Nazareth Care Charitable Trust

Nazareth House - Southend

Inspection report

111 London Road
Southend On Sea
Essex
SS1 1PP

Tel: 01702345627
Website: www.sistersofnazareth.com/united-kingdom/houses/46/nazareth-house-southend-on-sea

Date of inspection visit:
29 April 2019

Date of publication:
05 June 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: Nazareth house is a care home supporting people who required residential and nursing care for up to 64 people over the age of 65. At this inspection, 41 people were living at the service.

People's experience of using this service:
We inspected this service in September 2018 following concerns received about the service and the standard of care and treatment of people using it. At that time, we found that the service had deteriorated from being good and required improvement in each key question.

This inspection was prompted by information of concern from relatives and the local authority that people's needs were not being safely met. During this inspection, we found that people were not receiving safe care and treatment.

There was poor managerial oversight of staff competencies and practice and this left people at risk of neglect. This was complicated by the poor layout of the building. Whilst the provider had identified this as an issue, processes to rectify this had been delayed and enough measures were not put in place to manage this risk in the interim.

Where people had complex physical and mental health needs, these were not monitored and managed in a manner that could inform staff of deterioration or improvement. Risk assessments and care plans did not adequately address people's needs and care staff did not refer to them. Where external professionals had provided guidance for care interventions, these were not always followed.

A significant number of staff members were supplied from local care agencies as the service had struggled to recruit regular staff. These members of staff were not always inducted to the service in line with the providers own policies and procedures. On the day of inspection, we observed this led to unsafe and neglectful care practices.

There was a poor level of leadership across both the residential and nursing units. Senior care staff and nurses had either not completed or completed quality audits poorly. This meant risk to the quality of care was not identified and left people at significant risk.

These failings resulted in people being placed at risk of harm. As a result of this, we have placed the service into special measures.

Rating at last inspection: At the last inspection in September 2018 the service was rated as Requires improvement in all key questions and had breached The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Why we inspected: This was a focused inspection of Safe and Well led key questions, following information

of concern about risk to people at the service.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: The service has been placed in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Nazareth House - Southend

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This was a focused inspection, prompted by information of concern and risk to people living at the service. At this inspection we checked whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection included an inspector, assistant inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, they had experience of supporting a family member with dementia in a residential care setting.

Service and service type: Nazareth House was a residential care home with nursing. There was a manager registered at the service but they had left suddenly three weeks before our inspection. In their place a regional manager had been drafted in to manager the service. All providers registered with the Care Quality Commission are required to have a registered manager. On the day of inspection, the service was interviewing for this position.

All persons registered with the Care Quality Commission are responsible for how a service is run and for the quality and safety of the care provided.

Notice of inspection: This was an unannounced inspection.

What we did: Before the inspection we looked at all the information we held about the service. This included notifications from the service relating to incidents and accidents, which are reportable to the Care Quality Commission. We also looked at safeguarding incidents, and information received from external stakeholders, such as the local authority and relatives of people living at the service.

We spoke with 10 members of care and nursing staff, including the regional matron supporting the service in

