

Nazareth Care Charitable Trust

Nazareth House - Birkenhead

Inspection report

Manor Hill
Claughton
Birkenhead
Merseyside
CH43 1UG

Tel: 01516534003

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 21 and 23 February 2018 and was unannounced.

Nazareth House- Birkenhead is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Nazareth House is registered to provide accommodation, nursing and personal care for up to 51 people. At the time of the inspection there were 39 people living in the home.

At the last inspection in December 2016, we found that the provider was in breach of regulations and the service was rated as requires improvement. The breaches were in relation to the safety of equipment and care planning. Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the service and ensure regulations were met. The provider told us that all improvements would be completed by the end of March 2017. During this inspection, we looked to see whether the provider had followed their plan and necessary improvements had been made.

We found that concerns identified at the last inspection had been addressed. For example, windows had appropriate window restrictors fitted to prevent accidental falls from height, fire doors were not wedged open, appropriate bed rails were in use and systems were in place to ensure air mattresses were set at the correct settings. However, we found that other areas required improvement.

At the last inspection we identified concerns as care plans did not always reflect peoples' current needs. During this inspection we found that although many care plans were detailed and person centred, not all had been updated when peoples' needs had changed. We also found that planned care was not always evidenced as provided. The provider was in breach of regulations regarding this.

Checks to monitor the quality and safety of the service were regularly completed, but were not always effective in identifying areas that required improvement. Not all risks previously identified had been addressed by the provider. The provider was in breach of regulations regarding this.

Not all risk assessments accurately reflected the risk people faced, however we found that appropriate action had been taken to address risks. Personal emergency evacuation plans did not provide sufficient information to ensure people could be safely evacuated in the event of an emergency and not all identified risks had been addressed. The provider was in breach of regulations regarding this.

We found that medicines were not always managed safely and we made a recommendation regarding this.

A registered manager was in post. 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. Feedback regarding the management of the service was positive.

Systems were in place to ensure safe staff recruited procedures were followed. We received mixed feedback regarding staffing levels, but found that there was sufficient staff on duty to meet peoples' needs at the time of the inspection.

All people we spoke with told us they felt safe living in Nazareth House. People told us, "I have nothing to be afraid of" and "Staff are around so I never have any worries." There were systems in place to help ensure that lessons could be learnt from incidents and accidents were recorded and reported appropriately. Internal and external checks were completed to help maintain the safety of the environment.

Applications to deprive people of their liberty lawfully had been made appropriately to ensure people received care with least restrictions. Consent to care was gained in line with the principles of the Mental Capacity Act 2005, including best interest decision making when people were unable to provide their consent.

People living in Nazareth House were supported by staff and other healthcare professionals in order to maintain their health and wellbeing.

Peoples' nutritional needs were met by the service. The chef told us that they provided meals based on people's dietary needs and we saw that they had detailed information regarding the nutritional needs for people with varying religious, medical or cultural requirements.

A range of policies and procedures were available to help guide staff in their role and they received regular training and supervisions and completed an induction when they started in post. .

People told us that staff were kind and caring and that they were treated with respect. We observed interactions that were friendly, familiar and respectful and peoples' dignity and privacy was maintained.

People told us and records reflected, that staff encouraged people to be independent as possible and relatives agreed. People were given information and explanations regarding the service to enable them to make choices and decisions about their care.

Peoples' friends and family were able to visit the home at any time and relatives told us they were always made welcome. For people that did not have any family or friends to support them, details of advocacy services were available within the home.

Care files contained advice and information regarding people's medical conditions. They also contained information regarding peoples' preferences in relation to their care. This helped staff get to know people as individuals and provide support based on their needs and preferences.

Staff had completed training to enable them to provide effective end of life care to people. Care files showed that this had been discussed with people and their preferences had been recorded within their plans.

Peoples' religious needs were met by the service. There is a chapel on site which is used by people living in the home and the local community. The chapel can be used by clergy from various religions.

A system was in place to ensure people knew how to complain if they needed to and we found that

complaints had been dealt with appropriately.

A schedule of activities was available to people, both within the home and in the local community. People told us they enjoyed the activities available.

Systems were in place to gather feedback from people regarding the service and actions had been taken to address any issues raised through these processes.

