Nazareth Care Charitable Trust

Nazareth House - Cheltenham

Inspection report

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Date of inspection visit:
12 May 2016
17 May 2016

Date of publication:
11 July 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 12 and 17 May 2016 and was unannounced.

Nazareth House provides care and accommodation for up to 63 older people. At the time of our inspection there were 45 people using the service. Many people reside at Nazareth House because the Sisters of Nazareth provide spiritual support and guidance to those of the Catholic faith. There is a chapel attached to the care home where people can take part in daily devotions. Nazareth House however welcomes and cares for people of other faiths and those who have no particular faith.

At the time of this inspection the service was without a registered manager and had been since May 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Since May 2015 there had been other managers, both permanent and interim, but not registered with the Care Quality Commission. During this inspection the management team were different to those present at our last inspection in January 2016.

We carried out an unannounced comprehensive inspection of this service on 28 and 29 January and 1 February 2016 where we found breaches of regulations relating to the Mental Capacity Act 2005, management of risks, staff training and support and quality monitoring arrangements. The provider wrote to us to say what they would do to meet legal requirements in relation to these breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since then we received further information with concerns relating to: 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 possible poor moving and handling practices which we were having difficulty establishing whether these had been fully investigated and acted on. As a result we undertook this unannounced focused inspection to check if people were safe. We also checked on the progress made by the provider on some areas of the breaches found in January 2016, which the provider told us would be met at the end of April 2016. This included: some aspects of risk management, staff training and the recording of people's food and fluid intake where people needed this monitoring closely. This report only focuses on the above areas and is not a follow up on all breaches of regulation found in January 2016. These will be followed up in due course when we carry out the next planned comprehensive inspection.

During this inspection we were concerned enough about the lack of suitable arrangements to ensure the safe evacuation of people in the event of a fire, to share our concerns immediately with a local fire safety officer. They carried out a fire safety assessment on 13 May 2016. Immediate guidance and advice was given to the new interim management team 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. They will follow this up in due course to ensure the provider meets with the relevant requirements of the Regulatory Reform (Fire Safety) Order 2005.

During this inspection some aspects of the management of medicines were not safe. Previous and current management staff had begun to take some action to address this. However, this was still work in progress. People's needs were not always being met in a timely way and support was not always available when people wanted or needed it. The service had continued to use high numbers of agency staff to be able to meet people's basic needs. Some progress had been made in recruiting new staff and good recruitment practice helped to protect people from those who may be unsuitable to care for them.

Some of the provider's processes for making sure that agency staff received the information they needed to be able to work safely had not been followed. This was found in a lack of awareness in what to do in the event of a fire and how information about people's needs or changes in their care and health were communicated. Just prior to this inspection new and simple guidance had been prepared about people's basic care needs which could be given to staff at the beginning of their shift in the staff hand-over meeting. We have however made a recommendation in this report that the provider take appropriate advice on how to improve staffs' access to their electronic systems. These systems hold information about people's risks and their plans for care.

The management of the service had altered twice since our last visit in January 2016. The then, new permanent manager had left in April 2016. Since then there had been one interim manager present for six weeks and two new interim managers had started on 9 May 2016. During this inspection the provider carried out interviews for a new and permanent manager. Subsequently a successful candidate was appointed and has started in post at Nazareth House.

You can see what action we asked the provider to take at the back of the full version of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nazareth House – Cheltenham on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. We found not all actions due to have been completed by the provider by the time of this inspection had been met.

People were not protected against risks that may affect them.

Arrangements were not always in place to make sure people received their medicines appropriately and safely.
People did not always have their needs met when they needed them met.

The provider's recruitment practices protected people from the employment of unsuitable staff.

Is the service effective?

Requires Improvement

The service was not effective.

People received care and treatment from staff who had not yet been sufficiently trained and supported to provide this.

People's food and fluid intake had been recorded when this was being closely monitored to help maintain a person nutritional well-being.

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 unannounced inspection was carried out on 12 and 17 May 2016 by three inspectors one of whom was a pharmacist inspector.

This inspection was carried out because the Care Quality Commission had received information of concern since the last inspection which was carried out on 28 and 29 January and 1 February 2016. In the inspection in January 2016 we asked the provider to take action to make improvements in how they: ensured the principles of the Mental Capacity Act 2005 were adhered to, identified and managed risks to people, trained and supported the staff and monitored the performance of the service. The provider wrote to us and told us when compliance with these breaches would be met. Some of which will be checked in a future inspection. In this inspection we focused on ensuring that people were safe and if the service was effective in certain areas.

