Nazareth Care Charitable Trust

Nazareth House - Cheltenham

Inspection report

London Road
Charlton Kings
Cheltenham
Gloucestershire
GL52 6YJ

Tel: 01242516361

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Nazareth House - Cheltenham is a residential home which provides personal care to 63 older people and people living with dementia. The home consists of a home contains, a range of communal areas, including lounges, dining rooms and a café and reception area. At the time of our inspection 40 people were living in Nazareth House - Cheltenham.

People's experience of using this service and what we found
Since our last inspection the management of the service had changed. The interim manager, head of care and provider had identified a number of the concerns we had found prior to our inspection. However, actions at the time of our inspection were still ongoing and had not been fully implemented and evaluated to ensure people would always receive safe and effective personalised care. We continued to identified breaches of regulations at this inspection. The provider had not demonstrated that they were able to consistently meet the requirements of their registration and operate effective systems to ensure that Nazareth House – Cheltenham met the requirements of the Health and Social Care Regulations. Therefore, we have rated the key question 'Is the service Well-led?' as 'Inadequate'.

People and their relatives told us their views had not always been sought and listened to. They told us that due to the changes in the management of the home they were not confident the service was managed well. Healthcare professionals, senior care staff and agency staff told us that communication was not always effective, which impacted on people's wellbeing when requests had not been acted upon.

People did not always receive care which was personalised to their needs. People told us they did not always receive care which made them comfortable or maintained their wellbeing. Staff told us they did not have the time to spend with people and promote their wellbeing. Staff did not always take opportunities to engage with people and ensure care was tailored to their needs.

People did not always receive their medicines as prescribed. Senior care staff did not always follow recognised good practice to ensure people received their medicines as prescribed. Staff did not have effective systems to ensure people's prescribed medicines were in stock and effectively replenished. People could not be assured that they would be safe if an emergency evacuation was required. Fire evacuation practices had not taken place regularly and people's personal evacuation plans were out of date.

People were not always protected from the risks associated with their care as staff did not always follow their assessed plan of care.

There were enough staff deployed to keep people safe. People, their relatives and staff told us that staffing was an issue and impacted the quality of care people received. The provider was heavily reliant on agency care staff to ensure safe staffing levels. People told us how this impacted on the care they received.

Care staff followed recognised infection control procedures. We observed, and people and their relatives told us that the home had not always been cleaned. The interim manager was aware of these concerns and was taking actions to improve this. People were protected from the risk of malnutrition or choking. The interim manager was taking action to improve the quality and variety of food people received.

Care staff required further support to enable them to meet people's day to day needs. Not all staff had received effective supervision and staff told us they would benefit from more training in relation to dementia care. People spoke positively about the caring nature of permanent staff.

People told us they generally enjoyed their time at Nazareth House – Cheltenham. A new activity co-ordinator had started to work at the home, and previously the Sisters of Nazareth had provided a range of activities whilst the service were recruiting. People were supported to maintain their personal relationships. However, there was limited record of the activities people enjoyed, particularly those who were cared for or chose to remain in their own rooms.

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

Rating at last inspection
The last rating for this service was requires improvement (published 4 April 2019) and we identified two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, we found that improvements had not been sustained and the provider was still in breach of these regulations as well as other regulations. We have used the previous ratings of the service and enforcement action taken to inform our planning and decisions about the rating at this inspection. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about the service from healthcare professionals and people's relatives. These concerns related to the quality of care people received, staffing skills and communication from staff at the service. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the 'Is the service Safe?'; 'Is the service Effective?'; 'Is the service Responsive?' and 'Is the service Well-led?' key question sections of this full report.

Enforcement
We have identified breaches in relation to the safe care and treatment people received, including the administration of people's prescribed medicines at this inspection. We identified that people did not receive care and support which was tailored to their individual needs. Staff did not have access to effective supervision and did not have the training or skills they required to meet the needs of people living with dementia. The service did not have effective systems to monitor the quality of the service people received.

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
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will meet with and work alongside the provider 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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.

Inspection team
The inspection team consisted of an inspector, an assistant inspector, an inspection manager 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 - 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.

There was not a registered manager at Nazareth House Cheltenham. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An interim manager had been in place for six weeks. They informed us they would remain in place until a new permanent manager had been recruited.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection as we had brought the inspection forward due to concerns. 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.

