Nazareth Care Charitable Trust

Nazareth House - Cheltenham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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 was carried out on 22 and 23 November 2016 and was unannounced. We had previously carried out an unannounced inspection of this service on 28 and 29 January and 1 February 2016 where we found breaches of regulations relating to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included a lack of adequate staff training and support, the principles of the Mental Capacity Act 2005 not adhered to, a lack of management of risks and ineffective quality monitoring arrangements. The provider wrote to us to tell us how these would be met and by when. During this inspection we found these regulations had been met, although, the systems and ways of working which had achieved improvement still needed to be fully embedded and sustained.

On 12 and 17 May 2016 we carried out another inspection after receiving information of concern which included: not enough care staff to meet people's needs, issues arising from a high dependency on agency care staff, poor staff practices relating to people's safe moving and handling, unsafe medicines management and a lack of consistent and effective day to day management. We had also received several notifications from the provider reporting incidents of poor moving and handling practices which we had difficulty establishing whether they had been fully investigated and acted on. At this inspection we had checked on the progress made by the provider on some areas of the breaches found in January 2016, which the provider had told us would be met at the end of April 2016. We looked at some aspects of risk management, staff training and the recording of some people's food and fluid intake.

During the inspection in May 2016 we were concerned about the lack of suitable arrangements to ensure the safe evacuation of people in the event of a fire. We requested that the local fire safety office carry out an urgent visit. They carried out a fire safety assessment on 13 May 2016. Immediate guidance and advice was given to the management team in place at the time by the fire safety officers, on how to improve staffs' awareness on what to do in the event of a fire. A notice of non-compliance was issued by the fire safety department under relevant requirements of the Regulatory Reform (Fire Safety) Order 2005. This was subsequently met by the provider.

Nazareth Care Charitable Trust is a Charity which works closely with the Sisters of Nazareth. Nazareth House - Cheltenham is one of the Charity's care homes. It can accommodate up to 63 people who require support and care. During this inspection 53 people were receiving care. Although many people who followed the Catholic faith chose to live at Nazareth House all faiths' and backgrounds were welcomed. Care was provided predominantly to older people by staff who were employed by the Charity. A group of Sisters and one Catholic Father lived on site and provided pastoral support and guidance to those who lived there. The Sisters were involved in some decision making and had some financial input in the up keep of the building. They were very visible within the care home.

A new manager had been employed since the last two inspections. They had been in post since May 2016 and were now the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe. They were looked after by staff who had received support to access necessary training since the last two inspections. This had included update training in areas that were considered not safe in May 2016 such as fire safety, the safe moving and handling of people and medicine management. People's medicines were now managed safely. Further on-going training had also been booked.

Risks to people's health had been identified and these were managed and monitored. Risks in the environment were also assessed, managed and monitored. Staff were aware of the risks of potential abuse and of harm to people from poor practice. They had been supported to report any concerns they may have. Episodes of proven poor practice had been managed appropriately. The registered manager worked with local safeguarding professionals appropriately and took any concerns raised seriously.

There were enough staff to meet people's needs although, the way staff sometimes worked and the decisions made around work routines did not promote or always ensure personalised care was delivered. People were receiving care but not necessarily in a way that suited them or in a way they preferred. You can read what we asked the provider to do about this at the back of the full version of this report. There were not always opportunities for people to receive the support they needed to take part in meaningful activities. However, the activities and social events provided by the Friends of Nazareth House were enjoyed by those who took part in these.

The use of agency staff had been reduced by the registered manager but staff sickness, increased admissions and the need for staff to attend necessary training had necessitated their use again more recently. This was to ensure there were enough staff on duty each day but was not at the levels previously seen. Staff recruitment was therefore on-going. Where possible the same agency staff were used so the impact of staff changes on people were reduced. Staff recruitment had been successful and safe recruitment processes protected people from those who may not be suitable.

People had access to appropriate health care professionals and there were good working relationships with local GPs and community nursing services. A lot of work had been done to ensure people's care records were up to date but these now needed to be personalised. Work had started to involve people and/or their relatives more in the planning of their care. Care was only given if people consented to it and where they were unable to do this the principles of the Mental Capacity Act 2005 were adhered to. People were supported to make independent decisions and decisions made on behalf of people were made in their best interests.

There were arrangements for people to raise a complaint and have this addressed. The registered manager worked in a proactive way by communicating with people or relatives and making herself available so that any areas of dissatisfaction or concern could be discussed and resolved quickly. The care home had received many expressions of thanks for the care received. People received care which was delivered in a kind and caring way. Where this had previously not been the case, those staff no longer worked at the care home. Those who mattered to people were welcomed.