Ratings from the last inspection were displayed within the home and on the provider's website as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Risk was not always assessed and managed appropriately.

Medicines were not always managed safely.

Internal and external checks were completed to help maintain the safety of the environment.

Staff were recruited safely. People told us they felt safe living in the home and there were sufficient staff on duty to meet their needs.

Staff were knowledgeable regarding safeguarding procedures.

Is the service effective?

Good ●

The service was effective.

Applications to deprive people of their liberty lawfully had been made appropriately. Consent was gained in line with the principles of the Mental Capacity Act 2005.

Peoples' needs were assessed holistically and systems were in place to ensure information regarding peoples' needs was shared when they transferred between services.

Peoples' nutritional needs were met by the service.

Systems were in place to support staff in their roles.

Is the service caring?

Good ●

The service was caring.

People told us that staff were kind and caring and treated them with respect. People were encouraged to maintain their independence.

Peoples' private and personal information was stored confidentially.

Peoples' friends and family were able to visit the home at any time.

Is the service responsive?

The service was not always responsive.

Not all care plans had been updated when peoples' needs had changed and planned care was not always evidenced as provided.

Staff knew people well including their needs and preferences. People enjoyed the activities available.

Staff had been trained to provide effective end of life care to people and people told us their religious needs were met by the service.

A system was in place to ensure people knew how to complain if they needed to and we found that complaints had been dealt with appropriately.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not always effective. Not all risks previously identified had been addressed by the provider.

Systems were in place to gather feedback from people regarding the service and actions had been taken to address any issues raised through these processes.

Ratings from the last inspection were displayed within the home and on the provider's website as required.

Requires Improvement ●

Nazareth House - Birkenhead

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 21 and 23 February 2018 and was unannounced.

The inspection team included an adult social care 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 reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the Local Authority and the local Clinical Commissioning Group to get their opinions of the service.

We used this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, Sister Superior, head of care and seven members of the staff team, including the maintenance person and the activity coordinator. We also spoke with seven people who lived in the home, seven relatives and two visiting health professionals.

We looked at the care files of three people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various times during the inspection.

Is the service safe?

Our findings

At the last inspection in December 2016, the provider was in breach of regulations in relation to safe care and treatment and the safe domain was rated as requires improvement. The breaches were in relation to the safety of the environment and equipment. During this inspection we looked to see if improvements had been made and found that although previously identified concerns had been addressed, other areas required further improvement.

In December 2016 not all windows had appropriate window restrictors fitted to prevent accidental falls from height. During this inspection we found that improvements had been made and windows restrictors had been fitted to all required windows. The provider was no longer in breach of regulations regarding this.

At the last inspection we saw that a number of fire doors had been wedged open. This meant that they would not close in the event of a fire and put people at risk. During this inspection fire doors were either closed, or held open with an automatic closing device which would allow the door to close in the event of a fire. The provider was no longer in breach of regulations regarding this.

In December 2016 we identified that there were no systems in place to ensure staff were aware of what settings peoples' air mattresses should be set to and that they were checked regularly. During this inspection, records showed that mattress settings for people receiving nursing care were recorded within their care plans and a system was in place to check and record the setting of the mattress each day. There were no records of these checks for people who received residential care, but settings were recorded in care plans and those we checked were accurate. The registered manager told us they would ensure that the system in place would be used consistently throughout the home. The provider was no longer in breach of regulations regarding this.

We identified concerns regarding unsafe bedrails at the last inspection. However, during this inspection we found that all bedrails in use were integral to the bed which reduced the risk of entrapment. In the care records we viewed, we saw that risk assessments had been completed to ensure it was safe for people to use the bedrails.

We saw that risk assessments were also in place in areas such as falls, moving and handling and skin integrity. However, we found that not all risk assessments had been accurately completed. For example, one person's care file showed that they had some difficulty swallowing foods, but this was not reflected within their nutritional risk assessment. Their continence assessment also did not accurately identify their current needs. This meant that risk was not always accurately assessed. We found however, that appropriate actions had been taken and referrals made to other health professionals to support them with these needs.