During the inspection
We spoke with 15 people who used the service and six relatives about their experience of the care provided. We spoke with 14 members of staff including three senior care staff, an agency senior care staff, five care staff, an agency care staff, a dining room assistant, the head of care, interim manager and a representative of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records; this included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection:
We spoke with one healthcare professional who routinely visits the service. We also spoke with two other healthcare professionals visiting the home. We also reviewed feedback received from local authority commissioners and safeguarding team.

Requires Improvement

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.

Requires Improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection the provider had failed to ensure people received their medicines as prescribed. 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 fourth consecutive inspection where concerns had been identified in relation to people's prescribed medicines.

● People did not always receive their medicines as prescribed as senior care staff had not always followed the instructions on people's medicine prescriptions. For example, we identified one person had received a larger dose of one of their medicines than prescribed by their GP. The person had received an increased dose of their dementia medicine over four days.
● Staff had not followed recognised medicine management practice as they had not checked that people had taken their medicines before signing their medicine administration chart. During the inspection an agency member of staff found two tablets on the floor of one person's room. These medicines were identified as prescribed medicines the person was supported with on a daily basis. The person had a visual impairment and required the support of staff with eating, drinking and taking their prescribed medicines. A senior member of care staff had signed to say these medicines had been administered as prescribed although this person had not taken them. One person told us, "I self -medicate but I am worried that it would be unsafe if I did not. I see problems when I am sitting with other people, people sometimes are given the wrong pills and medication is often just left unattended and some of these are vulnerable people".
● People were placed at risk of not receiving their prescribed medicines as their medicines as the service had not always ensured that sufficient stock was made available. One senior care staff and an agency senior care staff informed us of concerns regarding the stocks of people's prescribed medicines. For example, on the first floor, the current medicine cycle started two days before our inspection. However, some people's prescribed medicines had not been supplied. An agency senior care staff had communicated this concern to care staff on the 31 July 2019, three days into the cycle as people had not received some of their medicines as they were not available. Senior care staff employed had not taken effective action to check that sufficient stock of people's prescribed medicines had been delivered and to promptly address any shortfalls.
● Additionally, senior care staff did not take action when the stocks of people's prescribed medicines were

running low. For example, on the ground floor, staff had not taken action to ensure one person had their prescribed medicines in stock, before they had run out within the middle of their cycle. This meant the person went without their prescribed medicines.

● Senior care staff had not always kept an accurate record of the stocks of people's medicines and had not followed good practice regarding people's prescribed medicine stocks which increased the risk of medicine errors occurring. For example, one person had two boxes of their prescribed medicines on the medicine trolley. Staff were administering from both these boxes, however had not documented when one of the boxes had been opened to support them to monitor that people had received their medicines. We found one tablet less than we would have expected to find when counting the stock against the person's Medicine Administration Records. We raised these concerns with the interim manager and the head of care. They took action to help minimise continued risk to people.

People had not received their medicines as prescribed. Senior care staff did not follow recognised good practice when managing people's prescribed medicines. This was the third continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's medicines were stored securely, and they were stored within appropriate temperatures as per manufacturers guidelines in the afternoon on both days of our inspection. Where people received support with prescribed controlled drugs, these were managed safely and securely.

Assessing risk, safety monitoring and management; Preventing and controlling infection

● People were not always protected from the risks associated with their care. One person was living with dementia and was assessed as being at high risk of falls. The person had a sensor mat in place, with the purpose of alerting staff when the person was moving. On the second and third day of the inspection, the sensor mat was placed under the person's bed. The person was easily disturbed and on both days used a four wheeled frame to access the hallway. As the sensor mat was placed under the bed there was no system to alert staff placing the person at risk of falling. We raised this concern with the interim manager and the head of care who informed us they would take immediate action. Prior to our observations the person had fallen and had sustained a cut to the head. Staff at this time ensured paramedics attended to the person.

● People could not always be assured that staff would know what to do in the event of a fire to keep them safe. A newly recruited maintenance worker had carried out a number of fire safety checks, including checking fire exits and fire extinguisher equipment. They carried out a weekly fire alarm test to ensure the system was effectively working. Whilst, these tests were recorded, there was no evidence that fire evacuation exercises had been carried out to check whether staff knew how to evacuate people safely from the building.