The registered manager had provided strong leadership and they had made improvements to the way the care home operated. They used audits and other checks to ensure the care home was meeting relevant regulations as well as the provider's expectations. Some improvements were still needed by the managements team as we identified a breach of regulation at this inspection. Representatives of the provider were contactable when needed and visited the care home. The provider had systems in place to

monitor the service's performance, identify shortfalls and promote improvement.

The provider had sought people's views of the service in the last year but this information had not yet been collated and shared. The registered manager was continually seeking people's views. This helped her to gauge what they felt about the improvements made so far and to learn about what further improvements and changes they would like to see.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected against risks that may affect their health and well-being.

Arrangements were in place to make sure people received their medicines appropriately and safely.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

People were protected from potential abuse and poor practice because staff knew how to identify this and report any concerns they may have.

Environmental risks were monitored, identified and managed. People lived in a clean environment where there were arrangements in place to reduce the risk of infection.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this. Where staff were new to care there were arrangements in place to support them.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and choices of food were provided.

Staff ensured people's health care needs were met by making sure they had access to appropriate health care professionals.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in a compassionate way.

People's dignity and privacy was maintained. People's different beliefs were respected and supported.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires Improvement

The service was not always able to be responsive. People's needs were not met in a personalised way and their preferences not always upheld. Care plans lacked the detail which could help promote and deliver personalised care.

People did not always have the support they required to take part in meaningful activities. Although, the activities and social events provided by the Friends of Nazareth House were enjoyed by those who took part in these.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service was moving towards being well-led. Whilst we found some areas still needed improvement people had benefited from strong leadership. Support had been given both by the provider and the registered manager to start embedding the improvements already made.

Monitoring processes had been improved which would help identify areas for improvement in the future and maintain regulatory compliance. These improvements needed to be embedded and sustained.

The management team were open to people's suggestions and comments and sought feedback in order to improve the service further.

Nazareth House - Cheltenham

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 22 and 23 November 2016 and was unannounced. One inspector and an expert by experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case people who are elderly.

Prior to the inspection we reviewed the information we held about the service since the last inspection. This included statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events. We also spoke to commissioners of the service.

During the inspection we spoke with ten people who use the service and two relatives. We reviewed the care records of five people. We reviewed applications and documents related to the Mental Capacity Act 2005. We reviewed a selection of medicine administration records. We spoke with four staff and the registered manager, head of care, administrator, maintenance person and senior care staff. We reviewed the staff training records and three staff recruitment files. We also reviewed a selection of audits and the service's action plan. We read the service's Brochure and Statement of Purpose which gave information about the service to people both on admission and afterwards. We attended one staff hand-over meeting.

Good

Is the service safe?

Our findings

On 28 and 29 January 2016 and 1 February 2016 we found the provider had not fully assessed risks to people and taken action to fully mitigate those risks. This was a breach of regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. The provider told us how they would meet this and by when. During this inspection we found this breach of regulation had been met.

When reviewing people's care records we found risk assessments had been completed. These identified risks to people's health and welfare, determined the level of the risk and recorded the actions needed to reduce the risks. We observed staff carrying out care which ensured people were protected from risk. For example, those at risk of developing pressure ulcers used pressure reducing equipment, such as mattresses and cushions. Staff repositioned people to alleviate pressure from their skin at regular intervals. People at risk of falling had been assessed and action taken to try to prevent recurrences. For example, assessments had been carried out by physiotherapists and occupational therapists and equipment and exercises provided to help people move safely. We spoke with an external fitness trainer, paid for by the care home, to provide regular exercise sessions. People at all levels of mobility and ability attended these. The sessions focussed on balance, muscle strengthening and confidence building and were popular with people.

We also reviewed the fire safety arrangements. On 12 and 17 May 2016 we had been sufficiently concerned about these to request an urgent visit by the local fire safety team. They had visited and made immediate recommendations to improve fire safety awareness and evacuation plans. Following a notice of non-compliance under the Regulatory Reform (Fire Safety) Order 2005 the provider addressed these shortfalls. We also reviewed records relating to checks the maintenance person carried out which were related to fire safety. For example, weekly fire drills, tests on the alarm system and fire exits. A contract was in place with a specialist company to service and maintain the overall fire alarm and fire prevention system. A specialist company had completed a fire risk assessment in June 2016 of which the registered manager was aware. Some actions from this had been completed for example, portable appliance testing had been done but an action to ensure the IT server room was locked for example, had not been addressed. This was unlocked and open during the inspection. The registered manager was going to address this. Any issues relating to the proper closure of fire doors were addressed by another outside contractor. Another company checked the emergency lighting system.

