Nazareth Care Charitable Trust

Nazareth House - Lancaster

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 22 and 28 June 2017.

Nazareth House is registered to accommodate 43 people in need of nursing and personal care. Accommodation is provided over three floors with 43 single rooms, all with en-suite facilities. Established in 1899 by the Sisters of Nazareth, the home is set in landscaped gardens, which includes a wildlife pond. There is also a greenhouse for people who like gardening and a sensory garden area for people to relax in. On the days of the inspection there were forty people residing at the home.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last comprehensive inspection of the service took place on 04 June 2016. At this inspection we found the service was not meeting all the fundamental standards. The registered provider did not consistently treat people with dignity and respect and people's nutritional needs were not always suitably managed. We carried out a focussed inspection on 08 December 2016 to check if the required changes had been made and found suitable improvements had been made.

At this comprehensive inspection visit carried out on 22 and 28 June 2107, we found breaches relating to staffing, dignity and respect, safe care and treatment and good governance.

The service was not meeting all the fundamental standards. People who lived at the home and relatives told us they did not think staffing levels were adequate to meet people's needs. From our observations we found this was the case and staff were not always suitably deployed. Deployment of staffing in communal areas was inconsistent and people were left unsupported despite us being there was a staff member in communal areas at all times. Similarly, at meal times deployment of staffing was poor. This resulted in people having to wait and not always receiving the meal of their choice. We found errors in paperwork. Staff told us they had not been able to fulfil all their duties due to the workload pressures. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2013 as the registered provider had failed to ensure suitable numbers of staff were deployed to meet the needs of people who lived at the home.

People were not always treated with dignity and respect. We observed one person trying to leave a communal lounge in their wheelchair. Staff intercepted the person and brought them back into the lounge. They did not speak with the person to find out their wishes and left them in the lounge without any stimulation. This was a breach of Regulation 10 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as the registered provider failed to ensure people were consistently treated with dignity and respect.

Arrangements were in place for managing and administering medicines. Medicines were secured in line with

current guidance. Regular audits of medicines took place. However we observed that good practice guidelines were not consistently followed. This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as the registered provider failed to ensure suitable systems were in place for the administration of medicines.

People who lived at the home were consulted with on a regular basis. However we found evidence to suggest people's views were not always listened to and acted upon. We have made a recommendation on effective communication and consultation.

People who lived at the home told us that person centred care was not always provided. We looked at care records to establish if this was the case but were unable to make any judgement as care records were not fully completed and accurate. This was a breach of the Health and Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as the registered provider failed to ensure people were consistently treated with dignity and respect.

Staff had knowledge of safeguarding procedures and were aware of their responsibilities for reporting any concerns. Suitable recruitment procedures were in place to ensure people employed to work at the home were of a satisfactory standard for working with vulnerable people.

Care plans were in place for people who lived at the home. Care plans covered support needs and personal wishes. Plans were reviewed and updated at regular intervals and information was sought from appropriate professionals as and when required.

A visiting health professional told us they were confident the service met the health care needs of people who lived at the home. People's healthcare needs were monitored and referrals were made to health professionals in a timely manner when health needs changed.

Staff had received training in The Mental Capacity Act 2005 and the associated Deprivation of Liberty Standards (DoLS.) We saw evidence these principles were put into practice when delivering care. Consent was gained wherever appropriate.

There was a training and development plan in place for all staff. We saw evidence staff had been provided with relevant training to enable them to carry out their role. Staff praised the training opportunities provided by the registered provider. Staff told us they received supervisions.

We received mixed feedback about the staff who worked at Nazareth House – Lancaster. We were told that some of the staff were kind and caring.

We observed the activities coordinator carrying out activities taking place on the first day of our inspection visit. People told us they were supported to remain busy with activities if they wished.

The service had a system in place for managing complaints. People told us they were confident if they raised any complaints they would be dealt with professionally. We saw evidence that formal complaints were taken seriously and acted upon.

