Nazareth Care Charitable Trust

Nazareth House - East Finchley

Inspection report

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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 is a residential care home providing accommodation and personal care to people aged 65 and over, some of whom were living with dementia. The service is registered to support up to 84 people. At the time of the inspection there were 77 people living at the home.

The home is a large adapted residential house which has living space and bedrooms over two floors.

People's experience of using this service and what we found
During this inspection we found significant concerns around the overall management oversight of the home, documentation relating to care, medicines management which placed people at the possible risk of harm. There was a high number of unwitnessed accidents and incidents occurring within the home resulting in people sustaining injuries. There was no management oversight of these, which meant that people were being placed at risk of avoidable harm.

Risk to people were not always identified or assessed. Where risks were assessed, risk assessment documents were not always comprehensive and were generic. Guidance and direction to staff on how to minimise risk was not clear and detailed, placing people at risk of harm.

People were not always receiving their medicines safely and as prescribed. Systems and processes in place to manage medicines safely were ineffective and placed people at risk of harm.

The provider was not implementing current government guidance on the prevention and control of infection especially related to COVID- 19. We have made a recommendation for the provider to implement current government guidance on infection, prevention and control.

Daily monitoring and recording of people's health and care needs was inconsistent which meant that people may not have been receiving the required intervention in response to their needs.

There was a lack of managerial oversight of the home. There were no documented audits or checks of any aspect of care delivery. Whilst senior managers were aware of some of the issues identified during this inspection, ineffective service improvement plans meant issues were not being addressed as priority and within specific timeframes depending on the seriousness of the issue.

Staff understood safeguarding and how to keep people safe from abuse. Staff told us that they received training on safeguarding to support them in their role.

People and relatives told us in general they were happy with the care and support delivered at Nazareth House. Care staff were seen to be kind, caring and approachable.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 requires improvement (published 22 September 2021) and there were breaches of regulations 12 and 17.

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 the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about medicines management and administration and the high level of notifications received about unwitnessed accidents and incidents resulting in injury. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

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.

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

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

Enforcement and Recommendations
We have identified repeated breaches in relation to regulation 12; safe care and treatment and regulation 17; 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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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 in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Nazareth House - East Finchley

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 Health and Social Care Act 2008.

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
This inspection was carried out by three inspectors and one pharmacist inspector. The inspection was also supported by three Experts 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. One Expert by Experience spoke with people and relatives during the inspection and two Experts by Experience contacted people's relatives and friends by telephone to request their feedback.

Service and service type
Nazareth House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Nazareth House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection the registered manager in post was not available to support the inspection process. Regional Quality Managers supported this inspection process.

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. We reviewed the action plan the provider had submitted following the last inspection and all subsequent updates. We also looked at notifications that the service had sent to the CQC. Notifications are information that registered persons are required to tell us about by law that may affect people's health and wellbeing. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service about their experience of the care provided. We spoke with two regional quality managers, the operations director, three senior care workers, four care staff, one activities co-ordinator, the catering manager and two visiting healthcare professionals. We undertook observations of people receiving care to help us understand their experiences, especially for those people who could not talk with us.

We reviewed a range of records. This included 13 people's care records and 17 people's medication records. We looked at nine staff files in relation to recruitment. A variety of records relating to the management of the service, including quality assurance and health and safety were also reviewed.

The two Experts by Experience contacted relatives of people living at the home to gather their feedback on the quality of care people received. This exercise took place on 11 May 2022 and we spoke with 19 relatives.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to manage and administer medicines safely. This was a breach of regulation 12 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

- People did not receive their medicines safely or as prescribed.
- Policies and procedures in place were not always being followed by care staff administering medicines. Care staff were not aware of the process to follow when medicine incidents or errors had occurred.
- The provider used an electronic Medication Administration Record (eMAR) system to manage and record the administration of medicines. Information about the medicines administered populated within the system was not always sufficient and detailed. There was a risk that this would lead to errors and omissions in the administration of medicines. Care staff did not feel adequately skilled or trained to address this.
- Medicines were not always administered as prescribed. One person who had been prescribed pain relief patches to be administered every 72 hours, had been administered the patch daily. This meant that the person may have been placed at risk of receiving an overdose of this medicine.
- We identified examples of people not receiving their medicines as they were recorded on the eMAR system as being out of stock. This included pain relief, anti-depressants, blood thing medicines and medicines administered for managing specific health conditions. One relative told us, "My sister tells me that sometimes she doesn't have her medication because the staff allow them to run out."
- Recording of the administration of medicines was not always clear or consistent. There were gaps or omissions and recording including staff recording that medicines had been 'left in cup' with no clear indication or assurance that medicines had been administered as prescribed and at the time required.
- Where PRN 'when required' medicines were prescribed, there were not always protocols in place to guide care staff as to when to administer these. PRN medicines can be administered to help with pain relief or anxiety.
- Care staff had received the required training and were assessed as competent to administer medicines. The training also included specific training on the eMAR system. However, care staff told us that the training was not advanced enough and did not include additional duties such as stock control on the eMAR system the care planning of medicines especially where people were prescribed high risk medicines.
- Medicines audits had not been regularly completed. This meant that the issues identified at the time of inspection, had not been recognised and addressed by the provider.