● Staff did not have clear guidance on how to support people in the event of a fire or evacuation. There was not a Personalised Emergency Evacuation Plan (PEEP) for each person living at Nazareth House. There were only 37 documented PEEPs and at least one of these related to a person who no longer lived at the home. A number of these PEEPs had not been updated since 2018 and were not current of people's needs, which room they lived in or the support they required. In the event of a fire, people might not receive the support they needed to keep them safe. We discussed these concerns with the interim manager and head of care. They informed us they would take immediate action to ensure people's PEEPs were current. They would also ensure that staff would receive training and support (including fire evacuation tests) so they have the knowledge they needed in the event of an unplanned fire alarm.

Staff did not always ensure people were protected from the risks associated to their care and current guidance to keep people safe in the event of a fire was not always available to staff. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's risks were identified and assessed by the head of care and care staff. Staff completed risk and care assessments in relation to people's health as well as the actions needed to be taken to reduce these risks. Staff had clear guidance on how often people required to be supported with repositioning to promote healing and help protect their skin integrity. Where people had pressure relieving equipment this was recorded, as well as how the equipment should be set up to maintain the person's skin integrity. Staff recorded when they had assisted people with repositioning or the application of topical needs. Where necessary care staff worked alongside district nurses who monitored people's dressings and kept clear records of how they were treating the wound.
● People could be assured the equipment used to assist people with their mobility was safe and routinely service and maintained. Moving and handling equipment was maintained and serviced as per manufacturers' guidelines.
● Staff were aware of the actions they should take to ensure people were protected from the risk of infection. The interim manager had identified some issues around general cleanliness within the home and was taking action to address these concerns. One person and their relatives explained how one of their relatives had to vacuum their room due to a lack of domestic staff. One person told us, "We're starting to see a bit more cleaning, however it hasn't been good."

Staffing and recruitment
● There were enough staff deployed during the course of our inspection to keep people safe. However, the staffing levels, agency usage and staff skill set meant that people did not always receive person centred care. Comments included: "When it's an emergency the staff come running. However, if you just press the normal button it can take a long time. The afternoon changeover is the worst"; "The last three months things have really gone downhill. Staff are confused. Sometimes we don't know who the carers are" and "I have a call bell, but I am reluctant to use it- I don't want to interrupt unless it is serious."
● One person discussed the impact staffing levels had on the quality of care they received during their morning wash. They said, "I was being assisted with a wash, then they (staff) had to leave and come back. I was left for a bit, it's not nice and it made me feel uncomfortable. It's not right, I've been messed about." Another person explained the lack of staff impacted the amount of times they had a bath in a week, although they had been supported with having a wash daily. They said, "I was promised two baths a week. Trying to get a bath is difficult."
● Care staff told us they had enough staff to meet people's care needs, however did not have the time they would like to sit and engage with people to maintain their wellbeing. Comments included: "Everywhere (home) you go there is an issue. We don't have enough of our own staff. If we organise ourselves properly, things run well, however I feel so tired"; "Sometimes when we have one less staff it works well. We don't have time to sit with people, talk to them, give them the reassurance they need" and "I think we could do with more staff. We are very busy and the staff mod is very low."
● The interim manager and head of care explained recruitment was ongoing for a new manager and for care staff and other ancillary staff. The interim manager explained they would review any potential resident to Nazareth House to ensure their needs could be maintained.

People did not always receive care which was person centred and reflected their needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment systems and records showed pre-employment checks were completed to help protect people from those who may not be suitable to work with them. All staff worked a probationary period and disciplinary action was taken, when needed, to ensure expected standards were met.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People felt safe when receiving care from staff. Comments included: "I do feel safe from attack here" and "I feel safe."

● Staff knew what action to take if they suspected abuse, poor practice or neglect. All staff were aware of the need to report concerns to the manager or provider and knew which organisations to contact outside the home if required.

● The provider reported and shared appropriate information with relevant agencies to safeguard people. The interim manager and head of care ensured people and their relatives were informed of any concerns or incidents at the time of our inspection.