Personal emergency evacuation plans (PEEP's) were in place for people. However, they did not explain what support people required if they needed to fully evacuate the home. For instance, one person's PEEP stated they would require support from two staff members to use a stand aid hoist and transfer into a wheelchair. It did not identify how the person would get down the stairs. We saw that evacuation chairs were in place and

staff we spoke with had been trained how to use them. Following the inspection the registered manager has provided evidence that all PEEPs had been updated to include the use of the evacuation equipment where necessary. This meant that staff had access to clear information regarding the support people required and risk to people had been reduced.

We found however, that not all identified risks had been addressed. For example, a fire risk assessment had been completed in June 2017. This identified a number of actions that needed to be made to improve the safety of the home. For instance, high risk actions included fitting intumescent strips around the fire doors within the home to help prevent the spread of smoke in the event of a fire. There was no evidence that this had been addressed and the registered manager confirmed that it had not been done. High risk actions should be completed within seven days according to the risk assessment tool. A medium risk action was to replace the sluice room door as it was not a fire door and it should be, however this had also not been completed. Since the inspection the registered manager has confirmed that they have been given the authority to fund these works straight away.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

During the inspection we looked at how medicines were managed within the home. Medicines were stored within trolleys in locked clinic rooms. The temperature of both the clinic room and the medicine fridge were monitored and recorded each day and we saw that these were within safe ranges. If medicines are not stored at the correct temperature it can affect the way they work. We saw that a medicine policy was in place which provided guidance to staff on the safe administration of medicines. Records showed that staff had completed medicine training and had their competency assessed in this area to ensure they were safe to manage people's medicines.

We also found that protocols were in place for medicines that were prescribed as and when required. This helped to ensure staff administered these medicines in a consistent way. People we spoke with told us they received their medicines when they needed them. Relatives also told us that they thought medicines were managed well. One relative told us, "We've seen the nurse give him his medicines and she explained what it was" and another relative said, "[Family member] gets it [medicines] regularly and it has improved his mental outlook. We can't believe how settled [family member] is."

However, when we reviewed the medicine administration records (MARs), we found that allergies were not always accurately recorded. For instance, one person's records showed that they had allergies to a number of medicines, but this was not reflected on the MAR chart. Since the inspection, the registered manager provided evidence that allergies have been recorded on the MAR charts for all people who are allergic to any medicines. This helped to ensure people were not given medicines they were allergic to.

Medicines were usually booked in correctly, but we saw one occasion that the incorrect amount of medicines had been booked in and signed by two staff. This meant that we were unable to audit the stock balance of medicines. Other stock balances we checked were correct. We also identified some gaps in the signing for the administration of medicines. This meant that records regarding medicines were not always maintained accurately.

We recommend the provider reviews and updates its procedures to ensure medicines are managed safely in line with best practice guidance.

Systems were in place to help maintain the safety of the environment. For instance, external contracts were

in place to check the safety of the gas, electric, fire alarm, lifting equipment and water safety and these were in date. Records showed that regular internal checks were also completed in areas such as water temperatures, fire alarms, emergency lighting, call bells, first aid boxes, fire doors and closures, bed rails, air mattresses and fire-fighting equipment.

We looked at how staff were recruited to the home and found that recruitment files contained two references, a full employment history and a Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. Risk assessments were in place to ensure any potential concerns identified during the recruitment process, were fully considered before employing staff.

We also saw that registration with professional bodies were regularly checked where required, such as for qualified nurses. These showed that all nurses PIN numbers were up to date. This showed that all safe recruitment processes were adhered to

All people we spoke with told us they felt safe living in Nazareth House. When we asked people why they felt safe, comments included, "I have nothing to be afraid of", "Yes, nothing much can go wrong as [staff] all do their job and they've got extra codes on the doors", "Yes, because it's secure" and "Staff are around so I never have any worries." Relatives we spoke with also agreed that the home was safe. Their comment's included, "Yes, we have no worries, the door is safe and we sign in and out", "Yes, absolutely. Our experience of other homes is poor but this exceeds them all. We are delighted [family member] is here" and "Yes, because [family member] is happier here than he's been in years."

Staff we spoke with understood local safeguarding procedures and were able to clearly explain how they would report any concerns they had. A safeguarding policy was available to guide staff in their practice and contact details for local safeguarding teams were on display within the home. Records showed that staff had completed safeguarding training and we saw that appropriate referrals had been made to the Local Authority when required.