On 12 and 17 May 2016 we found medicines had not been managed safely. This was a breach of regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014. The provider told us how they would meet this and by when. During this inspection we found this had been met. The head of care had taken responsibility for addressing this and had reviewed the medicine system and its arrangements in full. They said, "Medicines are now totally under control." Earlier in 2016 the care home had transferred to a different supplying pharmacy and the arrangements for supplying medicines to the care home had improved. A system was in place to chase up missing prescriptions and undelivered medicines. This ensured people's medicines were always available.
The head of care took responsibility for ordering all medicines. When these were delivered, one extra member of staff was allocated to be on duty and all the medicines were checked against the prescriptions

and checked in. Any medicines returned to the Pharmacy were also checked out by the head of care. They knew exactly what was in stock and what had been returned. Stock levels were under control with no excessive stock seen. Stock checks on more secured medicines were carried out daily. People's medicine administration records (MARs) were well maintained. Staff audited each other by checking at the beginning of each medicine round if these had been fully completed on the previous medicine round. Any gaps in recording were followed up straight away. We were told since this system had been in place there had not been any missed signatures on the MARs for some time. MARs were also fully audited twice a week by a senior member of staff. A full medicine audit was completed monthly. The last one had been on 29 October 2016 with no required actions.
People told us they felt safe. One person said, "Oh yes I feel safe the doors get locked at night." We spoke to another person who was dependent on staff to move them. They told us they felt safe when staff used their hoist. They said, "Yes that's my hoist in my room and they are very good with me when they lift me. Very careful they are." Another person said, "Yes I feel safe, the only time you don't feel safe is when there's agency staff on but it has got better, not so many now. But some days they have more than others." This person went on to indicate that changes in staff affected them. For example, they said, "What I don't like is staff coming from downstairs and upstairs, they don't know where your things go like your clothes."

There were arrangements in place to protect people from potential abuse and harm. Staff had received training on how to recognise abuse and what to do if they witnessed this or received an allegation. The senior staff shared safeguarding issues appropriately with external agencies who also had responsibilities in safeguarding people. For example, the local authority, the police and the Care Quality Commission. The registered manager had spoken to staff in meetings about the importance of reporting poor practice. Staff whistleblowing was kept anonymous, taken seriously and investigated. The registered manager, with HR guidance had taken appropriate action against poor practice. Some staff therefore no longer worked at the care home because of this. This protected people from unsafe and inappropriate care and actions.

Staff recruitment practices helped to protect people from those who may be unsuitable. Recruiting permanent staff to address the care home's history of a large usage of agency care staff had been one of the registered manager's main challenges. Recruitment had been successful and had reduced the usage of agency staff to almost nothing until a recent spate of staff sickness. A few staff had also left. Staff recruitment was therefore on-going. Staff sickness was managed and monitored by the registered manager and each member of staff attended a back to work interview. Recently a new catering manager had been recruited and was due to start very soon. New senior care staff, night staff and dining room staff had also been recruited since the last inspection.

Recruitment files demonstrated that appropriate steps had been taken to recruit staff safely. Some staff had just started after all their checks had been completed, others were still waiting for clearances to take place before they could start work. This included a clearance from the Disclosure and Barring Service (DBS). A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, when past jobs had been with another care provider. Employment histories and the reasons for any gaps in employment had been explored. The registered manager's main goal was to recruit enough permanent staff and have a reserve bank of staff to be able to call on when needed. The registered manager told us in the future they planned to get people involved in the recruitment process.

The registered manager assured us there were enough staff on duty to meet people's needs and to keep them safe. They used a dependency tool to help them assess this. At the time of the inspection agency staff were used to help achieve this. The registered manager told us they were averaging one agency member of

staff each morning and afternoon, so nowhere near the numbers used previously. The numbers of staff on duty had recently been increased because of several new admissions. The need to increase occupancy had been another one of the registered manager's key actions. The other challenge had been to staff the care home adequately whilst releasing staff for necessary training. Agency staff had also been used to help with this. Where possible the same agency staff were used so as not to be such an impact on people. The registered manager told us the use of agency staff was not ideal but necessary to ensure there were enough staff on duty each day. Actions had therefore been taken to staff the care home appropriately.

The staff had mixed views on whether there were enough staff. One member of staff's view was there were not enough staff. They said, "There is nowhere near enough staff. Call bells are ringing and you do not know who to go to [meaning – who to go to first]. There is a lot of agency and not enough of us [meaning permanent care staff]." Another member of staff's view on this was there were enough staff in number but they needed to be better deployed by their immediate seniors and work better as a team.