Prior to the inspection we reviewed the information we had received and the notifications sent to the Care Quality Commission by the provider. A notification is information about important events which the service is required to send to us by law. We reviewed the information shared with us by local adult social care commissioners.

During the inspection on the 12 May 2016 we spoke with 15 members of staff (employed by the provider and agency staff), the new interim manager and a representative of the provider. We spoke with two people who live at Nazareth House. We looked at three staff recruitment files and three staff training files. We reviewed the care records for three people and food and fluid monitoring charts for two other people. We reviewed a

print out of one day's call bell response times. We reviewed records relating to fire safety and people's fire evacuation assessments. We attended a staff hand over meeting on the ground floor and on the first floor and reviewed relevant hand over records. We also reviewed the service's moving and handling and fire safety policy and procedures. We spoke with the county's fire safety and fire prevention team.

During the inspection on 17 May 2016 we spoke with seven members of staff and the new interim manager. We spoke with four people who live at Nazareth House. We reviewed the care records of two different people from the 12 May 2016 and the repositioning monitoring chart of one other person. We also reviewed records relating to room and refrigerator temperatures where medicines were stored. We reviewed stock records relating to medicines on both floors. We reviewed 45 medicines administration records (MARs) charts (17 on ground floor and 28 on first floor) and two people's care records. We reviewed the arrangements for storing medicines on each floor. We reviewed the training records of seven staff and completed staff competency records in relation to medicines. We reviewed the most recent medicines audit completed in February 2016. We also reviewed the provider's medicines policy and procedures for Nazareth House.

Requires Improvement

Is the service safe?

Our findings

During our inspection on 28 and 29 January and 1 February 2016 we found insufficient action had been taken to fully assess, reduce and mitigate risks to people who lived at Nazareth House. You can see what action we asked the provider to take in the full version of the above inspection report. The provider wrote to us telling us how and when this would be addressed. Some of the actions were due to have been met by the end of April 2016 so we followed these up during this inspection. Others were due to be completed by the end of June 2016 and we will follow these up in due course.

People were not kept as safe as they should be. During this inspection staff were unclear of what to do in the event of a fire. This confusion was seen in staff employed by the provider and agency staff. We spoke to nine care staff in total and all had a different view on what was expected of them in the event of a fire. Each member of staff gave a different account of how they would react in the event of a fire. This varied from staff running outside and waiting for instruction, to staying with people until the emergency services arrived, to taking people living upstairs out to safety via the lift. No staff were able to explain the process as set out in the provider's fire policy and procedures for Nazareth House. The risk to people was further compounded by the number of agency care staff being utilised by Nazareth House. For example, between the 7th May 2016 and the 11th May 2016 300 hours of agency staff had been requested. Agency staff were reliant on a robust introduction to the service's policy and procedures in relation to fire safety arrangements in order to be able to react appropriately to an emergency. The provider's arrangements for ensuring this took place had not been followed. In addition there were potential increased risks to people due to a large refurbishment programme underway in the care home. For example, the refurbishment had rendered one escape route unusable on the ground floor but the fire risk assessment had not been amended to reflect this.

Agency staff we spoke with said that they had only received a very terse introduction to Nazareth House on their first shift. For one member of staff this had included being shown where the fire exits were but for two others they had not had any guidance on what to do in the event of a fire. Nazareth House had introduced an agency staff induction check list, to include fire safety instructions, but this had not been completed with all agency staff.

All staff employed by the provider said that they had received fire training although the dates of this last training, as shown on the service's main training record, varied enormously from, recently for newer staff to two years ago. From the mixture of answers we received from staff in what to do in the event of a fire we assessed this training as not having been effective. The training provided had consisted, in the main, of a DVD. Although one member of staff said they could remember a person coming into the home and explaining about how to use the fire extinguishers at the beginning of the year. The DVD training was generic and did not include the specific requirements of Nazareth House. For example, there had been no training on how to use the ski sheet provided to help evacuate people who were unable to get out of bed and get down the stairs. There had been no scenario based training. For example, helping staff to think through the use of certain escape routes, the process of horizontal evacuation and how they would evacuate certain people all in the safety of a training session. These shortfalls were raised by us in our inspection in January 2016. We were informed by one manager that face to face fire training had been booked for 20 May 2016.