The provider had failed ensure people received their medicines safely and as prescribed. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely. Daily temperature checks were recorded of medicine storage areas to ensure medicines were stored in the required environment.
● We discussed our findings with the regional quality managers and the operations director who were aware there were significant concerns with the overall management and administration of medicines. Some concerns were linked to the inconsistent relationship between the home, GP and pharmacist. Work was in progress to address this.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. Poor oversight and management of accidents and incidents place people at the risk of harm. This was a breach of regulation 12 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

● Risk's associated with people's health and social care needs had not been comprehensively assessed to keep people safe from the risk of harm.
● At the last inspection in July 2021 we found that whilst, risks associated with people's health and care needs were identified and assessed, these lacked detail and information contained within the risk assessments and care plan was inconsistent. At this inspection we found that these concerns had not been addressed. Furthermore, we found that certain risks had not been assessed and guidance had not been provided to care staff on how to manage people's risk to keep them safe.
● Risk assessments were not in place for people with specific health conditions such as diabetes and epilepsy.
● For other people who had been prescribed high risk medicines such as blood thinners, their care plans did not have a corresponding risk assessment to guide care staff on the risks associated with those medicines.
● Another person had a colostomy bag in situ. This has not been risk assessed. Clear guidance and direction were not in place for care staff to identify the risks related to infection or blockage of the bag. A colostomy bag is a plastic bag that collects faecal matter from the digestive tract.
● One person had two risk assessments in place for falls. One risk assessment had assessed the person as high risk and the second risk assessment assessed the person as medium risk. The support plan had then documented the person to be at low risk of falls. The inconsistent information contained within the care plan and risk assessments meant that the person may not have been receiving care that was appropriate to their needs and ensured their safety.
● Other people had been noted to have sustained unexplained bruising on their body. This had not been risk assessed for those people, and the care plans had not been reviewed and updated to guide care staff on how to prevent and protect the person from further bruising.
● Risks associated with COVID-19 had not been assessed for people and staff.
● Accidents and incidents were not always documented, appropriately acted upon, investigated and follow up actions recorded where required. This meant that people were at the possible risk of avoidable harm.
● There had been 13 unwitnessed falls and injuries in the 28 days prior to this inspection.
● We identified three examples of where people had sustained unexplained bruising, with no incident report

completed.
● We were not assured that accidents and incidents including medicine administration errors occurring at the home were being reported by care staff in line with the provider's policy.
● People's care plans and risk assessments were not updated to reflect any changes in support required or identified risk following an accident or incident.
● The lack of detail or no detail recorded following an accident and incident meant that the registered manager and senior managers had minimal management oversight of these.
● There was no analysis or review of the incidents and accident occurring within the home. This meant that any trends or patterns were not identified so that improvements, learning or development could be implemented

The provider had failed to monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Health, safety, equipment and environmental checks were routinely completed to ensure people's safety.
● Personal emergency evacuation plans in place outlined people's specific support needs in an emergency and how they were required to be supported.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
● Policies and procedures were in place to prevent and control infection. However, these were not always adhered to. The service not always working in line with current government guidance.
● The home was seen to be clean. Daily cleaning processes were in place to prevent the spread of infections. Current guidance was also available on managing COVID-19 safely. Posters on COVID-19, hand washing and wearing of Personal Protective Equipment (PPE) were displayed around the home.
● However, on the first day of the inspection we observed that care staff, when entering the home to begin work in the morning, were not wearing masks. Care staff on shift were also seen not to be wearing any masks.
● Screening checks were not undertaken to ensure we were safe to enter the home in order to keep people safe from infection.
● As per government guidance, the home was not undertaking regular lateral flow testing of its staff to ensure protection and safety from infection.
● Whilst care staff told us that they had access to PPE, care staff told us that PPE was not always consistently worn in the home. One care staff told us, "Everybody does what they want with masks." Another

staff member, when asked about wearing PPE stated, "It's more relaxed at the moment."

