

# Nazareth Care Charitable Trust

# Nazareth House -

# Manchester

## Inspection report

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02 August 2022

03 August 2022

04 August 2022

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11 October 2022

## Ratings

Overall rating for this service	Inadequate ●
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Is the service safe?	Inadequate ●
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Is the service well-led?	Inadequate ●
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# Summary of findings

## Overall summary

### About the service

Nazareth House – Manchester is a residential care home providing nursing and personal care for up to 66 people. The service provides support to people over the age of 65. At the time of our inspection there were 32 people using the service, some of whom were living with dementia. The service consisted of one nursing unit and one residential unit.

### People's experience of using this service and what we found

Since our last inspection, the provider had started to make some improvements in the governance of the service. However, during this inspection, we continued to find concerns relating to the safe management of medicines.

We identified medication had been out of stock for five people in the four week period prior to the inspection. People had therefore gone without medication they required. We also found the service still required improvement in relation to recording of topical creams being applied, protocols for medication which is to be given 'when required' and medication which is to be given at specific times or with food. There continued to be concerns around the storage of creams and medications for waste disposal.

Staff were recruited safely and gave positive feedback about recent face to face training they had completed. Relatives were supported to visit the service. People had detailed risk assessments in place to mitigate risks. However, we found one person's care plan did not include a falls risk assessment. We raised this with the provider who informed us that these were in the process of being updated.

There were improvements with the oversight of the service, however we found accidents and incidents had not been consistently reviewed by a manager. We also found some inaccuracies with medication audits. The service had begun to identify medication concerns themselves and raised these appropriately with the local authority. Staff and people living at the service gave positive feedback about the recent changes in management at the service. People were aware of the management team and how to raise concerns. Staff morale had also improved at the service. We received positive feedback from people about the support they received from staff.

People were supported to have maximum choice and control of their lives and staff supported /did 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](http://www.cqc.org.uk).

### Rating at last inspection and update

The last rating for this service was inadequate (published 11 May 2022). At this inspection we found some

improvements however, the provider remained in breach of regulations.

#### Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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.

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 remained inadequate.

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nazareth House – Manchester on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

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

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

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will monitor the progress made by the provider in response to the action plan they have devised with the local authority. 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 remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Inadequate ●

The service was not safe.

Details are 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 - Manchester

## **Detailed findings**

## Background to this inspection

### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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

The inspection team consisted of two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

### Service and service type

Nazareth House – Manchester is a 'care home.' People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Nazareth House – Manchester is a care home with 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 there was not a registered manager in post.

At the last inspection, a registered manager who already worked for the provider, had moved to the service. This manager had submitted an application for their registration to be updated to include this service. This application had not been completed. This registered manager was not in post during this inspection. At this inspection there was an interim manager in place and the newly appointed manager, who intends to apply to register, commenced employment at the service on the second day of the inspection.

#### Notice of inspection

This first day of the inspection was unannounced. The second and third day of the inspection was announced. Inspection activity started on 2 August 2022 and ended on 11 August 2022.

#### What we did before the inspection

We reviewed the information we had received from the service since the last inspection. We also contacted the local authority for feedback on the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

#### During the inspection

We reviewed records relating to the running of the service including four care plans, two recruitment files and audits. We spoke with ten people living at the service and two relatives. We also spoke with 13 people who worked at the service including care staff, support staff, nurses, the interim manager and the regional managers.

# 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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

### Using medicines safely

At our last five inspections, we found that the provider did not ensure the safe and proper management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People did not always receive their medications, as prescribed. Five people had missed some doses of their prescribed medicines in the four-week period prior to the inspection. This was because systems for ordering medicines were still not effective. The system had failed in ensuring there was an adequate supply of stock available for people to receive their medicines as prescribed.
- Systems in place were not effective in ensuring that people who were prescribed medicines to be given at specific times or with a specific time interval between doses, were administered their medicines safely.
- Records about medicines and creams were still not always accurate and did not always show they were accounted for, or that they were administered safely as prescribed.
- Protocols were not always in place for medicines which were prescribed to be given 'when required.' Where protocols were in place, staff did not always follow the protocols when administering these medicines. There were no records to show if the administration of the medicines had been effective.
- Topical medicine patches were not always rotated safely in line with the manufacturers' directions.
- Professional advice had not been sought to administer medicines safely, which needed to be given covertly by hiding the medicines in food or drink.
- The system for checking the expiry dates for medicines was not effective as one rescue medicine for the treatment of hypoglycaemia was out of date.
- The system for ensuring that peoples' medicines were accurately listed, and dose changes were managed safely was not fully effective. People's dose changes were not managed safely.
- Medicines were not always stored safely. Creams were stored in bedrooms and waste medicines were not stored safely in line with current guidance.