A new maintenance person was in post and although they linked up with the registered manager on a day to day basis, their work was predominantly managed by the regional estate team. We spoke with them about some of the health and safety related checks they carried out. They carried out tasks such as flushing infrequently used water outlets and checking water temperatures as part of reducing risks of Legionella disease. A specialist company was also involved in taking water samples from tanks and various outlets to monitor the general health of the water system. A plumber was due to visit soon to remove ends of pipes which could hold pockets of water which is a Legionella risk. We were informed that the schematics (a structural and procedural diagram) of the water and heating systems and the Legionella risk assessment were held by the estates team. Visual checks were carried out on wheelchairs although no record was kept of this. Checks on window restrictors were not being carried out and we fed this back to the registered manager who was going to add this to the health and safety check list. Another specialist company serviced and maintained for example, the lifts and all lifting equipment.

The environment was kept clean by the domestic staff who we observed carrying out cleaning tasks, which included high level dusting. Two members of this team told us they carried out the cleaning required, either by direction from the Sisters (if in the area managed by them) or following their own cleaning program. They told us they did not follow a written schedule of cleaning or recorded what cleaning they had completed. The registered manager told us there were cleaning schedules but when they went to get these from the relevant file they were not in there. One member of staff however, was able to tell us exactly what bedrooms and communal areas they cleaned, on which days and what tasks they carried out in rotation. The rooms we reviewed were clean, tidy and smelt fresh. In the budget there had not been provision for a domestic lead/housekeeper and the registered manager told us the team needed to be managed. This task was therefore going to be allocated to the new catering manager.

There were arrangements in place to prevent cross contamination and the spread of potential infection. Soiled laundry was segregated and washed separately. Staff wore plastic gloves and aprons when delivering care and changed these and washed their hands between each person's care. Similar arrangements were in place when food was served. This was predominantly done by designated dining room/servery staff although, when care staff helped, they wore protective tabards. Different equipment was used to clean different areas of the care home. For example, mops used to clean toilets were only used for these areas. This prevented the potential spread of infection.

Good

Is the service effective?

Our findings

On 28 and 29 January 2016 and 1 February 2016 we found the provider had not fully provided staff with the training and support they needed to enable them to perform duties safely and effectively. This was a breach of regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. The provider told us how this would be met and by when. During this inspection we found this breach of regulation had been met.

The co-ordination and organisation of 73 members of staffs' training was the responsibility of the registered manager with support from the head of care and administrator. Staff training records showed updates in mandatory subjects since the last inspections. This had included, fire safety (with more booked after Christmas 2016), safe moving and handling, basic life support and safeguarding people. Also booked for January and February 2017 was infection control training. Staff had received additional support and training from the registered manager and head of care on the principles of the Mental Capacity Act 2005, care planning and risk assessments which included nutritional risks. Modules had been completed by staff as part of the care certificate and these were with the provider waiting to be signed off. The care certificate provides a framework of training and support which new care staff can receive. Its aim once completed is for staff new to care, to be able to deliver safe and effective care to a recognised standard. Plans for the future included a 'buddy system' for new staff.

The registered manager had carried out individual support meetings with most staff. They told us they just needed to now complete these with the night staff. The previous catering manager had completed individual support meetings with their team. The registered manager said, "I'm developing the staff." They told us all staff were enrolled to complete further recognised qualifications in care. All senior care staff had completed or had been enrolled to complete qualifications in care but at a higher level. This support had provided staff with opportunities to improve and enhance their knowledge and skills in order to safely and effectively meet people's needs.

Also on 28 and 29 January 2016 and 1 February 2016 we found the provider had not fully ensured the principles of the Mental Capacity Act (MCA) 2008 had been adhered to. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider told us how this would be met and by when. During this inspection we found this breach of regulation had been met. 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.

We observed people being supported to make day to day decisions. Some people's care records also recorded this as happening in certain situations. Where people had been unable to provide consent for moving into the care home and for the delivery of their care and treatment, their mental capacity had been assessed. Where they lacked mental capacity to make specific decisions these had been made on their behalf and in their best interests. We reviewed mental capacity assessments for one person who was

sometimes resistive to personal care and who was unable to remember meal-times and understand the need to take their medicines. These stated the person had been unable to retain information about their care needs and could not weigh up the risks to them if these were not met. Decisions had been made and recorded around these needs to ensure care was provided in the person's best interests. Another person had been assessed and found to lack mental capacity in relation to their personal care needs. Again, a best interests decision had been recorded for this care to be delivered. This person was able to make other simple decisions, such as whether to get up or stay in bed and these were recorded on a day to day basis. Care records showed these decisions were respected. Another person's care records recorded the person was able to make independent decisions, although they may at times require support to do this.