● Incidents and accidents were reported, recorded and investigated to find out why things had gone wrong and ensure appropriate action was taken to keep people safe. An incident occurred during our inspection, the interim manager implemented actions to reduce future incidents.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had the training and support they needed to meet people's core needs, however some additional training was required in relation to dementia care. People and their relatives spoke positively about the care staff that supported them or their relatives and mainly felt staff had the skills to meet their needs. Comments included: "The carers and staff are very good"; "I have no criticism of the staff, they're kind and they help me" and "I think the staff know what to do."
- Prior to our inspection, healthcare professionals had raised some concerns in relation to staffing skills, particularly around supporting the needs of people living with dementia. One healthcare professional had recommended that the service access local dementia training. One member of staff told us, "We could all do with a bit more training in relation to dementia. Some staff struggle assisting people, they often come to me and explain what's happening. However, they struggle to deal with repetitive behaviours."

We recommend the provider seek recognised support and training in relation to dementia care education.

- Staff spoke positively about the training they received and felt they had the skills required to meet people's needs. Staff comments included: "We have moving and handling training every year" and "I think the training is okay."
- The provider was developing opportunities for staff professional development, which would include completing qualifications in health and social care.
- The area manager and head of care had an overview of the training needs of all staff working at Nazareth House – Cheltenham. They had planned training in relation to moving and handling and medicine management for staff. The interim manager told us they were developing a plan around dementia training for all staff to improve the quality of dementia care for people living at Nazareth House – Cheltenham. Where agency staff were used, the service sought a copy of their profile to assure themselves they had the training and skills needed to support people at Nazareth House.
- Staff did not always have access to regular and effective supervision and support, including regularly one to one meetings with their line manager. The interim manager had identified this shortfall and was taken some immediate action which included group supervisions whilst they ensured staff had individual one to one meetings.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were fully assessed and where necessary based on their assessed needs from healthcare professionals.
● Universally recognised assessment tools were used to assess people's needs, including their mobility needs and the use of specific equipment. This ensured staff had access to evidence based-practice and followed recognised and approved national guidance.
● People's independence was promoted through the use of technology. This included assistive technology which alerted staff when people who were at risk of falls required assistance. For example, pressure sensor mats to identify when people who were at increased risks of falls were mobilising.

Supporting people to eat and drink enough to maintain a balanced diet
● People had mixed views on the quality and variety of food they received at Nazareth House – Cheltenham. Comments included: "The food is lovely here"; "The soup always tastes the same whatever name it is called" and "The tea (evening meal) is awful, it's usually just sandwiches. The food has gone downhill recently." The interim manager discussed that they were aware with concerns about the quality and variety of food people received, particularly in relation to evening meals. They discussed changes that had been made included providing a hot option at the evening meal. Additionally, they were in the process of recruiting a new head of catering and reviewing all meals, alongside people's views and preferences.
● The support people needed with their dietary needs was recorded in their care plans, including any specific dietary arrangements and textured diets. Care and catering staff were aware of people who required a textured diet, including pureed food or thickened fluids. Staff understood and followed Speech and Language Therapist (SALT) guidance to ensure people were protected from the risk of aspiration.
● Where people were at risk of malnutrition this information was shared with all staff and a record of the support people required was clearly documented and readily available for staff. This ensured that people who had been assessed at risk, received additional support including snacks and fortified food.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Care staff worked alongside two GPs (who was allocated to the home as part of the agreed local clinical commission group arrangements) and other healthcare professionals to meet people's needs and respond to any changes in their needs. Staff made referrals to healthcare professionals if they felt someone required specialist input.
● Advice from health care professional informed people's care plans to enable staff to follow this guidance to meet people's needs. For example, one person was living with a condition which affected their eyesight. Where support had been sought from opticians and optometrist, any guidance had been acted upon.
● Staff worked alongside community nurses to support people with some nursing needs to continue living at the home. During our inspection a community nurse was on site and senior care staff worked with them to identify those people who needed support.
● Where possible, people were supported to maintain their own medical appointments and had access to services such as opticians and dentists. Additionally, some people continued to use healthcare services external from Nazareth House, including chiropody.

Adapting service, design, decoration to meet people's needs
● Since our last inspection, a large refurbishment plan of Nazareth House – Cheltenham had been carried out. This included one unit which had been closed and had now been reopened with a lift in place to improve people's access. The home had a newly renovated reception area, which included a café area for people and their relatives to access and enjoy. The provider had plans to increase the number of places in the home in the future and informed us they would submit the relevant applications to CQC for this when required.