The service had systems in place for on-going monitoring of the quality of service. Monthly audits of care records, medicines and health and safety audits took place. Although audits were in place, they were ineffective as they had not identified the concerns we identified during the inspection process. This was a breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as quality audits

were ineffective.

The service had implemented a range of quality assurance systems to monitor the quality and effectiveness of the service provided. Feedback we reviewed was mixed.

Staff described teamwork as good. They told us they were regularly consulted with through team meetings.

You can see what action we have asked the provider to take at the back of the main body of the report.

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 sometimes safe.

People who lived at the home told us they felt safe.

Deployment of staffing was not consistent within the home to ensure people were kept safe.

Arrangements were in place for management of medicines; these were not consistently followed.

Risk was sometimes identified, managed and addressed.

Staff were aware of their responsibilities in responding to and reporting abuse.

The service had suitable recruitment procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Deployment of staffing at meal times did not consistently meet people's needs.

People's needs were monitored and advice was sought from other health professionals in a timely manner, where appropriate.

Staff had access to ongoing training to meet the individual needs of people they supported.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and the relevance to their work.

Is the service caring?

Requires Improvement

Staff were sometimes caring.

Staff sometimes treated people with patience, warmth and compassion.

People's preferences, likes and dislikes had been discussed so staff could deliver personalised care. However we found this was not always carried out.

Relatives were positive about the staff who worked at the home.

Is the service responsive?

Good

The service was responsive.

Records were person centred and showed people were involved in making decisions about what was important to them.

The service ensured there was a wide range of social activities on offer for people who lived at the home.

The service worked closely with people and their families to act on any concerns before they became a complaint.

Is the service well-led?

Requires Improvement

The service was sometimes well led.

Paperwork was not always completed as required.

Regular communication took place between the senior management team and staff as a means to improve service delivery.

Regular feedback upon the quality of the service was actively sought. However documentation maintained by the organisation demonstrated that people did not always think their views were taken seriously and acted upon.

Systems were in place to monitor the effectiveness of the service however these were not always as effective as they might have been given they failed to identify the concerns found during the inspection process.

Nazareth House - Lancaster

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 visit took place on 22 and 28 June 2017. The first day was unannounced. The inspection was carried out by an adult social care inspector.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people. In order to gain a balanced view, we consulted with the Local Authority, Clinical Commissioning Groups and Healthwatch to check if they had any concerns. Healthwatch Lancashire is an independent consumer champion for health and social care.

Information was gathered from a variety of sources throughout the inspection process. We spoke with eleven people who lived at the home and five friends and relatives who visited the home.

Because some people who lived at the home were living with dementia and were unable to speak with us we carried out a SOFI (short observational framework for inspection.) This allowed us to try and understand what people were experiencing through observations.

We spoke with eleven staff members at the home. This included the area manager, the registered manager, the administrator, the head of care, a qualified nurse, and six staff who provided direct care.

To gather information, we looked at a variety of records. This included care records related to five people who lived at the home and recruitment records belonging to four staff members. We viewed other documentation which was relevant to the management of the service including health and safety certification and training records.

We looked around the home in both communal and private areas to assess the environment to ensure it

was met the needs of people who lived there.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home told us they felt reassured and safe. Feedback included, "I feel safe here, very much so." And, "I feel safe here, whenever I get up at night there is always a member of staff sat at the computer desk." One relative said, "As a family we are delighted we can have peace of mind."

We looked at how the service was staffed. We did this to make sure there were enough staff on duty at all times, to support people who lived at the home. During the inspection visit we reviewed response times to call bells. We sought assistance from three call bells within bedrooms and found that call bells were answered within a suitable time frame. Although we found call bells to be answered in a timely manner, nine of the eleven people we spoke with home told us they had some concerns with staffing levels. Feedback included, "Sometimes we have to wait." And, "Staff can't be in two places at once, sometimes we have to wait." And, "I have never had to wait but I think some people have to wait a little while. They tend to know who is more urgent." And, "At a residents meeting we said we wanted a carer downstairs at all times. There were elderly people trying to get out of wheelchairs. They need people to be there to sit with them to make them feel like they're cared for." And, "If I ring my bell it depends on how busy they are. Sometimes I have to wait if they are right busy."