We recommend the provider implement current government guidance on infection, prevention and control within care homes including specific guidance related to the management of COVID-19.

Visiting in care homes

● Processes were in place to facilitate safe visits and was in line with current government guidance.

● Most relatives and visitors to the home confirmed that screening checks were undertaken to ensure they were safe to enter the home in order to keep people safe from infection.

Staffing and recruitment

● During the inspection we observed there to be sufficient staff available to support people with their needs.

● Due to the shortage of permanently recruited staff within this service, the home was commissioning a high number of agency staff to ensure the required staffing levels were maintained. This meant that people were not always receiving consistent care and support from care staff who knew their needs well.

● Whilst there were sufficient numbers of staff available, the deployment of staff was not always organised in a way which ensured people's safety.

● Senior care workers had little oversight of the staff on shift and their whereabouts. On one occasion we found an agency staff member sleeping in a communal lounge area. Whilst the agency staff member stated they were on a break, the senior care worker in charge was unable to confirm this and did not know how many of the care staff team were on a break.

● On another occasion we saw an agency care staff member dozing in the communal lounge whilst sitting with approximately 10 people, who they were meant to be monitoring and interacting with.

● There were occasions where communal lounges were left unattended, whilst people were present in the lounge. On one occasion we observed one person trying to get up from their chair to mobilise. There were no staff around to support them and we had to intervene to ensure the person's safety while we asked for help.

● We received mixed feedback from people and relatives about staffing levels within the home. Whilst some said that they felt there was enough staff available some people and relatives were not so positive. One person told us, "I think it's about right on staff." Relatives feedback included, "From what I've seen I think that there are enough staff", "There is enough staff now and good staff", "I think that they are short staffed now. The staff are struggling" and "It is mostly agency staff and they are all different and not continuous."

● Required recruitment checks and assurances had been obtained which included criminal record checks, evidence of conduct in previous employment and identity verification.

● However, we did find that in some staff files gaps in employment had not always been fully explored and that there was a lack of information obtained on past employment history. This was highlighted to the regional quality managers who assured us that this would be reviewed to ensure the requirements of the Health and Social Care Act 2008 were being adhered to.

Systems and processes to safeguard people from the risk of abuse

● Policies and procedures were in place to safeguard people from the risk of abuse. However, the lack of management oversight, leadership and guidance meant that people were not always protected from the risk of abuse and harm.

● Issues identified with medicines management and administration, risk management and lack of oversight of accidents and incidents meant that people were being placed at risk of avoidable harm.

● Several safeguarding concerns had been raised with the local authority in relation to some of the issues identified which were currently under investigation.

● Other incidents such as unexplained bruising which had not been reported as incidents may not have been reported to the relevant authorities.
● Despite the issues identified, feedback from people and relatives was that Nazareth House was a safe place for them and their family members to be living at. People told us, "Very safe place so far" and "Safe place, they [care staff] come whenever I press the buzzer at night."
● Relatives feedback included, "Yes, they do keep [person] safe" and "[Person] had one fall so they're very aware of the danger that he is under. They make sure that he has the walking aids that he needs."
● The regional quality managers demonstrated an understanding of their responsibilities to report incidents and events which placed people at the risk of abuse to relevant authorities including the CQC and the local authority.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to 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; Continuous learning and improving care

At our last inspection the provider had failed to implement systems to demonstrate that there was adequate oversight of the home. Records for people's care and treatment were incomplete. This placed people at risk of harm. This was a breach of regulation 17 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

- The provider did not have effective systems and processes in place to monitor and oversee the quality of care people received.
- The registered manager was unavailable throughout this inspection process. Two regional quality managers were in place overseeing the management of the home.
- There was a lack of management oversight of care delivery in the home. Senior managers were not seen to be observing care practices and were not visibly available to support senior care workers.
- Audits and checks were not being completed consistently, which meant that senior managers did not have adequate oversight of quality and risk within the home.
- Poor recording, review and analysis of accidents, incidents, safeguarding concerns and complaints meant that senior managers had little or no oversight of events taking place in the home. Trends and patterns were not identified so that specific actions could be implemented to prevent re-occurrence and to support further learning and improvement.
- Audits of care plans and medicines management were not taking place to ensure people were receiving safe, good quality care.
- Care staff did not receive the required leadership, supervision, guidance and direction to be able to deliver safe, good quality care. Care staff told us that they felt undervalued and that management had not been supportive, creating poor staff morale.
- Whilst senior managers were aware of some of the concerns within the home, there had been very little in terms of recognition, acknowledgement and actioning of issues to ensure people's safety. There was insufficient management and leadership within the home to address issues and drive forward improvement.