● Where appropriate, people could orientate themselves around the home and access facilities including a range of communal lounges and dining rooms. Some people also used the gardens and patio areas of the home independently. We observed people enjoying the communal areas available to them.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Where people were living with dementia, staff supported them to make an informed choice, by providing clear options. One member of staff told us how they supported one person to make simple decisions, such as what they would like to eat, drink or wear. They said, "We can't force people, but I'd try to explain why what we do is important." Another member of staff said, "There is always choice, with clothing meals and drink. Care is all about giving people the choice."
● One person living at Nazareth House - Cheltenham was being deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). The head of care explained they were reviewing where they had made requests to deprive some of their liberty to ensure the request was still current and, in the person's, best interest.
● People's legal representatives (those who held Lasting Power of Attorney for Finances and/or for Health and Welfare) were known to the organisation and they were included in decisions made about the person's care.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

Good: This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and their relatives spoke positively about the care staff who worked at Nazareth House. Comments included: "I have no criticism of staff, they're kind and really caring"; "I think the staff are lovely" and "The carers are lovely to me."
- We saw people responded to staff positively. We observed that people were comfortable with permanent staff and enjoyed spending time with them. Where possible, staff took opportunities to engage with people and ensure they were comfortable. For example, one member of agency staff took time to engage with one person who was agitated. They reassured the person and ensured they were comfortable.
- People were encouraged to do as much as they were able to independently. For example, one member of care staff explained how they supported one person to do as much for themselves as possible, respecting their choice. One member of staff told us, "They need help with transferring, however they are quite independent." The person told us, "Aside from hoisting, I do most things for myself."
- People and their relatives told us people's dignity was always respected by care staff. One relative told us, "I haven't seen anything that would concern me around people's dignity." One person said, "There are no problems."
- Staff told us how they respected people's dignity and the importance of making sure people were comfortable. We observed that staff ensured people's personal spaces were always respected. For example, knocking on their bedroom doors before entering (even if they knew the person was not in the room) and by talking and engaging with people before assisting them, whether with their meals or their mobility. One member of staff said, "I'd always make sure the door is shut and a do not disturb sign is on display, close the curtains, and use a towel to cover them when washing. There is one resident who doesn't want his curtains shut and we respect that."
- The service respected people's diversity. Staff were open to supporting people of all faiths and beliefs, and there was no indication people protected under the characteristics of the Equality Act would be discriminated against. The Equality Act is legislation that protects people from discrimination, for example on the grounds of disability, sexual orientation, race or gender.

Supporting people to express their views and be involved in making decisions about their care

- People's communication needs were known, recorded and understood by care staff. Staff could describe the support people needed to enable staff to understand their wishes and support their decision making.

● People were at the centre of their care and where possible were supported to make decisions. One person responded positively when asked if their decisions were support. They said, "I am able to spend my day as I choose."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Requires improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; End of life care and support

● People did not always receive care and support which was tailored to their needs and met their wellbeing needs. One person explained, "We have had a lot of agency staff, which hasn't helped. Often, I feel I am left to do things myself such, which I can struggle with."
● People's dietary requests were not always acted upon, because items of food that met people's preferences were not readily available. Two people and their relatives explained how their relatives brought food items in to the home as these were not available. For example, one family brought soups in because they had concerns over the quality of soup provided. The other family had provided an evening drink, as this had suddenly became unavailable within the home. The person told us, "We have to bring our own in now, it's not right." The interim manager was aware of some concerns regarding food options and changes were being made to rectify this.
● People were not always offered choice regarding their meals. One person was provided a soup, which they had not asked for. The person had to ask what flavour the soup was, when they were told, they asked for the soup to be taken away. No alternative was offered to the person.
● People's requests for support were not always acted upon in a timely manner. One person requested some biscuits from kitchen assistants, who did not respond to their request. They made a further request ten minutes later which was acted upon by a member of care staff
● One person had recently changed their room; however, they had not been supported to unpack their room. When asked they explained "I am trying to pick up the courage to unpack. I do not know who to go to now (for assistance)."
● Staff had limited guidance to know how to support people who could not communicate their pain. The service did not use recognised tools to monitor people's pain levels. Protocols for people's pain relief medicine that they used on occasion, did not always inform staff what visual and behavioural signs would indicate people were in pain and required their medicines to ensure they were kept pain free and comfortable.
● People were not always given the information they needed to promote their independence and autonomy. For example, one person's relative explained, "My [relative] is quite able to shower and bath them self but needs to be shown where things are first". They had to keep asking for someone to show her how to operate the bath."