We asked relatives about staffing levels. Four of the five relatives we spoke with told us that staffing levels did not always meet the needs of people who lived at the home. Feedback included, "I have sometimes heard staff saying, "We haven't enough time."" Also, "I get the impression they are short staffed." In addition, "I don't feel there is enough staff." And, "Sometimes there are three staff on duty, sometimes two go off on breaks together leaving only one. If [relative] needs a bed pan at dinner time it can be difficult. I come in and help over these times just in case."

We looked at staffing levels. Three staff were scheduled to work on the nursing unit to support fifteen people. This included one qualified nurse and two care assistants. In addition, three carers were scheduled to work on the residential unit which had scope for twenty seven people.

During the inspection visit we observed staff working on both the residential and nursing units. On the nursing unit we found staff were not rushing and responded to people's needs in a timely manner. Staff interacted with people as and when required. There was a calm atmosphere on the unit.

On the residential unit we found deployment of staff was not consistent to meet people's needs. We observed poor oversight in the communal areas which led to potential risk. For example, we observed one person in the dining room trying to mobilise. There were no staff present to help this person and the person tried to walk without using their mobility aid. A relative had to stop the person from walking unsupported. Another person wanted to use the bathroom; no staff were present to assist. The person waited for a member of staff to come but no one was present. We had to find a member of the kitchen staff who also could not find a member of staff. They had to ring up to one of the floors for a member of staff. In the meantime the person struggled and attempted to use the toilet themselves. The person had to wait four minutes until assistance from a staff member was deployed. This compromised the person's dignity. On

another occasion we observed one person asking for assistance whilst loudly banging a cup on the table in the lounge in an attempt to alert a member of staff.

We raised concerns about the deployment of staffing in communal areas on both days of our inspection visit and were informed that staff were allocated roles of overseeing communal areas. The head of care told us there was a protocol in place whereby staff had to contact another member of staff when they wanted to leave the communal area so that a replacement staff member could swap over. On both occasions we noted supervision was not consistent with this process in communal areas.

We asked staff if they felt staffing levels met the needs of people who lived on the unit. One staff member said, "Staffing levels don't always meet need. One staff member has called in sick at short notice today." Another staff member said, "We don't always have time to do all our jobs."

We spoke with the registered manager about staffing levels. The registered manager said they were trying to implement a whole home approach at the home so that staff could be deployed to areas of need. They said they were currently working on this. In addition, they told us there had been discussion about future staffing plans at the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider had failed to ensure suitable numbers of staffing were deployed to meet people's needs.

We looked at how medicines were managed within the home. Medicines were sometimes administered following good practice guidelines, 'Managing medicines in care homes.' Medicines were stored securely within a designated room on each unit. Storing medicines safely helps prevent mishandling and misuse. The rooms were temperature controlled to ensure medicines were stored at the correct temperatures. Controlled drugs were stored in a separate secure cabinet and the service maintained a register of all available stock. We checked the contents of one controlled drug and noted the stock and controlled drugs register matched up.

Medicines Administration Records (MAR's) belonging to each person had a photograph on them so the person could be identified prior to medicines being given. They clearly detailed any known allergies of the person. This minimised any risks of people being administered medicines which may cause harm.

Although we observed some good practice, we noted on one occasion the member of staff administering medicines left the medicines on the table for one person and then left the person alone. They then signed for the medicines. We asked the staff member how they could be assured the person had taken the medicine. They said they would go back later to check. On another occasion, one person asked if they could have two of their prescribed tablets for pain. There was only one tablet in the box on the medicines trolley. They gave the person one of the tablets and said they would return later when they had been upstairs to replenish the stock. The senior administering the medicines did not sign for the tablet taken. They said they would sign when they had given the additional tablet. We highlighted our concerns as it had not been documented the person had taken one tablet. The staff member said no one else was able to administer medicines that day.