The provider had a whistleblowing policy in place which encouraged staff to raise any concerns without fear of repercussions. An equality and diversity policy was also in place. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010. The registered manager told us there was nobody living in the home at the time of the inspection that required personalised support in relation to any of the protected characteristics.

There were systems in place to help ensure that lessons could be learnt from incidents. For example, the registered manager had signed up for safety alerts to be sent to them. We saw that when these came through, the registered manager printed them off and put them in the clinic rooms to make staff aware of the concerns and help prevent incidents occurring within the home.

Accidents and incidents that had occurred within the home had been recorded and reported appropriately. The registered manager had developed a falls team which met regularly to discuss any incidents and look at ways of preventing future accidents. We viewed the minutes from these meetings which showed that staff reviewed people's assessed needs and equipment and made referrals for additional support when necessary. The registered manager also reviewed all incidents each month to look for potential trends or themes. This showed that the service took steps to learn from incidents and reduce the likelihood of recurrence.

We looked at how the home was staffed. The registered manager told us that staffing levels were based around people's dependency levels and feedback from staff, although no staffing analysis tool was in use. Staffing levels had been reduced recently due to the home not being fully occupied. When we asked people about staffing levels within the home, we received mixed feedback. One person told us, "Yes [there is enough staff], I can't fault them" and another person said, "There seems to be enough and there is plenty this week." However, another person told us, "No, not really, [staff] have so much to do." When asked if they had to wait for care people told us, "It depends which shift is on; the night shift are not always so efficient" and another person said, "[Staff] come almost immediately."

Feedback from staff was also mixed, although most staff told us there were enough staff. Relatives we spoke with all told us they felt there were sufficient numbers of staff on duty. During the inspection we observed that call bells were answered quickly and there were sufficient numbers of staff to support people in a timely way, such as during lunch. We saw that staff were available to assist people if they needed it and people were not rushed.

The home appeared clean and people we spoke with told us they had no concerns regarding the cleanliness of the home. One person told us, "It's very clean. Every day they do my room along with the toilet" and another person said, "Yes, it's always nice and clean and no smells." A recent internal infection control audit scored 96%. Bathrooms contained paper towels and liquid hand soap, in line with infection control guidance. Personal protective equipment such as gloves and aprons were available to staff around the home and we saw that they used them appropriately, such as when providing personal care.

Is the service effective?

Our findings

During this inspection we looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The 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 make 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).

Applications to deprive people of their liberty lawfully had been made appropriately. Six authorised DoLS were in place and a further five applications had been made to the Local Authority. The registered manager maintained a spreadsheet which reflected when applications had been made, the date they were authorised and when they were due to expire. For each person who had an authorised DoLS in place, they had a separate file which included the applications, authorisations, care plan and notification to CQC. This helped to ensure that applications and authorisations were managed appropriately.

When people were able to provide consent to their care and treatment, this was recorded within their care file. For instance, one person's care file contained signed consent forms for the use of bed rails and agreement for their photograph to be taken. Another person's file reflected that the use of bed rails had been assessed and discussed with the person and that they had provided verbal consent, but was unable to sign the form.

When people were unable to provide their consent due to memory difficulties, decisions were made and recorded in their best interest. For instance, one person's file included a mental capacity assessment to decide whether the person was able to make a decision regarding cardiopulmonary resuscitation. It reflected that the person lacked capacity to make this decision, so family members had been consulted along with the person's GP and a decision was made and recorded in their best interest. This showed that consent was sought in line with the principles of the MCA.

Care files we viewed included care plans in relation to people's mental, physical and social health needs. This showed that people's needs had been assessed holistically. Staff in the home had access to relevant legislation and best practice guidance, in order to enable them to provide the most effective care. We saw copies of Care Quality Matters magazine on display for people to read, as well as copies of best practice guidance such as the National Institute for Clinical Excellence guides. The registered manager also attended the registered manager's network meetings. These included speakers from the Local Authority, Clinical Commissioning Group, CQC and other differing guest speakers, such as a representative from Merseyside Fire Service. This enabled the registered manager to be kept up to date with recommendations or changing practices and feed this back to staff.