● Care staff had missed opportunities to meaningfully engage with people and provide positive interactions. Throughout the inspection, we observed numerous times where people were supported without any communication from care staff. For example, when being provided with a drink, or their meal, this was done without an explanation. We also observed people requesting the attention of staff, having to wait whilst staff talked amongst themselves. Although we did observe caring and some person-centred interactions between staff and people; we found cares staff sometimes appeared withdrawn from the experience and did not use their time to promote an active and engaging mealtime experience.
● People's requests in relation to their care and treatment had not always been acted upon. One agency member of staff explained how a relative had requested a change in relation to their relatives prescribed medicine be discussed with their GP. The agency member of staff stated this had been passed to staff working at Nazareth House to act on. They explained that when they came back to the home to cover a shift after two weeks that this request had not been acted upon. They responded to this immediately and GP agreed to change the prescribed medicine dose to promote the person's wellbeing.
● People's views and wishes regarding their end of life care had not always been sought. For example, care files we reviewed for people did not always contain a document of the support they wanted at the end of their life, and who they would like involved in their end of life care planning. We discussed this concern with the interim manager who explained they would take action to ensure people's end of life wishes were sought and documented.
● There was limited evidence that people were protected from the risk of social isolation. Where people were unable to engage in group activities or chose to spend their time in their rooms, there was not always a record of the support they received. One person we spoke with had a change in their wellbeing and spent most of their time in the room. They said, "It can often be quiet. I need things near me. I have a phone, however it is the other side of my room, if someone calls I can't get to this." We discussed this concern with the head of care who told us they would look into this concern.
● People raised concerns about the responsiveness of staff when they became unwell. One person and their relative felt the care they received had not changed when they became unwell with an infection. They explained how the infection meant they were reliant on staff to provide them with drinks and meals. Following a short infection, the person was admitted to hospital for active treatment of their infection. The relative said, "The hospital told us she was dehydrated. I do not know if the support had changed. We don't see staff much."

People did not always receive care which was personalised to their needs and promoted their wellbeing. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our last inspection, the activity co-ordinator had left. Sisters from the Sisters of Nazareth had stepped in until a new activity co-ordinator had been recruited. People were grateful for their help, however felt activity provision and external events needed to improve. Comments included: "It is normally very quiet here; there are sometimes activities between 11 and 12 and 2 to 3 which I join in, it is good to take part and to know that I can"; "The weekends are always very quiet here" and "There wasn't a good overlap with activities. The nuns took it over, after people got really unhappy. They did a survey. We cannot fault them."
● A new activity co-ordinator had been recruited and they were carrying out a survey of people's activity preferences and interests. The activity co-ordinator was actively engaging with people throughout the inspection, including supporting people with knitting and a dog therapy session throughout the home. People were looking forward to the impact the activity co-ordinator could have on the home.
● Many people moved to Nazareth House – Cheltenham due to the religious connections the home maintained. People's religious views regarding their end of life care and the support they wished to receive had clearly been documented.

● People were supported at the end of their life by care staff and other healthcare professionals where required. There were arrangements in place to ensure necessary medicines and additional healthcare support was readily available for people to maintain their comfort at the end of their life.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Information was provided to people in a format which was appropriate for them. For example, people could have access to information in a large print format, braille or in different languages.

Improving care quality in response to complaints or concerns
● People's complaints had not always been responded to in accordance with the providers policies. For example, there had been three complaints raised since 14 July 2019. The interim manager explained "I don't think there has been a structure here. We are trying to formalise it." They had ensured all complaints had been brought to their attention and they were taking action to respond to these concerns.
● People and their relatives did not always know who to pass their concerns to. Comments included: "A lot of people (residents) here say they don't know who to go to when they have a problem" and "I do not know who to speak to here, I have never met the manager." The interim manager and head of care were aware of this and were arranging meetings with people and their relatives to ensure people understood who they could pass concerns to.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate.