This was to be the first of several training sessions which would be provided until all staff were up to date in fire training relevant to Nazareth House.

All people's personal fire evacuation plans had been recently updated. This requirement had therefore been met since our January inspection. These documents gave a brief explanation, for staff and the emergency services staff, about what each person's physical and mental abilities were and what kind of support they would need in the event of a fire. However, staff we spoke with, with the exception of one member of staff, were unaware of these. The information from these had not been converted into an easy to recognise system within the home. For example, the use of a discreet traffic light system on people's bedroom doors; red requiring all support to green being independent. The evacuation register kept as part of initial information for emergency services when they arrive had not been updated since 10th March 2015. This was the case in our last inspection in January 2016. This contained the names of people who no longer lived at Nazareth House.

This remained a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as found in our inspection in January 2016.

We saw evidence of regular fire exit, fire alarm, smoke detector and fire extinguisher checks by the maintenance person. The service confirmed that the last recorded fire drill took place in February 2016. The interim manager informed us that there were plans in place to commence fire drills in week commencing 16 May 2016.

We were suitably concerned enough about people's safety in the event of a fire to share our findings immediately with the local fire safety department. They carried out a fire assessment/inspection on 13 May 2016. They took immediate action and gave guidance to the provider in how to lower the risks to people. They issued a letter of non-compliance in eight areas of the Regulatory Reform (Fire Safety) Order 2005. They will follow this up in due course to check if the provider has met with this.

A member of staff has subsequently reported that one fire drill took place in March 2016 but records of who attended this and what the staffs' response had been had not been found.

People's medicines were not managed safely. The pharmacy provided printed medicines administration records (MARs) for staff to complete when they had given people their medicines. These provided a record of what medicines people had taken and when they had taken them. If kept accurately these helped to prevent errors relating to medicines. We looked at 17 people's MARs on the ground floor for the month beginning 18 April 2016. There were gaps in eight of these. On these occasions staff had not signed to show they had given the medicines or recorded a reason if they had not. For example, one person prescribed a medicine twice daily for treatment of diabetes had eight gaps in their MAR for the evening dose of this medicine. The medicine was missing from the container it was supplied in and staff told us they thought the medicine had been given. The inaccurate records did not help to demonstrate whether the person concerned had taken the medicine. Another person was prescribed two different eye drops to be used twice daily. There were gaps on the MAR for two days for the morning dose and gaps on three days for the evening dose.

We looked at 28 people's MARs on the on the first floor for the month beginning the 9 May 2016. We saw gaps on three people's records. For example, there were two gaps in one person's MARs. We checked the quantity of medicine left in the box; this indicated that staff had not given the medicines on these two occasions. Another person was prescribed an inhaler to be used twice daily but staff had only recorded administering the night time dose on two occasions. Records did not demonstrate that people always received their medicines as prescribed.

Several people were prescribed creams and ointments, which were kept in their rooms and applied by the care staff when they provided personal care. These records were not always consistently maintained to show the cream or ointment had been applied. People's care plans did not always make reference to the use of these during personal care and therefore gave staff no guidance for their particular use. Staff did not always sign the MAR for those creams and ointments which contained a medicine and were used for specific conditions. For example, a pain relief gel or hydrocortisone ointment. One person's MARs for such applications were blank. Staff told us this was because this person applied the creams themselves. This information was not included on the MARs. Records did not demonstrate that people' creams and ointments were applied as prescribed.

Some people were prescribed medicines to be given 'when required'; many of these were for pain relief. Although additional information/guidance was available for some of these medicines to support staff to give them in a safe and consistent way, this was not always the case. For example, one person had been prescribed a medicine usually used to reduce agitation, distress and behaviour which could be perceived as challenging. There were no written guidelines or care plan in place to explain when this person might need the medicine, so staff could administer it safely. The MARs showed that staff had given this medicine four times during the past month. There was no record of the circumstances leading up to the decision to use this medicine and no record to show that other strategies had been used before resorting to the use of this medicine. One member of staff told us they had not realised this was a 'when required' medicine when they gave it. Records did not demonstrate that staff had given this medicine in a safe and appropriate way. This did not follow the home's medicines policy, which stated that the reason for administration of' when required' medicines must be clearly defined and recorded in the person's MAR.

