Nazareth Care Charitable Trust

Nazareth House - Cheltenham

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Nazareth House – Cheltenham is a residential care home providing accommodation and personal care for up to 63 people aged 65 and over. There were 40 people living there at the time of our inspection.

People's experience of using this service and what we found
The provider had made some improvements to the service. However, not all the requirements of the warning notice had been met. The provider and the manager had taken steps to ensure people's risks were assessed. Care staff followed guidance to ensure people were protected from these risks.

However, the requirements of the warning notice in relation to the safe management of people's medicines had not been met. People were still not receiving their medicines as prescribed as care staff had not always administered people's prescribed medicines. Staff did not always accurately check the stock of people's medicines to ensure people's medicines would be available when needed.

Where changes to people's prescribed medicines had been made by their GP or relevant healthcare professional, care staff had not always ensured this was documented and shared, meaning people were placed at risk of not receiving their medicines as prescribed.

Staff responsible for administering people's prescribed medicines had received training and competency assessments.

Rating at last inspection and update:
The last rating for this service was requires improvement (published 20 September 2019).

Following our last inspection, we served a warning notice on the provider. We required them to be compliant with Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 30 September 2019.

Why we inspected
This was a targeted inspection based on the warning notice we served on the provider following our last inspection. CQC are conducting trials of targeted inspections to measure their effectiveness in services where we served a warning notice.

We undertook this targeted inspection to check if they now met legal requirements. This report only covers our findings in relation to the safe care and treatment of people, including people's prescribed medicines. The overall rating for the service has not changed following this targeted inspection and remains requires improvement. This is because we have not assessed all areas of the key questions.

Follow up

Following this inspection we met with the manager and a representative of the provider to discuss the inspection and understand the plans they had in place to improve the service and ensure legal requirements are met. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not always safe.

Details are in our safe findings below.

Nazareth House - Cheltenham

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. This was a targeted inspection. CQC are conducting trials of this type of inspection to follow up services where CQC have issued a warning notice.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Nazareth House - Cheltenham is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 did not have a manager who was registered with the Care Quality Commission. A new manager had been recruited and had been in post for two weeks, they were planning to apply to become a registered manager. A registered manager 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 inspection
We reviewed information we had received about the service since the last inspection. 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.

During the inspection
We spoke with four members of staff including the manager, two senior care staff and one member of care staff. We carried out observations of people who used the
service. We reviewed a range of records. This included four people's care records and 29 people's medicine administration records and associated medicines.

Following the inspection
We met with the provider to discuss our concerns and to understand the reasons why the provider was not meeting the requirements of the regulation. We also liaised and sought the views of local authority commissioners.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. We have not changed the rating as we have not assessed all of this key question area. We will assess all of the key questions at the next comprehensive inspection of the service.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had been made to ensure people were protected from the risks associated with their care. However, sufficient improvement had not been made to how the service managed people's prescribed medicines. Timely action had not been taken and the provider had not fully met the requirements of the warning notice and was still in breach of the regulation.

Using medicines safely.

At our last inspection the provider had failed to ensure people received their medicines as prescribed. Care staff responsible for administering people's medicines had not always taken appropriate action to ensure people's prescribed medicines were in stock and available for administration. This was a continued 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. This was the fifth consecutive inspection where concerns had been identified in relation to the management and administration of people's prescribed medicines.

- People had not always received their medicines as prescribed. We looked at 29 people's Medicine Administration Records and found that since 28 October 2019, 11 people had not always received their medicines as prescribed. When we counted the stock of these people's prescribed medicines we found more doses than we expected to find.
- With the exception of one person's medicines staff had not identified where people's medicines had not been given as they had not accurately checked people's medicine stocks. For example, one person had not received their prescribed medicines for two days, as senior care staff had not administered this medicine. When asked senior care staff were unable to explain why this person had not received this prescribed medicine.
- Staff had not always followed the provider's guidance in relation to the administration of people's prescribed medicines. A senior care staff member informed us one person had received a medicine which had been discontinued four days previously. The senior care staff had recorded this on the person's previous medicine administration record and the home's communication diary. However, the person received this medicine as the instruction had not been transferred onto the new Medicine Administration record when a new medicine cycle had started.

● Staff had not always followed the provider's guidance in relation to the management of people's prescribed medicines stocks. For three people we found less doses of their prescribed medicines than we would expect to find. There was no record of what had happened to these doses on people's medicine administration records or on the service's medicine returns books. This meant staff were not able to identify whether a medicine error had occurred.

Following the inspection we met with the provider to understand why improvements had not been made in relation to the management and administration of people's prescribed medicines. We also sought reassurance on how the provider was planning to address these concerns. This was the fifth continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some improvements had been embedded by the service. For example, where people were supported with topical creams, senior care staff had ensured these creams were stored appropriately and had been dated when opened.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure that care staff followed people's care and risk assessments. This placed people's health and wellbeing at risk. At this inspection, we found action had been taken to make some improvements.

● People's risks were identified and assessed by care staff and management at Nazareth House – Cheltenham. Staff completed risk assessments in relation to people's health and wellbeing as well as the actions required to reduce these risks.

● Where people required assistance with their mobility an assessment was in place which documented the support they required. Staff used recognised safe techniques to assess people with their mobility.

● Where people had been assessed at risk of falls, staff followed clear guidance. The manager and care staff understood the importance of using sensor mats to alert them when people who were at high risk of falls were moving so they could provide support. Care staff monitored people after a fall, especially if they were on blood thinning medicines or had hit their head, to identify any injuries that were not immediately visible so that medical assistance could be sought if needed.