Two people we spoke with told us they had not been given their prescribed eye drops the previous evening. Both people told us this was not an isolated incident. They said, "More than once they have forgotten to put the drops in my eyes." Another person said, "It's not the first time they have forgotten." We looked at the MAR records for these people. The records had been signed to show the people had received their medicines. This conflicted with what we were told.

We looked at protocols in place for administering of PRN medicines. PRN medicines are medicines which are not used on a regular basis. PRN protocols were sometimes vague and did not give clear direction. For example, records sometimes stated, "one or two when needed." There were no details on the sheet to specify what this meant and when they were to be used.

We looked at how creams and ointments were administered. Directions on how to administer creams and ointments were not always completed correctly. For example, instructions sometimes read, "Use as instructed." We found no other evidence within care records which gave clear instructions to indicate where creams were to be applied. We highlighted these concerns to the nurse on duty. They acknowledged the forms had not been correctly completed.

We looked at MAR records and creams and ointment charts to ensure medicines, creams and ointments had been signed for after they had been administered. Whilst we identified no concerns with the MAR records we found creams and ointments charts were not consistently completed on either unit. For example, one person was prescribed a cream to be administered twice daily. Over a twelve day period we identified only one day when the record had been correctly filled in. On another person's record, over a six day period, only one day had been correctly completed. In the afternoon of our second day we looked at the creams and ointment charts on the residential floor and noted no creams and ointments had been signed for that morning. We asked the senior in charge about this. They told us that creams and ointments had been administered but staff hadn't had time to complete these records yet. We spoke to the nurse on the nursing floor, they confirmed the records had not been correctly completed and signed for.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider failed to have suitable systems in place for the safe administration of medicines.

We spoke with the registered manager about our concerns. They agreed to look into these matters.

We looked at how risks were managed at the home to ensure people were kept safe. There was a variety of risk assessments to address and manage risk including risk assessments for moving and handling, management of pressure ulcers and management of falls and assessments for using bed rails. Although risk assessments were in place, we noted one person's risk assessment was not fully complete. We spoke to a member of staff about this. They told us the risk assessment wasn't fully completed as staff had not had time to complete this. They agreed to ensure action was taken to complete the document to address all risks.

Staff told us they routinely monitored risks and updated risk assessments after incidents had occurred or people's needs changed. We saw evidence in care records this occurred. For example, we saw a risk assessment had been reviewed following a person having a fall. This reduced any further incidents of harm from occurring.

Although risks were suitably managed, on the second day of the inspection visit we noted one fire door was wedged open. Similarly a linen cupboard door which had a fire door sticker upon it with instructions to keep locked at all times was open with the key still in it. We discussed this with the registered manager; they said they would look into this.

We looked at how safeguarding procedures were managed by the service. Staff were able to describe the different forms of abuse and systems for reporting abuse. One staff member said, "I would report anything that would have a direct impact upon the person. Even if I didn't have concerns or knew the allegations to be false I would report it and expect the registered manager to investigate."

We looked at recruitment procedures in place at the home to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed records relating to five members of staff. Records showed full employment checks had been carried out prior to staff commencing work. Two references were sought for each person, one of which was from their previous employer. This allowed the service to check people's suitability, knowledge and skills required for the role.

The service requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a statutory requirement for all people providing personal care within health and social care. We noted DBS checks were in place for all new starters. A staff member who had recently been recruited confirmed they were subject to all checks prior to commencing work.

As part of the inspection process we looked at accidents and incidents that occurred within the home. The service kept a record of all accidents and incidents. This allowed the service to assess all accidents and incidents to look for emerging patterns. Accidents and incidents were reported to the senior management team for trends and themes to be analysed.

As part of the inspection process we looked around the home and found it was clean and tidy. We checked the water temperature in several bedrooms and one bathroom. We found the water temperature was comfortable to touch. Audits of water temperatures were recorded on a daily basis.