Inadequate: 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 regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Working in partnership with others

At our last inspection we found effective governance systems were not in place and people were at risk of receiving unsafe care and treatment. This was a breach of regulation 17 (Good Governance) 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 17. This was the fourth consecutive inspection where concerns had been identified in relation to the provider's governance systems.

● The provider had failed to address all the concerns identified at the previous inspection in February 2019. This included not implementing an effective system to assess, monitor and improve the quality and safety of the service and not ensuring effective risk and medicine management systems were in place. The improvements the provider had made at our previous inspection to ensure people always received care that met their individual needs had also not been sustained. This meant the leadership team and provider would not know if people received an unsafe or poor-quality service.
● This was the seventh inspection of Nazareth House - Cheltenham where the service has been rated requires improvement. At six of these inspections the service had failed to meet all the requirements of the relevant regulations. Although improvements had been identified at our February 2019 inspection, these improvements had not been sustained. The interim manager, head of care and provider had identified a number of the concerns we had found prior to our inspection. However, actions at the time of our inspection were still ongoing and had not been fully implemented and evaluated to ensure people would always receive safe and effective personalised care. We continued to identified breaches of regulations at this inspection. The provider had not demonstrated that they were able to consistently meet the requirements of their registration and operate effective systems to ensure that Nazareth House – Cheltenham met the requirements of the Health and Social Care Regulations. Therefore, we have rated this question as 'Inadequate'.
● There were ineffective systems operated by the provider prior to this inspection to ensure they met all of

the legal requirements. However, the interim manager and the provider were implementing a new quality assurance system. At the time of the inspection, these systems had not been fully embedded within the home and therefore we could not evidence their impact. The interim manager explained the quality system would be the same across all of the provider's services and were based on recognised systems they had previously worked with and embedded in other care services.

● The provider did not always operate effective systems to monitor, assess and improve the quality of care people received at Nazareth House – Cheltenham. For example, there were no effective systems to identify trends and learn from incidents, accidents and complaints.

● Where audits had been carried out it was not always clear to see if shortfalls had been acted upon. For example, audits of people's care plans had not always been effective in ensuring people's records remained current and reflective of their individual needs.

● Quality assurance systems that had been used were not robust and did not always identify areas for improvement, including improvements to people's personal emergency evacuation plans and if staff followed expected practices around people's risks and person-centred care. This meant people were placed at risk of harm or poor-quality person-centred care because the quality assurance processes had not identified where actions were required, or where staff were not working to the providers expectations in relation to the management of people's medicines.

● An external quality auditor visited the home in July 2019 and supplied the service with a report of their views and where actions were required. This visit had identified some quality concerns, however at the time of our inspection there was no formulated action plan in respond to these shortfalls. Although the interim manager had developed a process for identifying areas of improvement across the home these were unstructured and did not ensure the people received high quality care, in line with accepted best practice.

● The interim manager, head of care and provider were aware of a number of concerns we had identified at this inspection. However, while they openly discussed their concerns there was limited formulated actions on how the service was managing these concerns in the short and long term to mitigate the impact to people in relation to their prescribed medicines and person-centred care.

● Senior staff did not always effectively communicate or provide firm shift leadership, so staff knew what was expected of them and tasks that required to be completed. Staff told us that key messages were not always communicated, and actions were not always taken which could impact on people's health and wellbeing. For example, one member of senior staff told us, "Requests are not always followed, some other senior care staff don't take any responsibility." A member of staff told us, "Sometimes the seniors do not help, they do not answer bells. Sometimes we are rushed because we are not properly organised." One person told us, "We have lost nearly all the senior staff in the Home. Some [seniors] are good but some are not, it is all a bit of a mess."

● The practice requirements set out by the provider were still not being operated effectively as senior staff did not always adhere to the provider's policies which placed people at risk of receiving unsafe care. For example, senior staff had not always followed the provider's medicine's procedures which increased the risk of medicine errors occurring. One person told us, "There have been some issues with the medicines- they lost some tablets and didn't know why and then they found them; we know that some people were given four tablets rather than two and there have been occasions when they have run out of tablets and you can't have that." Additionally, staff were not always meeting the expectations of the provider in relation to updating people's care records and ensuring monitoring charts were being correctly completed. While the provider had identified some of these concerns and concerns had been raised at our previous inspection, effective improvements had not been embedded or sustained. Following the inspection, a representative of the provider explained how they were planning to address these concerns with short and long term actions.