Staff had been allocated specific champion roles, such as training, dignity, medicines, tissue viability,

infection control, end of life and moving and handling. Each person attended additional training and took the lead in that area. Three moving and handling champions had recently attended training that enabled them to provide the moving and handling training to the rest of the staff in the home. These systems helped to ensure that staff were aware of and followed best practice in relation to the care they provided to people.

When people transferred between care services, such as when they transferred to hospital or another care home, the registered manager told us essential information was always copied and shared. This helped to ensure that people's needs were known by the service they transferred to and enabled consistent care to be provided.

People living in Nazareth House were supported by staff and other healthcare professionals in order to maintain their health and wellbeing. A practitioner from one local GP practice visited the home each week to assess any people who were registered at their practice. All people we spoke with told us they could see a doctor when they needed to. Comments included, "The nurse comes every week and she would get the doctor", "Yes, I've had the doctor twice, he came in when [staff] called him", "Yes, [GP] has been in and I know that [staff would] call her. She is very good" and "Yes, [GP] came in today and gave me medicine."

Care files showed that advice was also sought from other professionals such as the dietician, dentist, optician, chiropodist and the speech and language therapist. We saw that referrals for advice were made in a timely way. For instance, one person's records showed that they had begun having difficulties swallowing their food and a referral had already been made to the speech and language therapist for further assessment. In the meantime the person was provided with a softer diet which they found easier to swallow.

We looked at how people's nutritional needs were met within the home. The chef told us that they provided meals based on people's dietary needs and we saw that they had detailed information regarding the nutritional needs for people with varying religious, medical or cultural requirements. They were currently providing meals to meet people's individual needs, such as a diabetic diet, pureed and fortified diets.

Most people we spoke with told us they enjoyed the food and had enough to eat and drink. Comments included, "Meals are marvellous but I sometimes have some of my own food", "I can't fault them" and "They are mostly good and I've started having cooked breakfasts which I enjoy." Relatives we spoke with also agreed and told us, "[Family member] says it's nice, and he has put on weight", "It's well balanced and restaurant quality" and "It's wonderful and [family member] gets a choice."

Menus were available in the dining room and we saw that tables were presented well with condiments and napkins available. We joined people for lunch on the first day of the inspection and found that the food was warm and tasty. When people required their meals to be pureed due to swallowing difficulties, we saw that these meals were presented very well. Staff supported people with their meals in a discreet and caring manner. We also observed that tea, coffee and biscuits were offered in the morning and afternoon and a cold water machine was available for everybody's use.

We looked at how staff were inducted and supported in their roles. All staff we spoke with told us they received an induction and that it was sufficient to meet their needs. The registered manager told us staff completed a National Vocational Qualification (NVQ) and undertook regular training. We found however, that although staff completed NVQ's, the registered manager did not cross reference this training to ensure that all staff had the same knowledge that the Care Certificate would provide. The care certificate is an identified set of standards that care workers have to achieve and be assessed as competent by a senior member of staff. The registered manager agreed to review staff inductions and establish whether any further

induction training may be required.

Staff had access to e-learning training and told us that they completed this regularly. Records we viewed confirmed that training considered mandatory had been completed by most staff. Additional face to face training was also arranged when required. Clinical training was also available to nursing staff, such as catheter management.

Staff told us and records showed, that they were supported through regular supervisions and an annual appraisal, staff felt supported and were able to raise any concerns they had. People living in the home and their relatives told us that they felt staff were well trained. Their comments included, "Yes, the regular staff are fine but agency are not are so good", "[Staff] know what they are doing and don't have to be told", "We've got to know [staff] and they are encouraged to do their NVQ's" and "I've seen staff use the hoist and lift and they seem fine."

We looked around the home and saw that the environment was suitable to help maintain people's safety and orientation. For example, the corridors were wide, well-lit and had hand rails for people to use. Bedroom doors contained numbers and people's names to help them identify their room if needed.

Is the service caring?

Our findings

People living in Nazareth House told us that staff were usually kind and caring and that they were treated with respect by staff. Their comments included, "Most staff are lovely", "[Staff] are really kind, I can't fault them", "Couldn't fault them. I don't know how they manage to smile as they are so busy" and "They are lovely and do a good job." One person however, did tell us that some staff used their mobile phones whilst they were supporting them and they did not like that.