- Service improvement plans in place were not dated, lacked detail and did not give clear timeframes within

which issues identified would be addressed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not always promote good outcomes for people through person centred care. Risk assessments were not personalised and lacked individualised detail on how the risk specifically impacted people and how care staff were to support the person to minimise risk.
● People were not always receiving their medicines safely and as prescribed.
● Monitoring of people's food and fluid intake and weight was inconsistent. Gaps in recording were identified which meant that people may not have been in receipt of the required care, support and intervention to ensure their positive well-being.
● The provider did not follow and implement current government guidance on the prevention and control of infection.
● Staff deployment within the home was ineffective and meant that people were left unattended in communal areas placing them at risk of harm.
● Care plans were not always reviewed and updated following change in people's needs.
● Whilst we found that in general people's physical needs were met, we found significant failings throughout the inspection as detailed within this report that impeded the delivery of person-centred care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People, relatives and staff were not always engaged and involved in using the service.
● We saw records confirming that residents meetings had taken place since the last inspection. Agenda items included activities, menu's and maintenance and cleaning.
● However, we received mixed feedback from people and relatives about their involvement in the planning and delivery of care. We are also told that people and relatives had not attended any meetings related to care planning or to discuss and give feedback on the overall management of the home. People's feedback included, "Never heard about the meeting" and "We never know about any meeting and never get any questionnaire." Relatives told us, "We don't have any meetings. I've had no questionnaires" and "They have not asked me my views."
● People and relatives knew the registered manager and were also aware of them being on leave. Most relatives stated that they felt comfortable raising concerns and would approach the registered manager if required. However, some relatives also commented that communication between them and the home could be better. Comments included, "It is not quite well run because of communication" and "In the future I will be asking for more communication and for [person] to be reviewed."
● Care staff told us that staff morale was down and that they did not feel supported in their role. Records did not confirm that care staff were receiving regular supervision or an annual appraisal.
● Care staff also told us that the impact of staff shortages and the high use of agency staff also affected staff morale. Comments included, "We are not happy with the management. [Registered manager] came and started blaming the seniors. No support during COVID-19. We could be better", "No communication. Poor leadership and that's why everyone is leaving. There will be safety issues if agency staff keep coming in" and "We need support, that support is missing from this place. None of the management can be seen on the floor."

Systems and processes were not in place and implemented to demonstrate that there was adequate management oversight of the home. This placed people at risk of harm. People did not receive care that was person centred, open, inclusive and empowering. The provider had failed to engage and involve people and relatives on the quality of care delivery and the overall management of the home. Staff did not feel

supported in their role. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback about the issues identified as part of this inspection process was provided to senior managers representing the provider. Senior managers acknowledged the seriousness of the concerns identified and gave assurance that these would be addressed and that the required management support would be put in place going forward.
● The local authority was informed of the seriousness of the issues identified and plans were put in place to work with the home to ensure people's safety and make the required improvements.
● Records confirmed and staff told us that staff meetings were taking place. Topics for discussion included safeguarding, training, management and infection control.
● The home worked in partnership with other agencies to support people's physical health.
● Records seen confirmed that referrals had been made to varying healthcare practitioners.

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
● Senior managers clearly understood their responsibilities around duty of candour and being open and honest when something had gone wrong. Statutory notifications were completed and submitted to the required authorities including CQC.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments failed to document people's known risks. Where risks were documented these often failed to provide staff with adequate guidance to minimise the risk. Medicines management and administration was not safe.

The enforcement action we took:

We issued the provider with a Warning Notice on

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of management oversight systems and processes demonstrated that there was inadequate oversight of the home and that people were not always in receipt of care that was person centred, open, inclusive and empowering. This placed people at risk of harm.

The enforcement action we took:

We issued the provider with a Warning Notice on