● People and their relatives raised concerns about the culture of the home, including, how staff treated people and also their colleagues. Comments included: "We residents do not want to hear them (carers) saying they are short staffed all the time"; "I've never had so many refusals (to provide support) from her

(staff member) over the last few months; I do not go to her at all now"; "We have had nine managers in goodness knows how short a period; I don't think the staff accept any authority and even more unhealthily they defy publicly and in front of us in the dining room" and "I think the culture effects the care. I am surprised sometimes that if you do try too much to help some of the other residents you get told off."

● People and relatives did not always know who their key worker was and felt communication from staff was not always forthcoming. One relative showed us that their mother had a key worker and lead worker, however they said, "I do not know them or who they are." Another relative told us, "No one gets back to us at all. We are not sure if (relative) has been referred to the GP, I did not think I would have to check about her medication, we had asked for a repeat prescription to be arranged and were amazed when we found it had not been done."

● People and their relatives told us their concerns about the management of Nazareth House – Cheltenham and their hope for sustainability. Comments included: "We rarely see the managers. There's been too much change"; "It often feels like there are days with no management or no authority on the premises" and "We have no confidence in the service."

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

● People and their relatives views had not always been sought or listened to. The provider had not operated effective systems to seek and act on the views of people and their relatives. People and their relatives told us they did not feel able to express their views, or that their views and concerns were not acted upon. Comments included: "No one gets back to us at all"; "We have the odd Residents Meeting; I did not used to go; then I did because it was the only way I could find out about the new building (renovations) and what was going on" and "No one has asked for our views."

● The service had some systems to seek the views of care staff, however some staff felt due to the changes in management that their views had not always been acted upon. Comments included: "I do not always feel we are listened to" and "There is not much interaction with managers. I haven't met them all." However, one member of staff spoke positively about upcoming changes. They said, "Team meetings are happening with bigger changes. The next one is on the 5 August."

The provider had failed to ensure staff had followed the systems they had implemented to protect people from the risk of harm. This meant people could be placed at risk of unsafe care and treatment. People and their relatives' views had not always been effectively sought and acted upon. The service did not currently operate systems to monitor, assess and improve the quality of care people received. This was the fourth consecutive breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoke positively about the interim manager and the immediate impact they were having on the service. Comments included: "They are working very hard for us" and "They've come in and they're focused on helping us."

● The interim manager had carried out a group supervision with care staff and a meeting with domestic staff to start communicating their expectations of staff. For example, new admissions had been discussed and how people should be welcomed into the home, staffing levels, recruitment and communication.

● A new activity co-ordinator had been recruited who was immediately carrying out a survey on people regarding the meals at Nazareth House – Cheltenham and people's individual preferences. The activity co-ordinator was carrying out this survey during the inspection.

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

● The interim manager, head of care and provider were aware of their legal responsibility to notify CQC of notifiable events. The interim manager and head of care understood their responsibility to be open and honest when an incident had occurred.

● The interim manager and head of care had reacted quickly and effectively to an incident which occurred at Nazareth House – Cheltenham. They had informed the families of the people involved, as well as a range of external agencies to ensure appropriate action had been taken.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and support which was tailored to their individual needs. Staff did not provide care in accordance with people's choices and taken into consideration their wellbeing needs. Regulation 9 (1)(a)(b)(c)(3)(a)(b)(h)(i)

The enforcement action we took:

We have issued a positive condition against the provider's registration for the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not received their medicines as prescribed. Senior care staff did not follow recognised practice when managing people's prescribed medicines. Staff did not always ensure people were protected from the risks associated to their care. Regulation 12 (1)(2) 9 (b)(f)(g).

The enforcement action we took:

We issued a warning notice to the provider which they must meet by 30 September 2019

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Staff did not always follow the systems implemented by the provider. This meant people could be placed at risk of unsafe care and treatment. People and their relatives' views had not always been effectively sought and acted upon. The service did not currently operate systems to monitor, assess and improve the

quality of care people received.
Regulation 17 (1)(2)(a)(b)(c)(e)

The enforcement action we took:

We have issued a positive condition against the provider's registration for the location.