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). Senior staff had correctly completed DoLS applications if a person was deprived of their liberty in the process of meeting their needs. We reviewed applications which had been completed and where people were still waiting to be assessed by a Best Interests Assessor. One example was an urgent DoLS application for a person who attempted to leave the building and was unable to understand the risk this posed to them. Another example was a person who had not wanted to move into Nazareth House but who had been admitted as an emergency and where there had been concern about their mental capacity at that point. This person's capacity had been re-assessed and an Independent Mental Capacity Advocate (IMCA) had been involved. This person had subsequently been assessed as able to make their own decision about where they lived. These processes helped to protect people who lacked mental capacity by ensuring that decisions made about their accommodation, care and treatment, were made in their best interests. They also ensured people received the support they needed to make decisions independently.

People gave us their views on the food provided and there was a mix of positive and negative comments. One person said, "There's room for improvement, the food has got better and today it was very good. I never get hungry at night." This person confirmed they were provided with a hot drink before bedtime and had access to a drink and a snack at night if they wanted it. Another person said, "Sometimes the food is very good like today but not always. The girl who cooks here is fantastic. Supper could be better, and if anybody says salad or sandwiches I will scream." Another person said, "Supper is at 5:30pm and then you get a cup of [name of drink] at around 9pm if you want and I think you might be able to get a sandwich but I'm not sure." Another person said, "It's [the food] quite good on the whole, nothing wildly exciting, we used to have a choice but now you get one choice, take it or leave it. My favourite is [name of dish] and sometimes we get it. The meat can be a bit tough and not very good. The soup is good most of the time, when they don't water it down." Another person said, "I prefer to have my meals in my room. The food is very good and yes I get a choice but I can't remember and they always come around with the tea and coffee and biscuits." Another person said, "The food is very good I have nothing to grumble about. Yes I get a choice. I eat in my room."

The registered manager told us people could choose what they wanted for breakfast (which included a cooked breakfast). At lunch time there were two options and other alternatives and alternatives were also available at tea-time. The registered manager was aware the menus needed a review and how people were supported to make their choices needed looking at. We did not see printed menus on tables to support people to remember what they had chosen at that particular meal. The registered manager also planned to extend the kitchen hours to better accommodate the needs of the care home. They were looking forward to the new catering manager starting and being able to implement these improvements. To monitor what was happening at mealtimes the registered manager sat and had lunch at least once a week with people and sought their views and ideas. People had liked the suggestion of a food forum where people could meet with the catering manager and discuss their menu ideas. To improve people's dining experience the dining

rooms were being refurbished, with one of the two already completed. This now offered people a comfortable, light and airy space to eat. A new open plan kitchenette in the dining room provided the dining room staff with new equipment, storage and the space they needed to support mealtimes. Tables were laid attractively with table cloths, napkins, flowers and condiments.

People's weight and their appetites were monitored and if there were any concerns with these they were discussed with the person's GP. The head of care had been supporting senior care staff to assess people's levels of nutritional risk and ensure these assessments were kept up to date. Where closer monitoring of what people ate and drank was required, food and drink charts were completed. These were also being checked at the end of each shift to make sure they were being accurately maintained. We reviewed one person's care records because they had needs which if not supported could affect their ability to maintain their nutritional well-being. A nutritional assessment had been completed and their nutritional risks were low. Their weight was steady, their appetite was average and no new problems had been reported. We observed staff supporting two people who were unable to feed themselves. Their food was given to them in an unrushed and dignified manner and the amounts eaten recorded.

People had access to health care professionals. A local GP visited the care home on a regular basis to review people's medical needs. GPs also visited as required in-between. People's care records recorded visits from other health care professionals such as, physiotherapists, occupational therapists, community nurses, the Parkinson Disease Nurse Specialist, speech and language therapists and mental health practitioners. A Chiropody service was available on a regular basis which we saw visiting during the inspection. NHS dental and optical appointments could be organised.

Good

Is the service caring?

Our findings

People lived in a care home that had a warm and welcoming atmosphere. One person said, "The regular staff are really caring and I've made some lovely friends with the staff." Another person said, "Yes I feel comfortable, everybody's friendly and the staff are good." Another person said, "I think the staff here are very good, they make you feel you're still part of life, we have a good laugh and a joke together." One relative said, "This might not be the all singing all dancing home but it has the best atmosphere we have found. My [relative] was in a really nice up to date care home but it was cold with no atmosphere." They also said, "They [staff] have been so caring and nothing has been too much trouble."