All of the relatives we spoke with agreed that staff were caring. Their comments included, "We can't say enough about the staff. So compassionate. Like friends and family", "[Staff] never come across as being abrupt or unhelpful", "[Staff] are gentle and kind, we think they are lovely. We are so glad we found this place" and "[Staff] are kind and patient, they take time to talk."

During the inspection we observed interactions between staff and people living in the home. We saw that support was provided in a friendly, familiar and respectful manner. We heard staff ask for people's consent to provide care and explain what support they were going to assist them with.

It was clear through these observations and discussions with staff, that they knew the people they were caring for well. For instance, a staff member told us how they observed a person for specific facial gestures which indicated they were in pain, as they were unable to communicate this verbally to staff. This information was also recorded in the person's care plan. One person told us, "[Staff] know my likes and dislikes."

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection. For example, all staff knocked on people's bedroom doors before entering and support was provided in a discreet way. During discussions, staff were able to clearly explain how they ensured they protected people's dignity and privacy when providing personal care. Examples included ensuring the door was closed, asking for consent, ensuring the person was covered as much as possible and closing curtains/blinds.

Care files we viewed showed that people were encouraged to be as independent as possible. For example, one person's personal care plan clearly recorded what support the person required, but also what they were able to do themselves and for staff to encourage this. We viewed the service user guide and this also reflected that people had a right to accept a degree of risk so not to have their independence restricted. One of the aims of the service was to promote independence. Risk assessments were also in place to help ensure people remained safe whilst being as independent as possible. People we spoke with told us staff encouraged them to be independent and relatives also agreed. One relative told us, "[Family member] is very limited but they [staff] encourage her as much as possible."

We looked at the service user guide and the statement of purpose for the service, which were available in the entrance of the home. They contained information about the service and what people could expect when they moved into the home. It also included information regarding the complaints and safeguarding

processes. The aims of the service and a resident's charter were also included within the service user guide. This showed that people were given information and explanations regarding the service.

People we spoke with were happy with their care and told us that their family members were kept involved. Relatives we spoke with agreed that they were involved in the care planning process and that staff informed them of any changes. One relative told us, "I've discussed the care plan with the manager and the nurse." Another relative said, "I know about them [care plans] and I feel informed."

We saw that care files were stored securely within staff offices that were locked when nobody was in them. This helped to ensure that private and personal information was stored confidentially and only people who needed to know people's confidential information had access to it.

We saw people's friends and family visiting throughout the inspection and all those we spoke with told us they could visit at any time and were always made welcome. The registered manager told us that there were no restrictions as to when people could visit and this encouraged people to maintain relationships they had built in the community before moving into the home. During the inspection we saw that staff had set up a room to accommodate a private birthday party for a person who lived in the home. They had arranged food, drinks and music and the person's family and friends joined the person to help them celebrate their birthday. This helped people to maintain relationships that were important to them and prevent isolation.

For people that did not have any family or friends to support them, details of advocacy services were available within the home. The registered manager told us that they had arranged for a representative from a local advocacy service to attend the resident and relative meeting in January 2018; however they had unfortunately had to cancel at the last minute. The registered manager was in the process of rescheduling this.

Is the service responsive?

Our findings

At the last inspection in December 2016, the provider was found to be in breach of regulations regarding care planning and the responsive domain was rated as requires improvement. During this inspection we looked to see if improvements had been made.

In December 2016 we found that care plans did not always reflect people's current needs. During this inspection we reviewed care plans and saw that although most plans were detailed and informative, not all were up to date. For instance, one person's care file showed that they had developed a difficulty when swallowing food and required a blended diet to help prevent choking. However, their nutritional risk assessment did not reflect this change in their needs. Their eating and drinking plan showed that they required one aspect of their health to be monitored twice each day prior to medicine being administered. However, staff told us this medicine had changed and was only administered once per day and so the health check was only required once. We saw that this had been completed each day. This meant that the care plan did not accurately reflect the person's needs.

We also found that planned care was not always recorded as provided. For example, one person's file showed that they required a health check each day in order to monitor their health and wellbeing. However, records showed that this had not been completed for two days prior to the inspection. We discussed this with the nurse on duty who told us that agency staff had been on duty for the past two days at the time this check should be completed.

