Nazareth Care Charitable Trust

Nazareth House - Manchester

Inspection report

Scholes Lane
Prestwich
Manchester
Greater Manchester
M25 0NU

Tel: 01617732111

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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 Manchester is a care home providing personal and nursing care to 58 people aged 65 and over at the time of the inspection. The service can support up to 66 people. The service consists of one nursing unit and two residential units.

People's experience of using this service and what we found
Since the last inspection the provider has made limited improvements at the service and there continue to be breaches of regulation at the home.

Poor practice was observed during the inspection around the administration of medication. The frequency of medication audits has increased since the last inspection however, errors continue to be found and there are continued breaches relating to the management of medication within the home. At the last inspection, it was identified that patch medication was not applied correctly in line with the guidance. At this inspection we found continued errors in the application of patch medication.

Concerns around pressure area care were not escalated to healthcare professionals in a timely way. Pressure wound management was not consistently and accurately recorded to ensure appropriate care was given. Insufficient action was taken to provide pressure area care. This may have increased the risk of harm to people.

Appropriate infection prevention and control measures were not maintained. We observed staff wearing their personal protective equipment (PPE) incorrectly on multiple occasions. For example, staff had their masks around their chins. The registered manager had failed to ensure that visitors who needed to complete a lateral flow test had done so before visiting their relatives. This may have increased the risk of transmission of coronavirus within the home.

The provider's governance systems did not support the provider to have a clear oversight of the home. The systems did not provide an accurate reflection of the concerns within the home. The systems provided limited detail about people living at the home. Accurate records of complaints were not maintained. Records did not always show that the newly recruited staff had been supported in their role or that competencies checks had been completed.

At the start of the inspection there was a registered manager in place. Following the site visit we were informed by the provider that the registered manager had left the organisation. A manager came from another service within the organisation to take over this role.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was inadequate (published 15 June 2021) and there were breaches of regulation.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We carried out a focused inspection of this service on 15 April 2021 and found breaches of legal requirements. We undertook this focused inspection to check whether the Warning Notices we previously served in relation to Regulation 12 (safe care and treatment) and Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

This report only covers our findings in relation to the Key Questions Safe and Well-Led which contain those requirements. The ratings from previous comprehensive inspections for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection. You can read the reports from our previous inspections by selecting the 'all reports' link for Nazareth House – Manchester on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 found in our findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our findings below.

Nazareth House - Manchester

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a pharmacist specialist, a medicines team support officer 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.

Service and service type
Nazareth House Manchester is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection including action plans sent by the registered manager. We sought feedback from the local authority and clinical commissioning group. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service about their experience of the care provided. We spoke with eight members of staff including the provider, the registered manager and the recently appointed clinical lead. We reviewed a range of records including people's care plans, medication records, audits and staffing rotas.

After the inspection
After the inspection we requested further information from the provider and discussed the management changes within the home.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. This meant people were not safe and were at risk of avoidable harm

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. As the service is rated inadequate we have assessed this key question as a whole.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people were not always appropriately assessed and managed. This put people at risk of harm. A pressure wound was identified and recorded as requiring a referral to the tissue viability team for specialist input and support. This necessary referral was not made for approximately four weeks.
- Care records showed that staff did not always provide appropriate pressure area care. There were also times when the necessary wound dressings were not available. The recording of the wound deterioration was lacking.
- Staff had not received training in relation to pressure wounds and pressure area care. Following the inspection, the provider informed us that staff had previously received 'react to red' training. The provider did not provide any confirmation of this training. Following the inspection staff were enrolled on to training in this area.
- One person who had a high risk of falls had not been referred to the falls team for further support. The care plan in place stated that the person should be observed when attempting to stand. This was not effective as the person had 10 further unwitnessed falls at the home, some resulting in injury.
- At the last inspection there was an issue identified around the safety of the lift. Lifting equipment is subject to thorough examination every six months. Following our last inspection this examination has now been completed.

We found evidence that may have resulted in people being harmed and systems were not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection, the provider did not ensure the safe and proper management of medicines. This was a breach of regulation 12 Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice about this. This was fourth consecutive inspection and the second consecutive warning notice issued relating to the management of medicines.

● Medicines including controlled drugs were not always managed safely.
● Controlled drugs were not recorded correctly and were not handled safely so there was a risk of misuse. The administration records of controlled drugs is required to be signed by two people. The records and subsequent discussion with staff showed that this was not always done. We observed medicines being given to people unsafely.
● Systems were in place to ensure medicines were in stock, however we found one long-term antibiotic was not available in the home and necessary dressings had been out of stock.
● Body maps were used by staff to record where a medicine patch had been applied previously. Staff did not always leave enough time between using the same area of skin, which increased the risk of skin irritation and side effects.
● There were no clear directions to guide staff on how to administer medicines into a stomach tube in a safe way. This was also identified at the last inspection.