the absence of the registered manager and in response to the concerns. We also spoke with 10 people and three relatives, reviewed 12 care plans and risk assessments, daily charts and any quality audits completed by the service to monitor quality of care provided.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- At the inspection in September 2018, we found that people with complex health needs, such as diabetes were not being appropriately monitored and care plan interventions did not meet their needs. At this inspection, we found the monitoring of a variety of significant health needs was inadequate.
- People did not have robust risk assessments and care interventions in place for their complex needs. This included people at risk of developing pressure ulcers. The service did not follow best practice guidance. Risk assessments did not clearly identify what the risks were and how staff should mitigate these. There were limited instructions about how often people should be repositioned and where staff should record this information.
- On the residential unit, we requested people's turning charts and staff did not know the people who were on monitoring charts, or where these were kept. Staff later showed us monitoring charts for the day, but it was unclear when these had been completed and how accurate they were. They could not demonstrate that charts had been completed for the previous days. In addition to this, a number of people on both units had been identified as having poor skin integrity and had either red skin or skin pressure damage. For one person, care notes identified that they had a red sacral area, and this had been reported. However, staff had only documented them being repositioned once during the day, and the care plan had not been updated to reflect the increased risk of pressure damage.
- People's mental wellbeing was not considered. One person who was in emotional distress told us that, "No one wants me; I am not needed anymore; I want someone to hit me over the head to end it." Staff told us this was usual behaviour for the person and the reason they were nursed in bed, was because it distressed other people. Staff told us, "[Name of person] is in a bad mood, they are crying for no reason." They had not considered the level of distress the person was in and how they could support them. Staff did not always record this distress and behaviour in the person's care notes, and they had not explored whether a referral was needed to the GP for the mental health team to assess the persons mental health.
- People cared for in bed were not receiving regular welfare checks or meaningful engagement. Staff were not recording how often people needed to be checked when isolated in their bedroom, and not everyone was able to alert staff if they needed help. One person could not ring their buzzer for assistance. We asked staff how this person was monitored, and they told us, "We check on them every hour." There were no wellbeing checks recorded in the daily notes or care plan. We also found that the person did not receive any positive or engaging contact with staff at the service.
- An agency worker failed to respond to a person in considerable discomfort sitting in their lounge chair. The member of staff refused to help them when they were informed the person needed assistance. We reported this to the nurse in charge.
- People who had a risk of dehydration and poor nutritional needs were not adequately assessed and

monitored. Recording was lacking or poorly written. We saw entries were people's intake was simply described as "half a portion." This included when people had lost weight and required weekly monitoring using the MUST assessment to monitor for risks associated with malnutrition.

●Information was not stored where staff could access it and staff would not be able to identify if people's weight was deteriorating. Some people needing a specific diet did not have fluid and food charts, although care plans required staff to record intake. One person, who had frequent urinary tract infections, had a risk assessment intervention that staff should ensure they received 1600mls a day following a GP visit. However, care plans did not tell staff what to do if the person was not drinking and monitoring had not taken place. Where fluid had been recorded, staff were not calculating how much a person had drunk in the day. Staff did not know peoples' fluid goals and the reasons for obtaining these.

● Some people had bedrails assessments to prevent them falling out of bed. However, the assessments indicated they were at risk of climbing over the bedrails, Least restrictive options or assessments to deprive the person of the liberty by using bedrails to prevent them leaving their bed had not been considered.

● Staff could give us examples of when they would report potential abuse towards people. However, they did not always demonstrate they understood the risk of neglect.

Using medicines safely

● At the last inspection, the registered manager had sought an external review of medicine processes. At this inspection, we found that, whilst staff were completing random stock checks of medicines, regular medicine audits were not being carried out. The regional manager told us that staff and agency staff had not undergone competency observations for some time, "The observations are very out of date."

●Staff did not always follow PRN protocols [as required medicines]. They did not always record the reason for need and the outcome for some medicines given for agitation and or pain. Care plans for monitoring agitation in relation to medicines were insufficient. One simply stated, "On medicine to calm [person] down."

● The clinical room on the nursing unit was not kept in a clean uncluttered condition and this needed to improve. The manager told us, "It's not the first time we heard that."

This was a continued breach of Regulation 12, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014Safe Care and Treatment.

Staffing and recruitment

● We received complaints from relatives that there were not enough staff to meet people's needs. Online feedback submitted in January 2019 stated, "The staff always seemed under pressure due to lack of sufficient staff."

● We received concerns from the local authority that, on recent visits, there was insufficient staff to support people who required help with eating and drinking. They had observed a person in bed having to tip their food onto their chest to get it close enough to eat. Staff told us, "Meal times are difficult but we have a microwave, so we can heat things up if they get cold." They told us they would check the food temperature, but reheating food is not good practice. Some relatives told us, "People are always waiting for food and sometimes it arrives cold. Its unappetising, things haven't improved." This in part was due to the sprawling nature of the building and the management team told us how they planned to improve meal provision.