Equipment used was appropriately serviced and in order. Fire alarms and equipment had been serviced within the past twelve months. We noted recommendations had been made to upgrade the fire alarm and electrical wiring. We referred this on to the Fire and Rescue service who visited the home and told us they had no concerns. We saw other safety checks had been carried out including portable appliance checks and checks on equipment.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home provided us with mixed feedback about the quality of the food at the home. Feedback included, "The food is good. They give me plenty." And, "The food is nice." Also, "The food is not great. I don't think much of it." In addition, "The food isn't up to much."

We looked at how people's nutritional needs were met. People who lived at the home and relatives told us there was always plenty of choices at mealtimes. One person said, "Within reason there is always something for everyone. They will make sandwiches, salads or omelettes if there is nothing on the menu you fancy." One person said they enjoyed breakfast in bed. Their relative said, "It comes prepared on a tray. Like something you would get from a five star hotel!"

The dining room was pleasantly decorated. Tables were dressed with table clothes and condiments were available for people on the table. We observed a variety of drinks being offered during the meal.

On both inspection visits we observed meals being served in the communal dining room. We noted there was a menu on the wall outside the dining room showing meal choices for that day. Although there was a menu people who lived at the home told us this often did not reflect what was offered. On the second day of the inspection visit the menu stated that chips were on offer. We observed people asking for chips only to be told they weren't on the menu. One person said, "I am disappointed there were no chips." Another person said, "I don't know why they bother with a menu. It's always mixed up."

We found arrangements for serving meals at mealtimes were disorganised. For example, we observed a meal being taken back to the kitchen on the first day as the person was given a meal they never asked for. On the second day a person asked for sausage and received scampi. They said they didn't want to cause a fuss and agreed to eat the meal. Another person requested a jacket potato as they did not like what was on the menu. The member of staff forgot to tell the cook about the request so the person had to wait twenty minutes for their meal. They said, "We were supposed to be served first today and I have ended up waiting for my meal." Another person told us they had a medical appointment in their bedroom the night previous. This meant they did not get to the dining area for their meal. They told us as a consequence they never got a meal. They said, "I thought they may have brought me a sandwich up but they never. They must have forgotten."

This was a breach of regulation 18 of the Health and Social Care Act 2008 as the registered provider had failed to ensure staff were suitably deployed to meet the dietary needs of people who lived at the home.

We looked at how the service met the health needs of people who lived at the home. People who lived at the home told us staff provided support to access health care professionals when required. One person told us staff would call a doctor if they did not feel well. They told us, "We are looked after marvellously here." One relative we spoke with commended the way staff at the home had sought assistance for their family member when the person wasn't well. They said if the staff hadn't responded as quickly as they did they feared their relative may not have had a positive outcome.

We spoke with a visiting health professional. They told us they didn't have any concerns about the service and said staff always followed what was asked of them by the health professionals. They commended the way staff were able to use their initiative when managing people's health.

We looked at care records relating to five people who lived at the home. We noted there was clear documentation which detailed all health professional involvement and outcomes of meetings with health professionals. People who lived at the home had regular appointments with health professionals including GP's, dieticians and opticians.

Individual care records showed health care needs were monitored and action was taken to ensure good health was maintained. For example, one person was reportedly unsteady on their feet on the day of the inspection. A family member told us the home had contacted the rapid response team for extra support.

The registered manager told us they worked closely with the Care Home Support Team. They spoke positively about the links they had built with this team and the opportunities it provided them with. They described the support as "invaluable" as it offered them quicker access to the required healthcare services as well as support with health assessments.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Care records demonstrated the service had an understanding of the principles and the way in which the service was to be delivered. People were encouraged to make decisions in areas in which they had capacity. We saw evidence of a best interest meeting being held with family and professionals to discuss care and treatment for one person who lacked capacity.