We observed staff treating people with respect and maintaining their dignity. We observed one person become upset and distressed. Staff spoke to them in a kind and reassuring way. The person had become upset in response to another person's behaviour. They said, "It's so different [the care home] to how it used to be." They had decided after this to lock their bedroom door during the night. A member of staff took time to explain that they would prefer they didn't lock their door as they wanted to check them during the night. The member of staff was concerned they would disturb the person by doing this. After a chat about things it was agreed the person would lock their door and would not be too concerned if they were disturbed. The member of staff then went to make the person a bed-time drink to help them settle.

Family members were able to speak on behalf of their relatives and could be involved in their care as much as the person wanted them to be. People who mattered to people were made to feel welcomed and could visit at any time.

Although the care home was linked to a Catholic Order people were not discriminated against if they did not follow the Catholic faith or had a different faith or no faith at all. Many people chose to live at Nazareth House because of the links with the Sisters of Nazareth, but people were supported to practice their individually chosen faith. Time was found to support anyone who needed reassurance, compassion and counselling. Adjoined to the care home was a Chapel and two services were held each day for those who followed the Catholic faith. The Chapel was also there for use by people who did not follow the Catholic faith but who wanted a quiet place to either pray, contemplate or reflect. If people found it difficult to make their way to the Chapel independently, the Sisters helped them. For those who followed the Church of England (C of E) faith a regular service was performed by a person from one of the local (C of E) churches. Links had been made with a Synagogue for another person and a Sister was going to take them there.

People's privacy was maintained and all personal care was delivered behind closed doors. Conversations about people's care were carried out in private. Electronic care records were kept secure and staff could only access these with passwords. Paper care records were also kept secure in offices that were locked when not in use. People varied in how much they chose to discuss with the care staff and the Sisters. Some people were very private and preferred to manage their own affairs and not discuss a lot and others mainly discussed things with their families. For others the staff and Sisters were their family. Whatever people preferred it was respected. Information was only shared with people's consent with appropriate professionals and with staff on a need to know basis. Information was shared with family representatives

where it was appropriate to do so.

Requires Improvement

Is the service responsive?

Our findings

The service was not responding to people's needs in a personalised way. People were receiving care but not necessarily when and how they wanted it. How staff and the care home's routines were sometimes was not promoting or supporting this. We spoke with the registered manager and head of care about this. They were already aware that senior care staff needed further support and guidance to manage their staff teams in a more flexible and less task led way. They were also aware that care staff also required more support and training in how the achieve their tasks but in a way that met people's preferences. It was evident that a lot of work had been done towards changing staffs' views and their approach towards people's care. Systems and practices were being introduced which would support a more personalised approach to care. However, from people's feedback and from what we observed this was not yet having the desired impact.

When we explored people's care preferences and in particular their bathing preferences it was clear these were not being met. One person said, "I get to have a bath once a week but would really prefer one every day." They told us staff had explained to them that they were too busy to do this. Another said, "I can have one [a bath] once a week but I would like more. I have to ask them [staff] first and I'm fed up asking." Another person said, "I have one or the other [bath or shower]. Up until a month ago it was every Saturday but now it's when they like to give it. The last time I had a bath was a week last Saturday, I would like one at least once a week."

We also asked people if they considered the staff to be responsive to other needs and in particular how quickly staff responded to their call bell. One person said, "Yes, they're better than they used to be, they're quicker at night but during the day time not so good." Another said, "Yes I've used it [the call bell] but not that often, and they do come quickly and I haven't noticed a difference between the day and night." Another person said, "Yes I've used my call bell and I've waited up to forty minutes. This is during the day. It also depends how many staff are on." There were several other comments from people and relatives who were of the view the care home was short staffed because of these delays. They also thought not being able to have a bath when they preferred one was due to not enough staff.

A review of the call bell print out showed call bells were being answered more quickly than we observed in the last two inspections. However, poor decisions made by staff, at times when people needed them to respond to them, resulted in people having to wait. We observed two staff seated in a bedroom and talking for sometime whilst call bells were ringing. We asked the registered manager to investigate. These staff explained they had completed a person's care and had remained in the person's bedroom to talk through what needed to be done next. One person said, "Yes I use my call bell but it takes forever for them [staff] to come and see me." An example of this happened during the inspection. Although this person's call bell had been answered by an agency member of staff this member of staff could not meet this person's needs on their own; it required two members of staff. Rather than allocating another member of staff to help the agency member of staff a decision was made to continue with the staff hand-over meeting which was taking place and then address the person's needs, which were to use the toilet. These example's were of enough staff on duty but not working in a personalised and responsive way. We attended a staff hand-over meeting later in the inspection and call bells were answered by staff who left the meeting to do this.