Staff supported one person to self-administer a prescribed injection. Staff told us they had not had any training to help them support this person safely. There were no records to indicate staff had been assessed as competent in this task.

The lock on one medicines refrigerator had broken and this was stored in a room that was not always locked. During the inspection staff told us they had reported this problem to the relevant member of staff.

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

Suitable arrangements were in place for the supply of medicines. Staff had identified some issues relating to the ordering and supply of medicine that needed to be addressed. During our inspection staff met with staff from their pharmacy to request some improvements to address this. At the time of the inspection people's medicines were available for them; people we spoke to confirmed this. People were able to look after their own medicine if they wished to, if staff assessed this was safe for them. People told us they were happy with how staff looked after their medicines.

Other medicines were stored securely. Staff monitored the temperature of the medicines refrigerators and records showed this was appropriate for storing medicines. Medicines which needed additional security were stored and recorded safely.

A copy of the medicine policy was available for staff so staff could ensure they followed safe procedures. However, the policy referred to the current regulations in Scotland, rather than those in place in England, so this part was not applicable to this home.

The premises needed additional maintenance and refurbishment to make them safe and generally improve

the environment for people. During lunch time we observed a leak from the ceiling in the dining room. People's tables and chairs had been moved away from the leak however staff informed us that this had been going on for "a long time". We were told the leak occurred when it rained heavily. At the time of this inspection the floor was wet and covered with a towel and bucket and the ceiling tile was bulging. On speaking with the appropriate member of staff about this they confirmed that this tile had subsequently been bolted in and so would not be at risk of falling. We were informed that an initial investigation had not been able to locate the source of the leak. Therefore there was a plan to have the workmen who were on site, look at this to resolve it. We requested that a risk assessment be completed regarding this as one had not been done. On the second day of this inspection the risk assessment was in place as were the safety precautions.

People's needs were not always met when they wanted them met. We received mixed views from the staff with some staff saying they felt there were enough staff whilst others felt that, whilst they could meet people's needs, they did not ever have the time to sit and talk with them. One member of staff said "The mornings are hectic but people don't wait because we would see to them before taking a break". Another member of staff told us "There are not enough staff we have to run around and try and get things done". One person we spoke with told us that staff were always very busy and rushed. They told us about a recent incident when they had called for assistance to the toilet. They said, "I rang my bell and a member of staff came in, switched off the bell, went back out and said I had to hang on". The member of staff had explained to the person they would come back however, the person told us this had not happened. This had unfortunately led to the person being incontinent due to the delay. This incident had upset the person greatly.

We completed an audit of the call bells over a period of hours for one day. This showed on six occasions, at times known to be busy, for example at meal-times and at staff hand-over times, call bells rang in excess of seven minutes. The longest being 12 and 18 minutes. Whilst this showed that at busy time's people clearly sometimes had to wait excessive times for help the audit also showed at other times that calls bells were answered within two minutes and sometimes less. One member of the care staff and one manager also informed us that some of the call bells appeared to be faulty. For example, not turning off when pressed or ringing when not pressed. This told us that the management team had no accurate way to audit and assess call bell response times and our findings may not be accurate. The risk of a faulty call bell system was acknowledged during the inspection and a company was due to visit Nazareth House to undertake some work on the system to address this.

The problems associated with the utilisation of significant numbers of agency staff such as permanent staff having to spend time inducting them and people being cared for by unfamiliar staff was partially offset by the fact that many of these staff worked at Nazareth House on a frequent basis. However, one agency staff told us "Agency staff can make people anxious". A member of permanent staff said, "We use a lot of agency which is upsetting the residents". One member of staff told us about how one person had reported to them about feeling "intimidated and frightened" of the staff they did not know well (the agency staff). We spoke with this person who said, "That is an exaggeration of what I said but I don't like having so many agency staff looking after me. They don't know how I like things done. I have to keep explaining things and sometimes they are rough. Some waffle on in their own language in front of me. Others are really lovely".

There was a general consensus amongst agency and permanent staff that agency staff were not going to be so aware of people's particular preferences as permanent staff who knew people well. It was also not easy for agency staff to access people's care plans as these were electronic and they required support from permanent staff to access. Some of the electronic systems used to do this were very slow and time consuming.