We spoke with a member of staff about the Deprivation of Liberty Standards. (DoLS.) They told us one person who lived at the home had an authorised DoLS in place. Whilst the staff member did not know what DoLS stood for, they were aware of how the DoLS application impacted upon the care and treatment for the person.

People who lived at the home and relatives considered staff to be well trained and able to meet the needs of people who lived at the home. One person said, "Staff know what they are doing."

Staff told us training was good. We saw a variety of training was offered to staff to enable them to develop their skills and deliver effective care. Staff told us training had recently been reviewed and the registered provider was reintroducing more class room based learning to compliment e-learning training. The registered provider maintained a training matrix so training could be planned and organised to meet staff need.

We spoke to staff about supervision. Supervision is a one to one meeting between a manager and staff

member. One to one meetings are a means to discuss staff progress and conduct and discuss any concerns. Records showed staff received regular supervisions. Staff confirmed this was the case. Staff praised the approachability of the senior management team and said they could discuss any concerns they may have in between supervisions.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from relatives and people who lived at the home about the caring nature of staff. Feedback included, "Staff are kind." And, "Staff are caring." Also, "The majority of the staff are good." And, "80 per cent of the staff are super." In addition, "Staff are so-so. Some are good, some are bad."

We spoke to the registered manager about the values of the home. They told us staff were provided with 'servant-ship training." This training explored the common values that was expected from all staff who worked at the home. These were, 'Patience, hospitality, love, respect, compassion and justice.' The training was provided by the nuns at the home. Although this training was provided we found that not all values were consistently displayed by staff at the home.

During the inspection visit we observed interactions between people who lived at the home and staff. We observed some positive interactions between staff and people who lived at the home. For example, we observed one staff member in the lounge taking time to speak people. They used appropriate touch when necessary, touching a person on their arm whilst enquiring if they were okay. On another occasion we observed a member of staff talking with a person. They used eye contact and spoke to the person in a gentle manner to calm and reassure them. The staff member was courteous, and waited for the person to stop speaking before they spoke.

On another occasion however, we observed a person sat in the lounge in their wheelchair. The person wheeled themselves out of the lounge and into a corridor. Whilst they were in the corridor a member of staff came along, turned the wheelchair around and pushed the person back into the lounge. They did not speak with the person to ask them what they wanted or where they wanted to go. When the person was back in the lounge they placed the person's brake on the wheelchair to stop them for mobilising. The person was left in the lounge, with their back to the rest of the room without any appropriate stimulation. Forty minutes later the person spoke to a staff member and asked to go to her bedroom. The member of staff denied the person this choice and told them it was almost time for their evening meal. The person therefore remained in the lounge for another thirty five minutes until they were taken to the dining room.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider failed to ensure people were consistently treated with dignity and respect.

We raised this issue with the head of care on the first day of our inspection visit. They assured us they would look into the matter. On the second day of the inspection visit we discussed it with the registered manager. They told us they had been working to improve staff attitudes to care. They said, "There is always room for improvement, we need to do more work with staff around how they approach and interact with people."

People who lived at the home told us staff were sometimes impatient and rushed them. Another person told us that one staff member in particular told them not to ring their alarm bell so frequently. We noted staff on the residential units were rushed and interactions with people who lived at the home were limited. We spoke with one person about the care and treatment they received. They told us they were not always able

to tell staff what care they required. They said, "You don't have chance to tell them. They just rush in and out."

We looked to see if person centred care was delivered to people. The head of care told us they did not have a set routine for when people had baths or showers and said people could have them whenever they liked. However, one person told us that person centred care was not always delivered. They told us they liked to have a regular bath, however they said this did not happen as frequently as they would have liked. They told us they had only had two baths in a three week period. They said, "I could walk for miles after I have had a bath, it makes me feel so good." We looked at the person's care records to see when they had received a bath. We could not tell from the records when the person had last had a bath. We viewed another person's care plan. The care plan stated the person liked to have a bath every other day. We saw from the records this was not occurring. A member of staff said, "We sometimes forget to put it in records when a person has had a bath."