We found evidence that may have resulted in people being harmed and systems were not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
●Staff did not always use appropriate control measures to prevent and control the spread of infection.
●Staff did not always wear a mask when in communal areas or supporting people. Some staff were observed either wearing no mask or wearing them around their chins. This is not in line with government guidance.
●Staff meeting minutes showed that staff had been reminded about the correct wearing of PPE but this was not being followed by all staff at the time of the inspection.
●The registered manager had put together a list of people receiving end of life care. Relatives of these people were not required to book an appointment or have a lateral flow test before entering the home. This is not in line with government guidance or Nazareth House policy and potentially increased the risk of transmission of coronavirus within the home. Following the inspection the provider informed us that they had spoken with the relevant families and implemented the correct guidance for visitors.

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

●People were unable to have visitors at the weekend after 1pm on Saturday. This was due to the availability of staff to perform lateral flow tests. The provider stated there had been no complaints raised about this.

We recommend the provider refers to the government guidance and looks at ways to support people to visit the home safely.

Staffing and recruitment
● Staff were not fully recruited appropriately. Two staff files showed staff had commenced employment before receiving a disclosure and barring service check. An initial check had been completed but there was

no risk assessment in place to show why it was appropriate for the staff to start work.

● The service used agency staff to cover staffing shortfalls. There were limited records to show that the provider was aware of who was working at the service before they arrived and the rotas were not always updated to show who attended. Inductions were completed with agency staff on their first shift at the service.

● Since the last inspection several nurses had left the home. In response, the provider had reduced the nursing provision within the service to one unit.

● The provider did not always ensure newly recruited staff received Appropriate training, competency checks or supervision. Audits showed that training and competency checks were not completed. During the inspection, poor medicine administration practice was observed, which we shared with the provider. In response, the provider told us they would take appropriate action.

● People gave mixed feedback about the staffing levels within the home. People felt that the service would benefit from more staff but they had not seen any negative impacts due to the staffing levels. As one person told us, "There is not enough of them, but I never have to wait."

Systems and processes to safeguard people from the risk of abuse

● Systems were in place to safeguard people from the risk of abuse. Staff were aware of signs of abuse and how to report them. The clinical lead was appropriately gathering information relating to a safeguarding concern to share with the local authority.

Learning lessons when things go wrong

● The provider did not always learn lessons and improve practice. Following the last inspection an action plan had been implemented, however, insufficient progress had been made.

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.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and requirements;, How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the last inspection the provider failed to ensure there was a robust governance system in place. The checks, audits and systems in place were not used effectively to identify shortfalls, errors and omissions. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was issued in response to this identified breach. The provider continued to be in breach of this regulation.

- Following the last inspection warning notices were issued relating to regulations 12 (Safe Care and Treatment) and regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had not fully addressed the concerns identified in the warning notices.
- At the start of the inspection there was a registered manager in place. Following the site visit the provider informed us that the registered manager had left the organisation with immediate effect.
- The provider did not have an accurate oversight of the needs of people living at Nazareth House. The provider had a monthly report which focused on clinical key performance indicators such as pressure areas, falls, and complaints.
- People's care plans showed that this document was not an accurate reflection of people's needs. For example, the report showed one person with a pressure sore graded 3-4 however people's records showed another person had an ungradable pressure sore which was not documented. The provider was therefore unable to use their systems to monitor care effectively or drive improvements where needed.
- The provider had failed to ensure that accurate records of care were maintained. The oxygen levels for one person had been increased in October 2020. However, there were no records to show the levels of oxygen being administered. On the day of our inspection, the levels of oxygen being administered were lower that the oxygen levels stated within the care plan. This care plan had been reviewed 10 times by five members of staff and this inaccuracy had not been rectified. The registered manager had also audited the unit and this issue was not identified.
- Although the frequency of medication audits had increased since the last inspection, limited improvements had been made, and concerns in relation to the management of medicines had continued.

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

characteristics;, Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff told us they had shared their ideas with the registered manager however, they had not been used to drive improvement and promote engagement at the service.

● The activities coordinator held regular residents' meetings with people living at the service. Minutes from the meetings show trends identifying issues around food and laundry. The minutes showed some slow improvement in these areas. One person told us, "'There are residents' meetings; there's been one since I've been here. They discuss any complaints and suggestions."'

● The provider had not maintained accurate records of people's feedback. The provider was unable to provide up to date information relating to complaints at the service since the last inspection. The document which the provider used for oversight differed from that shared with us about complaints at the service.

●Following the last inspection, staff told us that the morale in the service was low. Staff expressed a commitment to making improvements at the service.

This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Continuous learning and improving care

● This is the fourth consecutive inspection at the service where breaches have been identified.

●The provider is unable to demonstrate their learning from the previous inspections and how they have driven sufficient improvement.

●The registered manager said they were supported by the provider. However, following the last inspection there were no records to show that they had received any formal supervision.

Working in partnership with others

● Following the last inspection the local authority offered support to the service to help drive improvement. However, the local authority found that the provider did not accept all offers of support.