Systems had not been established to ensure the safe and proper management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Assessing risk, safety monitoring and management

- Risk assessments were not all up to date. We found an example where a moving and handling risk



assessment was not completed. The provider explained that they were currently working to ensure that risk assessments were up to date following the move to a new electronic care system. We found two hourly welfare checks, for one person, were not consistently recorded as completed.

- Risk assessments, which were in place, were reflective of people's needs. Risk assessments relating to people's specific needs contained detailed information relating to their risk. For example, in relation to their behaviour or health needs.
- The service had appropriate systems to assure safety, relating to equipment and the premises, was monitored. Equipment was serviced in accordance with manufacturer's instructions and there were systems for reporting any maintenance requests or issues.
- A recent fire risk assessment had been conducted at the service. This identified areas to be addressed. At the time of the inspection, the provider was in the process of getting quotes for the work to be completed. Staff had recently undertaken fire training. Some staff were unclear on the evacuation plan. We shared this with the manager, and we were informed that another fire drill would be conducted.

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. One person told us. "I enjoy living here as I am not restricted and can still walk around when I want to."

#### Learning lessons when things go wrong

- Accidents and incidents at the service were appropriately recorded on a newly implemented electronic care system.
- Since May 2022, accidents and incidents, had not been reviewed by the manager to identify trends and patterns and mitigate future incidents. Following our inspection, the interim manager took action to address this.

#### Systems and processes to safeguard people from the risk of abuse

- The service had systems in place to safeguard people from the risk of abuse. Staff had received training in safeguarding and demonstrated an understanding of what should be reported to the safeguarding team.
- The service had a safeguarding tracker in place to monitor concerns and their progress.

#### Staffing and recruitment

- Staff were recruited safely. Staff recruitment files showed that all necessary pre-employment checks had been completed for newly appointed staff.
- The service continue to use staff from staffing agencies to support their needs. Where possible, the same agency staff attended the service to ensure continuity of care. Agency staff were also supported with supervisions, where necessary.
- Staffing levels were reviewed monthly or if there were any changes to people's needs. One person told us, "If I need anything, I ring my buzzer they [staff] always come, I don't have to wait long."

### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

### Visiting in care homes

- People were supported to visit the service at a time of their choice. Some people chose to inform the service before they visited. However, people were also supported to arrive unannounced at the service. One relative told us "I can come and visit when I want to, I sign in at reception and they always ensure that visitors wear a mask."

# 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 inadequate. The rating for this key question has remained 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 the last inspection the provider failed to ensure there was a robust governance system in place. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some recent improvements had been made, however there was not enough improvement and the provider remained in breach of regulation 17.

- This is the sixth consecutive inspection where breaches of regulation have been identified. We have found some improvements in provider oversight at this inspection. However, the most significant improvements were very recent and required embedding into practice.
- At the last inspection we found medication audits had failed to identify concerns. At this inspection we continued to find some inaccuracies with medication audits. The service had identified some concerns with medications themselves and had reported these appropriately to the safeguarding team. However, we continued to find concerns around the safe and proper management of medicines.
  - Accidents and incidents at the service had not been appropriately reviewed by the management team. Since May 2022, there were seven incidents which had not been reviewed. Following the inspection, the interim manager reviewed these incidents and analysed the information for any trends.
  - There were no audits conducted at the service by the provider. The regional team acknowledged this was a shortfall and stated that new policies and audits were planned to be implemented.
  - Risk assessments were not all up to date or completed at the time of the inspection.

Systems had not been established to ensure robust governance of the service. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection we found that lengthy inductions were conducted over one day for new staff. During this inspection we found inductions were completed over multiple days. The interim manager told us that an additional day had also been arranged to discuss any queries with newly appointed nurses.
- The service did not have a registered manager in post at the time of the inspection. The service had appointed an interim manager who was present throughout. On the second day of inspection, the newly

appointed manager commenced their employment. It is their intention to submit an application to register as the manager.

- Staff felt supported by the interim manager and wider management team. Staff supervisions were up to date.
- Following the last inspection, the provider had implemented a 'four weekly challenge report' to assist with monitoring of the service. This document contained greater detail for the provider however; there was no information to show that the actual audits were being reviewed.

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 service responded appropriately to complaints. Records showed that the service had apologised when things had gone wrong and spoke with the people involved.
- The service displayed their CQC rating and inspection reports in the reception area of the home.
- Resident meeting minutes were also available for people to read.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The management team had improved their engagement with staff. The interim and deputy manager held meetings with staff, where open discussions took place. The staff we spoke to told us that staff morale had improved at the service.
- The management had also held a meeting with relatives and had scheduled these to take place bi-monthly, moving forward.
- The service had taken steps to gather feedback from people using the service. Surveys had been given to people to complete. These were completed anonymously. The responses were mostly positive about staff, however people fed back negatively about the presence of the previous management. One person told us, "if I wasn't happy I would speak to any member of staff as they are all kind and approachable."

Working in partnership with others

- The service were engaging with the local authority to work through an action plan to implement improvements at the service.