Since the last two inspections work had been completed on people's care plans. These had all been reviewed and were relevant to people's needs. Those we reviewed still required more specific detail to provide staff with enough information in order to deliver personalised care. For example, one person was at risk of developing pressure ulcers. The relevant care records said they should be "checked". In this case the care staff knew they needed to reposition this person on a regular basis and were doing so, but the detail about this was not in the care plan. Care plans also lacked evidence that they had been written with the person's input. The person's voice, what they wanted and how they liked things done, was sometimes not present. However, one person said, "Yes I've seen my care plan and it has been updated." The head of care told us they had started to involve people and relatives in the care plan reviews. They told us the priority to date had been to ensure the care plans were reviewed on time.

Care staff delivered people's personal care and we observed them supporting people in other ways also. The care being delivered however, was not always following the written care plans or meeting people's preferences. For example, one person's personal care, care plan stated "would like to have a shower every other day". Records were kept by care staff of when people had a bath/shower and when they refused this. We reviewed this person's records for a period of 11 weeks. The record was unclear as to whether they had received a shower or a bath because the record did not differentiate which had been given. The intervals between these were predominantly a week. On three occasions they were between three and four days and twice over 10 days. Another person told us they liked to have a bath every other day. They said they averaged a bath two or three times a week. Their records recorded them as having a bath twice a week and this was on set days. These records therefore substantiated what we had been told by people that the care was not being designed or delivered around people's preferences.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they had opportunities to take part in activities which they enjoyed and which were meaningful to them. One person said, "There used to be a lady who done activities but she has left now and there's not much to do now. We used to be in the lounge and that got you to mix with other residents. Sometimes you get bored and that makes you miserable." Another person told us about their involvement with the activities that were provided. They said, "Yes I do a lot but the girl who used to do the activities has left and she would run a quiz and she was very good. We had bingo once a fortnight and they have a bible reading class. We do exercises and we used to do relaxation classes."

At the time of the inspection we did not observe the people who were seated in the lounge areas, for long periods of time, be provided with opportunities to take part in meaningful activities. One person said, "All I do is just sit here and watch TV, which I don't like and I sleep a lot." The registered manager subsequently explained that although there had not yet been a replacement for the previous activity co-ordinator, this had not prevented people having opportunities to take part in activities they enjoyed. They also explained that people had a choice as to whether they took part in activities or not and they said some times people decline the opportunity.

We were told there was no specific budget for the provision of activities although the registered manager told us they had requested there to be so in the 2017 business plan. The Friends of Nazareth House were very supportive and ran various social events in the care home. They also raised money for the Nazareth House amenities fund and were very involved in for example, organising the summer fete and other events which connected the care home with the local community. The Friends of Nazareth House for example, put on films, organised talks, quizzes and bingo sessions and we saw these were very popular with people. These arrangements however, did not support those who required more individual and dedicated time to

take part in activities.

People were able to raise a complaint or report a concern and for this to be listened to, taken seriously, investigated if needed, and addressed. The registered manager was available when people wanted to speak with her. She had addressed several areas of dissatisfaction about how the care home had been run when she had first been in post. There had been no new complaints since this. The registered manager explained that they would rather address people's queries or concerns straight away and try to resolve these before people felt they needed to submit a complaint. They also told us that learning could always be had from situations that had not gone well and those which had gone well should be celebrated. The care home also received many messages of thank you and appreciation.

Requires Improvement

Is the service well-led?

Our findings

On 28 and 29 January 2016 and 1 February 2016 and on 12 and 17 May 2016 we found the provider did not have effective systems in place to monitor the quality and performance of the service. The systems in place had not supported compliance with the required regulations and had not led to improvements. This was a breach of regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. The provider told us how this would be met and by when. During this inspection we found this breach of regulation had been met. There were systems in place to monitor the service which had subsequently led to improvements. However, some of these improvements had yet to lead to fully embedded and improved practices as evidenced by the breach of regulation we found in the service.

Since we visited Nazareth House in January 2016 there had been a change of permanent manager. Prior to January 2016 there had been several changes in permanent managers with intervals of interim management arrangements. The service had therefore lacked consistent leadership for a substantial period of time. We therefore asked people if they knew who the current manager was. We received positive comments back which included, "Yes I know the manager but I don't see her very often", "Yes I know the manager [name], she's always there if we need to see her and it's better to see her in the afternoon" and "Yes the manager is called [name] and if I need to see her I can." One person said, "No, never seen the manager I don't know who she is". One relative said, "Yes we have met the manager who seems okay". Another relative told us they felt the care home was "moving in the right direction" and they told us the current manager was "a good one". There had also been changes in the provider's regional support team which were due to alter again following this inspection.