We also reviewed records relating to the support staff provided people to help them reposition in order to prevent pressure ulcers developing. We found however, that these records had not been fully completed. For example, one person's care file stated that they required support from staff to reposition every two hours. We looked at the records relating to this after lunch on the second day of the inspection and saw that they had not been completed for that day. We asked staff if anybody else required support to reposition and viewed their records. This person also had no records for the day of the inspection and staff advised us the person did have some deterioration to their pressure areas. The staff member told us that this support had been provided, just not recorded at that time. We discussed this with the registered manager who agreed to ensure records were completed in a timely way.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other care files we viewed were detailed regarding people's needs and had been updated regularly. Care files also contained advice and information regarding people's medical conditions. For example, one person's diabetes care plan explained what symptoms the person may experience if their blood sugar was either too low, or too high. Another person's file contained a printed information sheet regarding their specific health condition. This helped to ensure that people were supported by staff who were knowledgeable about their needs.

We also saw that care files contained documents which detailed people's preferences in relation to their care and treatment as well as their life histories. This included information about where people lived, jobs they had, their family members, preferred activities and any special dates for the person, such as anniversaries and birthdays. Files also included a one page profile of the person, which recorded what was important to the individual, what others admired about them and how they wanted to be supported. Care plans reflected people's preferences in areas such as activities, meals and drinks, times people liked to get up each day and go to bed and preferred choice of clothing. This information helped staff get to know people as individuals and provide support based on their needs and preferences.

During the inspection we saw that technology was in use to help support people and ensure their needs were met. For example, call bells were available to people within their bedrooms and bathrooms. Other adaptations had been made, such as the purchase of cups with lids to enable people to drink independently without the risk of spilling hot drinks onto themselves. The registered manager told us that they had plate guards available should anybody require them and that they would obtain any resource necessary to support people who had specific needs, such as communication difficulties. Although not required at the time of the inspection, the registered manager told us they would provide information regarding the service in large print if required and could have it translated into other languages.

We looked at systems in place to help support people at the end of their life. We found that staff had completed training to enable them to provide effective care to people at this time. On the day of the inspection the service received their certificate for completing a locally recognised end of life training course; 'Six Steps'. This course aims to provide staff with the tools and knowledge to plan and provide the best possible person centred care to people at the end of their lives. Care files we viewed showed that end of life care had been discussed with people and their preferences had been recorded within their plans. Monthly assessments of people's condition were recorded in line with the 'six steps.' This allowed early identification of any changes in people's condition and ensured that all relevant health professionals were aware of people's individual wishes with regards to their end of life care. This helped to ensure people had a comfortable and dignified death.

The registered manager told us the home had a flat that was available for people's family members to stay in should they wish to stay in the home and be close to their relative at the end of their life.

People we spoke with told us that their religious needs were met by the service. Nazareth House has a chapel on site which is used by people living in the home and the local community and holds a service at least three times per week. Sisters of Nazareth live in the grounds and are actively involved in supporting people within the home. The chapel can be used by clergy from other religions and is not just for Roman Catholic services. The registered manager told us that a vicar from a local Church of England church also visits the home regularly. One person living in the home told us, "I'm not Roman Catholic but it is not a problem" and another person said, "I'm Church of England but I sometimes go to the chapel. I have learnt a lot."

A complaints policy was available and was on display within the entrance to the home. This provided clear information on how to raise concerns and included contact details for the local authority and the ombudsman. The registered manager maintained a complaints log and we saw that complaints made had been responded to appropriately. People we spoke with told us they knew how to raise any concerns they had and relatives told us they had not have to make a complaint, but felt confident they would be listened to if they did.

We looked at the social aspects of the home and what activities were available to people. Two activity coordinators were employed and provided activities most days. A schedule of activities was available, which included bingo, memory games, chair exercises, cake making and crafts. An activity coordinator told us they also arranged birthday parties and other celebratory events. External entertainers were also arranged and visited the homes most weeks. These included a ukulele group, folk groups, singers and local choirs. They also told us that local schools and youth groups also visited on occasion. During nice weather the activity coordinators arrange meals in the garden and take people out to a local park for a walk or to a café for lunch.

