had newspapers of their choice delivered daily. Activities had improved at the service and people had commented on this.

People knew how to complain. However, four people said that the staff would not respond to their complaints. One person said, "If I make a complaint nothing happens." Another said, "No point in complaining no one will listen and things will not change." The relatives we spoke with were aware of how to complain. We reviewed complaints that had been received by the service and saw these had been responded to in line with the provider's complaints policy.

Four relatives were aware who the registered manager was and would report concerns to her or the deputy manager. Six relatives told us they were unaware who was in charge of the service and who they should talk to if they had a problem. They told us, "If the units had had pictures of staff or information of which member of staff was in charge this would enable relatives to find this staff member quickly."

Requires improvement

Is the service well-led?

Our findings

The registered manager undertook several internal audits, these included health and safety, medicines and work place inspection. Although the service had systems in place they were not always effective and had not highlighted the issues we found during our inspection. We found problems with the service's medicines management, supporting workers and consent.

We reviewed the audits the service had completed in October and November 2014. The last medicines audit was completed 21 November 2014, this noted that eye drops and creams were being opened and not dated. However, this was not noted in the recommendations or actions section of the audit. We noted this was still an ongoing problem when we reviewed the medicines stored at the service. Therefore people may have been at avoidable risk of receiving out of date eye drops since 21 November 2014. This audit had not picked up the concerns in relation to the controlled drugs stored at the service that we found. The remaining audits that we reviewed showed that action had been taken when problems had been noted.

The provider completed a resident and relative satisfaction survey in 2013. This showed that people and relatives were happy with the service in 2013. The registered manager was unsure when the next one would occur. All the relatives that we spoke with had not been involved in the satisfaction survey in 2013.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had recently started daily staff meetings. We attended one on the day of the inspection. The registered manager and deputy manager attended along with senior care staff from each unit, the activities coordinator, the housekeeper, chef, maintenance and administrator. They discussed what was happening on each unit, plans for the day such as hospital appointments or people being discharged, activities, and issues with the kitchen or maintenance. These meetings were recorded. The registered manager said these meetings helped improve communication at the service. Staff agreed and we reviewed the daily report sheets where information was recorded for handover of care. These were badly photocopied and it was impossible to read the detail. Communication books were often not used as a way for staff to communicate information. However, when they were used they did not have dates when information was added therefore it was difficult to follow when items had been recorded and the outcome. Four staff told us that communication was an issue at the service. One said, "Sometimes you have no idea what is happening when you have been off a few days or worse on holiday." Therefore staff did not always have up to date information on people they were caring for, which may have placed people and staff at risk.

Four staff said the service had a whistleblowing hotline but they were unsure of the number though it was available in the staff room. The remaining staff understood whistleblowing and their responsibilities to report poor care. We fed this back to the registered manager who said staff should be aware of the policy and phone number. She told us she would ensure that all staff fully understood the provider's whistleblowing policy at the next team meeting.

The registered manager said she understood her responsibilities as a registered manager and was well supported by the provider. We met with the regional manager, he told us he often stayed over at Nazareth House when he was in London. This allowed him to see the service in action at night. He confirmed he was available and that resources were available for the registered manager to improve the service.

We saw the home was being refurbished, this included a new coffee/ tuck shop available to people and relatives who visited the service. One person told us the shop was good but did not stock their favourite biscuits. We informed the registered manager who said they would encourage this person to be involved in the next shopping trip to buy the coffee shop/ tuck shop food and drinks. Relatives told us that the refurbishment was welcomed but had not always been managed well. They said that they had been unaware of how noisy of all the work would be and the inconvenience to the people who lived in the home, such as people sitting in the activities room as no lounge was available and call bells not working. We fed-back relatives' concerns to the registered manager.

Accidents and incidents were reviewed by management and the staff team at Nazareth House. Meetings were set up to review these so that lessons were learnt and changes to

Requires improvement

Is the service well-led?

practice occurred. For example, care workers were encouraged to report immediately if they were unable to meet the support needs of people moving into the home. This assisted the service to ensure people were safe and they could meet their needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not assess risks to the health and safety of service users, do all possible to mitigate such risks, and ensure that medicines were managed properly and safely.** **Regulation 12(2)(a) and (b), and (g).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not assess, monitor and improve the quality and safety of the services provided, and assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others. Regulation 17(1), and (2)(a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person did not ensure that service users were treated with dignity and respect.** **Regulation 10.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

	The registered person did not ensure that care and support of service users was only provided with the consent of the relevant person. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed, and they received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18(1) and (2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not ensure that people received care and support that was appropriate, met their needs and reflected their preferences. Regulation 9(1).