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 medicines were available as needed, and had implemented a system to manage the stock of people's prescribed medicines. A daily auditing system was in place to address any errors and ensure people's health was not impacted by these mistakes.

However, the requirements of the warning notice in relation to the safe management of people's medicines had not been fully met. People were still not receiving their medicines as prescribed as care staff had not always administered people's prescribed medicines.

Where changes to people's prescribed medicines had been made by their GP or relevant healthcare professional, care staff had now ensured this was documented and shared, which reduced the risk of people not receiving their medicines as prescribed.

Staff responsible for administering people's prescribed medicines had received training and competency assessments. The manager had arranged for further training and had taken action to address any staff medicine administration errors.

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 had a discussion with a representative of the provider to discuss their continued action. We will work with the local authority and local clinical commissioning group 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 manager was in post and was in the process of registering 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 three members of staff including the manager and two senior care staff. We reviewed 36 people's medicine administration records and associated medicines.

Following the inspection
We had a meeting with a representative of the provider to discuss their progress and how they planned to meet the requirements of the regulation. We also sought the views of local authority commissioners and clinical commissioning group 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 reduce the risk to people not receiving their medicines as prescribed, which included improvements which ensured people's prescribed medicines were readily available. The manager had implemented a system which enabled them to address medicine administration errors and take effective action. However, people were still being placed at risk of not receiving their medicines as prescribed as care staff did not always work to the provider or managers expectations.

At this inspection while improvements had been made, 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.

- People had not always received their medicines as prescribed. We looked at 36 people's Medicine Administration Records and found that since 10 February 2020, eight 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.
- Staff had not always identified where people's medicines had not been given as they had not accurately checked people's medicine stocks. The manager had implemented a daily audit and stock count. While staff kept a record, they did not always take appropriate action when they had identified concerns or used the system to identify any discrepancy in stocks. One member of staff had identified a discrepancy in one person's stock, however had not taken action or raised this concern to the manager.
- Staff had not always followed the provider's guidance in relation to the management of people's prescribed medicines stocks. For five 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 had a discussion with two representatives of the provider of the continued actions they were taking 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 sixth 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. A senior member of care staff had been assigned to manage when people's prescribed medicines were received into the home and when they were disposed of. This had reduced the stock of people's prescribed medicines, reducing the risk of people not receiving their medicines as prescribed.
● Staff had used auditing systems to identify two occasions where staff had failed to administer a number of people's medicines as prescribed. These two concerns had been passed to the registered manager and action had been taken, which included removing one member of staff from administering people's medicines, removing one member of agency staff from working at the service and raising a safeguarding concern with the local authority.
● The manager and provider had carried out detailed audits to identify where medicine administration errors were occurring. Following this they had sent a letter to all staff to inform them of their expectations and their responsibilities. The manager had arranged for further training and had recruited new staff who were now assisting people with their prescribed medicines. The manager was ensuring competency processes were in place to ensure staff followed good practice.