We recommend the service introduce a robust quality management system to ensure people's personal care requests are documented, met and recorded.

We observed staff knocking on doors in bedrooms before entering. This showed us that people's privacy was respected. Dignity was sometimes promoted. For example, people were offered tabards to wear at lunch time to protect their clothing from spillages. On another occasion a person required assistance to go to the toilet over lunch time. Staff spoke discreetly between themselves and the person to ensure the conversation was kept confidential and to protect the person's privacy and dignity. On one occasion however, we noted one person required to use the bathroom. No staff were available to help so the person took themselves to the bathroom. The person could not attend to their own needs and left the bathroom door open. This compromised their dignity. We stayed in the bathroom area to limit any people from entering until the member of staff arrived to assist the person.

Relatives told us they were always made welcome when they visited. They said they could visit at any time and were always welcomed. Visitors had access to a kitchen where they could make drinks. There was also a visitor's room for relatives and friends to stay over, if needed. We spoke with one relative who had stayed at the home the night previous. They had been worried about their family members health so had stayed to look after them and reassure themselves. They said, "Staff always make us feel welcome."

We spoke to the registered manager about access to advocacy services. One person at present used an advocacy service. They explained the person had no family so an advocate was involved to support the person with decisions. Advocacy services support people to make independent decisions about care and support.

We looked at how end of life care was provided by staff who worked at Nazareth House – Lancaster. A nurse on duty told us the home was currently involved in some pilot work with Lancaster University looking at ways of improving end of life care. They told us the project encouraged proactive conversations to be held with people and their family members about plans for end of life care and treatment. It also involved linking with health professionals and reviewing people's health care needs on a monthly basis. The member of staff told us the new initiative had been positively received and was enabling them to provide better end of life care. They said however, "It has created a lot more paperwork and we don't always have time to do this."

Good

Is the service responsive?

Our findings

People who lived at the home told us they were happy living at Nazareth House – Lancaster. Feedback included, "I love it. I am so happy here." And, "It's not my own home but it's as good as I am going to get." And, "I call it home. I am so pleased I came here. It's very pleasant. I wouldn't want to go anywhere else."

We looked at care planning documentation related to five people. Care plans were detailed and addressed a number of areas including communication, health and wellbeing, medicines, nutrition, personal hygiene and safety. Care plans detailed people's own abilities as a means to promote their independence. There was evidence of relevant professional's and relative's involvement wherever appropriate, within the care plan. Care plans were reviewed and updated.

Daily notes were completed for each person in relation to care provided on each shift. Records were detailed and concise.

We looked at activities provided for people who lived at the home. The service employed two activities coordinator five days a week. People who lived at the home told us there was plenty of things taking place. One person said, "Activities usually take place. During the week there are arts and crafts. We are making cards at present. The choir comes in and sings on Sundays. Singers come in and dance too. We have a piano man who comes in every Wednesday." Another person told us they sometimes had trips out. They told us they had visited a garden centre.

On the first morning of the inspection visit we noted people were taking part in a chair based exercises. People looked happy and were smiling and laughing within the group. In the afternoon the activities coordinator held a raffle. One person was eager to get into the lounge for the raffle starting.

One person who lived at the home was partially sighted. We visited the person in their bedroom. They told us they rarely participated in the activities due to their limited vision. We noted however the person had a large print bible in their room and talking books to keep them occupied. They were happy with this.

People were supported to have their spiritual needs met. A church service took place in the home on a daily basis. Two people told us this was an important aspect of their care and support. One person told us staff provided support every morning to ensure the person could attend the service. One relative told us, "[Family member] gets a lot of comfort from going to church every day."

As part of the inspection process we looked at how the service managed and addressed complaints. Most people we spoke with told us they had no complaints about the way the service was managed and care provided. Feedback included, "I have no complaints. If you want anything they will do it for you." And, "I have no complaints, not a sausage!"