● Staff had a task orientated approach to care tasks. We observed how, when not providing direct care, they sat in communal areas, or in one case a lounge on their own, not engaging with anyone. Activities only took place in the morning, so this was a missed opportunity for staff to positively engage with people living at the service.

● Whilst there were sufficient staffing numbers to care for people in principle, the layout of the building made it difficult for any oversight of staff delivering care. On some floors on the residential unit, only one

member of staff would be present at any one time, as most staff would be needed to support the high amounts of people requiring assistance from two members of staff. This meant that these staff were unsupervised for extended periods, and were found not engaging with people.

● At the last inspection, relatives, regular staff and people using the service told us that the high level of agency staffing meant that these staff did not know people's risks and needs. At this inspection, we found this had not improved. Staff told us, "We have enough staff, but it is difficult with agency staff sometimes if they don't know people." We observed agency staff and found that, in some cases, they did not engage and support people in need in the way that was expected. In one incident, a person was in clear discomfort in a communal area and although the agency member of staff was sitting in the same room, they refused to support the person in anyway. They told the inspection team, "That person is not my responsibility I am looking after someone else." The person told us, "They [staff] don't come when you need them." We reported this concern to the regional manager.

This was a continued breach of Regulation 18, of the The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Learning lessons when things go wrong

● The service had not improved since the inspection in September 2018. Whilst action plans were in place, we found continued evidence of breaches of the Regulations. The management team did hold monthly staff meetings and we saw that incidents and actions were discussed with staff. Attempts were made to ensure that staff cared for people in the way that was expected of them, but observations demonstrated little had changed. We discuss this further in the well led domain.

Preventing and controlling infection

● At the last inspection we found the provider was failing in the management of infection control. On this inspection we found this had improved and staff were using positive infection control processes.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager had suddenly left the service three weeks prior to our inspection. The regional manager told us, "I think they couldn't manage the stress as we have had so many safeguarding's recently." We found that there had been very little managerial oversight at the service. Quality audits that were supposed to be completed by senior staff, such as the head of care, had not been completed for some time. The manager had not ensured appropriate oversight that senior staff were doing their job.
- Staff could tell us the visions and values of the service, which included compassion and hospitality. However, we saw little evidence of these values in action.
- The regional manager told us, "I was brought in to look at the quality of care and the audits, but I haven't been able to yet as I have had to get onto the units to work and guide staff to how they should be caring for people. It is something I need to do as we have recognised that our governance processes are poor. The audits I have found are out of date."
- People had made a number of complaints about the quality of food and the dining experience. This had also been identified in a recent dining experience audit. The same concerns had been identified by complaints from relatives and people using the service, and from the inspection in September 2018. However, the audit did not demonstrate how this observation would be used and shared with staff.
- The regional manager told us, "I am planning to complete some dummy audits and show staff how they should be completed; we are also planning to set up food forums where people can discuss the foods they would like. This is something we have done in other homes and it works well." The management team told us, "We have brought in our regional chef to review the food and we feel it is starting to have an impact."
- There was no recorded evidence of competency checks on the quality of staff care practices. The manager told us, "I have done some, but these are informal, I know I need to get better at writing observations down." They gave an example where competency observations had identified poor moving and handling of people and how they tackled this. They told us, "I need staff to all complete the Care Certificate again from the start and we need more face to face training as it is on line." The care certificate is a set of recognised fundamental standards that care staff should achieve. The senior management team told us they would arrange additional face to face training for staff.

Continuous learning and improving care

- There had been ongoing concerns about the quality of meal time experience and food given to people for many months, yet little action had been taken to improve. We observed some poor meal time experience, and this was echoed by some relatives. We saw a recent meal time experience observation form which identified that staff were not engaging well with people at meal times and that food was unpleasant.