The difference in how the care home was operating and how it had been managed since the registered manager had been appointed was very noticeable to us. The registered manager described the care home as "a lovely home" and they wanted the "lovely feeling" the home had to be present all the time. One member of staff discussed with us the differences they felt the registered manager had made. They said, "The atmosphere was terrible but it's now a lot better. [Name of registered manager] has brought it [the care home] up a lot." Another member of staff described the registered manager as "very supportive". They said, "She trusts what I'm doing but steps in when it's needed."

People and staff had benefited from the registered manager's strong leadership. She had been well supported by her immediate senior staff team, which had evolved and become stronger over time. The new catering manager, once started, would be the newest recruit to this senior team. A management structure had been developed with the head of care taking a lead on all care related issues; with support from the registered manager. The registered manager managed the overall service with the support of the administrator and provider's head office. The registered manager told us the administrator had been invaluable. They told us they were experienced and able to carry out their role independently which had allowed them to focus on improving the service.

The senior staff all felt they had worked well together and had made improvements but were also aware there were still issues to resolve, systems and practices to embed and sustain. We were told the next priority

was to further develop the skills of the senior care staff. For example, for them to be able to support and promote the need more personalised care. At present senior care staff required a lot of support and guidance from the head of care to ensure all day to day care requirements were met. This restricted the head of care in the tasks they could comfortably delegate. The registered manager said, "I want staff to take more responsibility and I want to see more initiative but they have to be trained and supported to do this."

In discussing the improvements so far with the administrator they told us they were due to leave soon. It was explained the provider had not planned to replace the administrator and the registered manager was to inherit many of their tasks. The registered manager told us they would have to see how this went.

The registered manager communicated her expectations, values and visions to the staff in various meetings and on a day to day basis. These were supported by the head of care and some senior care staff. We recognised that further shifts in staffs' thinking and approaches to care deliver would require more support from the management team and would not happen immediately

Where staff had continued not to perform to an expected standard or where they had been deliberately resistive to changes, this had been effectively managed. Some staff had left following necessary disciplinary action, some had chosen to leave and others had been supported to improve their performance. Examples of positive changes in how some staff were performing were discussed during the inspection. The registered manager wanted staff to work as a team and said, "I want staff to feel empowered, to feel valued and to have a say." The registered manager's fundamental message to us, throughout the inspection however, had been the people came first and the priority was to achieve good outcomes for them and provide a quality service.

The registered manager told us they received support from the provider and had access to staff at head-office when needed. Information was submitted by the registered manager to the provider's head-office on a regular basis. This included levels of risk, numbers of admissions, discharges and deaths, staffing numbers, staff sickness levels, usage of agency and any complaints. The registered manager had carried out various audits, produced by the provider, to help her assess performance and compliance against the provider's expectations and relevant regulations. These also helped her to monitor the progress of the improvements made. We were informed that the provider was making further alterations to these audit tools.

An on-going action plan had been in place since the last inspection in January 2016. This had been reviewed and amended with time but also reviewed with the registered manager in September 2016. This contained the actions required following the last two inspections and additional actions from the provider. We were informed that the last provider's quarterly audit had been completed by an external auditor, on behalf of the provider, in September 2016. In October 2016 a representative of the provider carried out an audit on a selection of care plans. This audit followed the work completed by the head of care on the care plans. It identified some further actions to be carried out and gave time frames for these to be completed, which was what the audit was designed to do.

The last full assessment of the service by the provider had been completed just after this inspection. We were subsequently provided with a copy of this during the period this report was being written. This reported on the service's progress so far and gave an overall score using the provider's quality assessment tool. It identified a lot of successful improvements. These monitoring systems along with a competent and consistent registered manager in post gave us reassurances that the service would improve further.

The provider had sought feedback from people and their relatives in the last year but this information was not collated at the time of the inspection. However, in managing the care home the registered manager had

been continually seeking feedback and receiving this from people and their relatives. This had helped them to gauge people's views on the changes made so far and learn what changes people wanted to see for the future. For example, opportunities to discuss the menus.

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 9 HSCA RA Regulations 2014 Person-centred care People's care was not always personalised. Care was not planned or delivered in a way that met people's personal preferences. Regulation 9 (1)(c) (3)(b)