We recommend that the provider take advice from an appropriate source on how best to improve staffs' access to their electronic systems; in particular people's care records.

The management staff were also aware that the paper copies of people's care records, which included their care plans had not been maintained so were not up to date. They told us this was a task that still needed to be addressed. They had however devised a new form to be given to staff at the beginning of their shift and during staff hand-over. This gave very basic details about people's care needs, for example, how the person was to be moved safely, if they required repositioning and how frequently or if they needed help with eating. This had just been introduced the day before the inspection and agency staff told us it would be helpful.

One of the priorities for the previous management team and now the current management team was staff recruitment. We reviewed the personnel files of three staff who had been employed since our last inspection in January 2016. Robust recruitment processes had been used to help protect people from those who may be unsuitable to care for them. For example, there were checks of people's criminal histories via 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. Full work histories and references had also been obtained to check if people were of good character and gaps in employment had been explored.

Requires Improvement

Is the service effective?

Our findings

During our inspection on 28 and 29 January and 1 February 2016 we found staff had not received sufficient training, adequate support, professional development and appraisal to enable them to carry out their duties safely and effectively. We asked the provider to take action to address this and their action plan told us this would be met by the end of September 2016. We also found that records used to monitor people's fluid intake were not being kept accurately. We asked the provider to take action to address this and their action plan told us this would be met by the end of April 2016.

During this inspection we followed up to check if people's food and fluid monitoring charts were being completed accurately. We found that they were. They were now kept in people's bedrooms so that as soon as staff had helped the person take a drink or eat some food they could record this detail immediately. We observed this being completed during the inspection.

People were cared for by staff who did not all have the appropriate training and support.

This remained a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as found in our inspection in January 2016.

However the provider was working towards this as part of their action plan from their previous inspection. We followed up the provider's progress in meeting their plan which related to staff training but only in the areas where we had an immediate concern. These included: fire safety and evacuation processes, safe moving and handling of people and medicines administration and relevant record keeping.

We had received several notifications from the provider which called in to question the practices of staff when they needed to support people to move. In particular support given to people following a fall. On the first day of this inspection 16 staff completed moving and handling training with trainers provided by the provider who were qualified to deliver this training. Further sessions were to be held on this training in order to ensure all staff were either initially trained or updated in safe and best practice.

We were informed that fire training, pertinent to Nazareth House was due to be held on 20 May 2016. We followed this up with the new manager following this inspection to check if this had taken place. They informed us there had been confusion as to when this was to be delivered and only six staff attended. We asked how this was to be managed moving forward to ensure all staff received this training. They explained the training would be repeated until all staff had completed it. They explained that the training dates would be better advertised, staff would be reminded of their contractual responsibility to attend training and ensure they are updated. Where possible training would be organised for when the staff member was in the care home. Finally, if after all of this the member of staff continued not to attend, disciplinary action would be taken.

We had also been informed just prior to this inspection that further first aid training and infection control training had been booked for dates later in April 2016.

We reviewed records which showed that since several medicine errors had been reported to us in March 2016 staff competencies in this task had been reviewed for all staff who administered medicines, except for one member of staff. A date was to be arranged with this member of staff. These errors had been investigated and the member of staff responsible stopped from administering medicines until they had been provided with further support and assessed as competent. As already reported on in this report, despite these competency assessments staff were still not keeping accurate records in relation to medicine administration. The management team were going to introduce more regular auditing of medicine records to address this. We will follow up on this further when we re-inspect the service.

Staff had not been provided with individual support (supervision) sessions to be able to discuss their learning needs and goals. Prior to this inspection we had been informed that two staff had been provided with supervision. The new management team had however not had time to address this further but were aware staff required their supervision sessions. The provider's action plan told us staff would be up to date with their supervision by the end of June 2016. We will follow this up when we next re-inspect the service.

We saw evidence that two out of three staff had received some form of induction training. Two staff had a completed induction checklist recording an introduction to the provider's policies, procedures and other relevant processes as well as some systems; one did not. One member of staff had completed two modules from the care certificate and was booked to complete other trainings which would be organised. The care certificate lays down a framework of training and support which staff can receive. Its aim is for new care staff to be able to deliver safe and effective care to a recognised standard once completed. We were informed that in the future certain modules of the care certificate would be completed by all staff who were new to Nazareth House as part of their induction training.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed properly and safely. Regulation 12 (1) and (2) (g).