However, action to tackle this was not recorded.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The quality of care provided to people significantly varied. Care plans and risk assessments were not person centred and did not tell staff how to support people in a person-centred way. Senior staff and the head of care had oversight and review of risk assessments and care plans and care plan audits took place. However, these did not identify the significant shortfalls discussed in the safe key question as they did not adequately respond to risk and need.

● Agency staff were not always inducted properly to ensure they knew people's needs. This was the role of the shift leader on the residential unit and the head of care or nurse in charge of the nursing unit. An agency worker on the nursing unit told us, "They didn't show me round, they didn't tell me what people needed. I was asked to go and help one person and they didn't tell me how. I didn't see the care plan." This member of staff was later observed supporting a frail person to walk across the room in a manner that put the person at risk. They had not seen the person's mobility plan.

● Whilst the regional manager had attempted to engage with staff to encourage improvements and that they were extremely well regarded by staff, people and relatives, we found that staff did not follow through on instructions. The manager had asked the head of care to complete a risk assessment and referral for a person following an incident. When we checked, this had not been completed. The manager had also instructed the head of care to induct an agency member of staff in the morning. But as described in the safe key question, the agency worker received no such induction or instruction how to safely support people.

● The management team were transparent and open about the issues they were facing to drive up improvements. On the day of inspection, they had revised their improvement action plan to draft in additional support and oversight at the service. They also had plans to condense the service over a smaller part of the building to improve oversight and mitigate the needs for frequent agency staff.

●The provider had not lifted their self-imposed restriction on admissions to the service, recognising that they needed to improve the quality of the care provision. However, they had failed to move forward since the inspection in September 2018 when rated as Requiring Improvement in all key questions. At this inspection the quality of care had deteriorated further.

● The provider had considered that the online training staff had received had not improved performance. The regional manager told us, "We will now be expecting all staff to undergo the Care Certificate, regardless if they already have this and we are commissioning face to face training as online training has not worked."

This was a continued breach of Regulation 17, of the The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014Good Governance.

Working in partnership with others

● We found that the management team were working with safeguarding teams from the local authority in an open and transparent way and had revised and adapted action plans to try and force improvements at the service They had identified that the governance and staffing oversight was poor, and that this was in part due to the poor layout of the building and high numbers of vacant care hours.

● On the day of the inspection, the provider had recruited an interim manager and planned to move an existing deputy manager from another location with experience of turning around care. In addition to this, they had sought to appoint an interim manager support from an agency that specifically supported failing services.

● The provider was seeking an independent review of all care provided at the service to overhaul their governance processes and were re energising their recruitment campaign.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Care plans were not person centred and did not demonstrate how people had been involved in them. In the care plans we reviewed, there was little information recorded about people's specific characteristics, such as their disability, ethnicity, culture, sexual orientation. One person was supported however, to attend Mass in the Chapel on site.

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 17 HSCA RA Regulations 2014 Good governance The service had not carried out robust quality audits of the service. Where some audits had been completed these were not used to improve the service, although shortfalls were found.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 People with complex physical and mental health needs did not have adequate assessments in place to safely manage their conditions. Staff did not know peoples monitoring needs. Monitoring for pressure care, welfare checks, nutrition and diet were not always occurring. When information was collected this was not used to inform staff whether people needed additional support or assessment.

The enforcement action we took:

We placed this service in special measures and issued a urgent conditions on the service to review the care needs of all people living at the service within a short time frame. This condition also included that the service must send us a report every second Monday of the Month to update the commission on progress in this area.

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 There was insufficient oversight of staff and staff competencies. Staff did not always engage with people in a caring, compassionate and dignified manner. Staff did not always care for people in line with best practice guidance. Agency staff were not properly inducted and this placed people at risk as they did not understand peoples needs.

The enforcement action we took:

We placed this service in special measures and issued a urgent conditions on the service to review the competency and training needs of all staff to ensure appropriate induction and oversight of staff.