People we spoke with were happy with the activities available, especially the music and singing. Relatives are kept informed of activities and events. One relative told us, "I have been to a few of the events and enjoyed them" and another relative said, "The coordinators do a great job, the Christmas activities were great."

Is the service well-led?

Our findings

We looked at what systems were in place for the provider and registered manager to be able to monitor the quality and safety of the service provided at Nazareth House. Records showed that senior management staff visited the home to complete audits which looked at a variety of areas, including staff training, supervisions, the appearance of the home, activities and medicines. Regular internal checks had been completed which covered various areas of the service, including infection control, mealtime experience, accidents, medicine management and care planning. A general managers' audit was also completed regularly and looked at areas such as catering and health and safety. When areas of improvement were identified through these checks, any actions taken had also been recorded.

We found however, that these check did not identify all of the concerns highlighted during the inspection, such as those relating to personal emergency evacuation plans, evidence that planned care was provided and medicines management.

We also identified that actions identified through external checks had not all been addressed in a timely way. For example, not all of the fire safety concerns highlighted within the fire risk assessment had been completed despite the date of compliance having passed. The health and safety audit completed in June 2017 also showed required actions that the registered manager confirmed had not all been completed.

This showed that the systems in place to monitor the quality and safety of the service were not always effective.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection the provider sent us an action plan which told us what actions they were going to take to make improvements to the service. We found that all of these actions had been addressed.

People told us that the service was run well and we received positive feedback regarding the registered manager. People described the registered manager as, "Approachable", "Supportive" and "Lovely." Through discussions and observations it was clear that the registered manager knew people as individuals and spoke to people about things that were relevant to them. People we spoke with agreed and one person told us, "Yes, [manager] is a nice fella, he knows me well."

All people we spoke with told us that they were happy with the care and support they received at Nazareth House. Relatives agreed and their comments included, "It is very good, friendly and people seem happy", "Couldn't better it. It's excellent and no faults", "[Staff] are all very supportive here to residents and their extended families. We always feel comfortable. They go the extra mile", "I would recommend the place to others, it couldn't be better" and "I wouldn't hesitate to come here myself."

Systems were in place to gather feedback from people regarding the service. As well as the complaints

procedure, a survey had also been completed with people which looked at the six core values of the organisation; justice, patience, respect, love, hospitality and compassion. This was completed with people living in the home and staff members. We saw that actions had been taken to address any issues that had been raised. For instance, it showed that not all staff felt they were kept informed when authorisations to deprive people of their liberty had been received. In order to improve this, a system was introduced which enabled staff to quickly identify who had an authorisation in place. This showed that the registered manager acted on feedback in order to improve the service.

More general surveys had also been issued to people living in the home, their relatives and staff. They had last been completed in February 2017 and were due to be issued again. The results of these surveys had been summarised and most feedback was positive. These also showed that any issues raised had been addressed. For example, a number of people stated they did not feel involved in care planning. In order to address this, the registered manager implemented a 'resident of the day' system, which allowed each person to be included in a full review of their support each month. Actions identified through the staff surveys had been summarised and progress of these actions was on display in the staff room.

There was also a schedule of meetings for staff, people who lived in the home and their relatives. These were advertised within the home so people were aware of them and we viewed the minutes of previous meetings. It was clear that people had the opportunity to share their views of the service.

A range of policies and procedures were available to help guide staff in their role. Staff had access to these policies and those we spoke with were aware of the policies and the aims of the service. When staff commenced in post they were provided with and signed for, an employee handbook which included information on the essential policies of the organisation.

The registered manager had notified the Care Quality Commission (CQC) of all but one incident that had occurred in the home in accordance with our statutory requirements. This meant that CQC were able to accurately monitor information and risks regarding Nazareth house. The care manager told us that they had not submitted a notification regarding one incident, as they understood CQC were already aware of it. They agreed to submit notifications for all incidents in the future.

Ratings from the last inspection were displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

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 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
Treatment of disease, disorder or injury	Risk was not always managed appropriately to ensure people would remain safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Care plans were not always updated to reflect peoples' current needs. Planned care was not always evidenced as provided. Systems in place to monitor the quality and safety of the service were not always effective.