The service kept a log of complaints and all actions taken following a complaint. Complaints were recorded centrally so themes and trends could be identified. We spoke with the registered manager; they were able to

describe situations when a complaint had triggered change. This showed the service was proactive in listening to complaints and making the required improvements after complaints were raised.

Requires Improvement

Is the service well-led?

Our findings

People who lived at the home told us the home was well organised and managed. They praised the skills of the registered manager. People described them as, "Lovely." And, "[Registered Manager] is sweet. They made us feel really welcome." Also, "They are a nice manager."

During the inspection visit we found that principles of good governance were not always carried out. Paperwork relating to people who lived at the home was not always completed in accordance with the services' procedures. For example, we noted a risk assessment profile for one person who had recently moved into the home was not fully completed. The person had moved into the home, three weeks previous. The document stipulated the risk assessment profile had to be completed within five days. We asked the member of staff about this. They acknowledged it still had not been completed and said, "Sometimes we don't have time."

We also found other paperwork was missing, inaccurate and incomplete. Creams and ointment charts lacked instruction. Also, signatures for creams and ointments were missing to show that medicines had been administered. Records did not always reflect what care had been provided, for example bath books and care records did not always show when a person had received a bath. A MAR record for two people stated the people had had eye drops administered but this conflicted with what the people told us.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider did not maintain accurate and complete records in respect of each person they supported.

We spoke with the registered manager about quality auditing systems. We noted that auditing systems were in place and audits took place in relation to care records and medicines . Although systems were in place we found these were ineffective as they failed to identify and address the concerns we found during the inspection process. For example, it had failed to identify the lack of completed documentation within care records and medicines documentation. Similarly no one had identified that risk assessments were not being followed in relation to fire safety. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as systems or processes were not established and operated effectively to ensure compliance.

We spoke to the registered manager about improvements made since the last comprehensive inspection. They told us improvements within the service was on going but progress was slower than anticipated. They said the head of care had not been able to carry out their role proficiently as they had been covering shifts to cover staffing voids.

People told us they were able to attend residents meetings to discuss their care and support. We looked at minutes of residents meetings and saw that people were encouraged to have a say in the ways in which the home was organised and run. Although we saw evidence of people being involved, we noted there had been some negative comments recorded about the effectiveness of the meetings. For example, one person had

asked for corned beef sandwiches to be on the menu but said this had not occurred. Another person had raised a concern as there had been a working party set up to look at meals but no further activity had taken place to review these concerns.

We recommend the service consult best practice guidelines and implements processes to ensure opinions of people who lived at the home are listened to and acted upon.

We saw evidence of team meetings taking place on a regular basis. We reviewed minutes of the meetings, staff were able to contribute at these meetings.

Staff told us morale at the home was sometimes limited due to the lack of staff available. They cited staff sickness as a major factor contributing to low morale. One staff member said, "One staff member has called in sick at short notice today. This can put a strain on staff." Another staff member said, "We have to make the most of what we've got. We have staff but we have to use agency for annual leave and sickness." We spoke with the registered manager about staff sickness. They told us they were working with the senior management team to address this.

We spoke with the registered manager about the general management of the home. They told us improvements at the home were ongoing but said they were occurring slower than they would have liked. They said the head of care had been restricted in making improvements as they had not had the time to carry out improvements as they had been covering shifts as opposed to managing.

Staff described teamwork as good. One staff member said, "In the main we give good care. People are working together as a team."

Communication at the home was described as good. On the first day of the inspection visit we attended a daily handover meeting. This was attended by senior members of staff off each unit, the head of care, a member of the catering team, an administrator and an activities coordinator. Discussions took place about people who lived at the home and any relevant changes to their care needs. The head of care told us these meetings took place every day.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to ensure people were consistently treated with dignity and respect. 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure the proper and safe management of medicines. 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to ensure systems or processes were established and operated effectively to ensure compliance. The registered provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. 17 (1) (2) (c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider failed to ensure sufficient numbers of suitably experienced persons were deployed in order to meet the needs of people who lived at the home.

18 (1)