Nazareth Care Charitable Trust

# Nazareth House - Northampton

## Inspection report

118 Harlestone Road
Northampton
Northamptonshire
NN5 6AD

Tel: 01604751385

Date of inspection visit:
01 March 2016
02 March 2016

Date of publication:
28 April 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This unannounced inspection took place on the 1 and 2 March 2016. Nazareth House Northampton provides accommodation for up to 50 people who require residential care for a range of personal care needs. There were 42 people in residence during this inspection.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were not protected against the risks of avoidable harm and abuse. Some staff were not aware of their responsibilities with regards to safeguarding people who lived at the home. The provider had not ensured that assessments of risk and associated risk management plans were up to date and accurately reflected people's circumstances. This left people vulnerable to significant risks to their health and wellbeing.

The provider had failed to deploy sufficient numbers of staff in order to meet the needs of people who used the service and failed to demonstrate a systematic approach in determining the number of staff required. People were not cared for by staff that had the knowledge, skills, experience and support to carry out their roles. Staff did not receive appropriate supervision, appraisal or training to enable them to fulfil their responsibilities.

The provider failed to protect people who used the service against the risks associated with the safe management of medicines. Medication was not administered as per instructions; errors were identified on Medication Administration Charts (MAR) and MAR records could not be relied on as an accurate account of the medicines administered to people. Medicines were not kept securely.

People living at the home did not always consent to their care and treatment. Mental capacity assessments were not carried out for the people living in the service to measure whether they were able to make their own decisions. Staff did not have a good working knowledge of the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005.

There was poor monitoring of peoples nutritional and hydration needs which put people at risk. Records could not be relied upon as an accurate account of people's food and fluid intake. There was lack of monitoring and oversight of people who were at risk of not eating or drinking enough.

People were not always given the opportunity to have stimulation or follow their hobbies and interests. The newly appointed activities coordinator was very proactive but was unable to provide a stimulating environment for all people living at the home without the support and input from other staff members.

Some staff had a caring approach to the people they cared for but there were significant shortfalls in the caring attitudes and approaches of other staff due to low numbers of staff. There was a task focussed culture at the home, positive, caring relationships between staff and people who lived at the home had not been developed.

People were not always treated with dignity and respect. There was limited interaction or conversation with people during personal care or when supporting people with other activities. People were not spoken about in a dignified or respectful manner and people were not listened to.

People were supported by staff who did not have guidance on people's current needs and how they should be supported. Care plans did not reflect people's current or changing needs and many had not been reviewed or updated. People were at risk of inappropriate care.

Although assessment, auditing and monitoring of the service took place, this was limited, insufficient and not designed in a way to address existing shortfalls and make improvements. As a result, people's safety and the service they received was compromised.

The provider had not ensured that there were clear lines of responsibility and accountability at all levels. Leadership was poor and staff were not fully aware of what was expected of them.

The provider had not changed their practice in relation to issues raised in complaints and actions had not been identified to prevent similar concerns being raised.

The home had been without a registered manager in post for eight months and this lack of leadership had significantly impacted on the quality of care that people had received. At the time of our inspection a manager had been appointed and an application for the registered manager position had been submitted to the Care Quality Commission.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Safeguarding incidents were not being recognised and reported to the relevant authorities and to the management team.

There were not enough staff to meet people's needs and keep them safe.

There were no effective risk assessments in place which Identified and managed the risks to people living at the home.

The provider failed to protect people who used the service against the risks associated with the safe management of medicines.

### Is the service effective?

**Inadequate**

The service was not effective.

People were not supported by staff who had the appropriate level of knowledge and skills to carry out their role. Staff did not receive adequate support, supervision, appraisal and training as was necessary.

The service did not always seek consent in line with legislation and national guidance. Staff did not fully understand their responsibilities with regard to the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People were not supported to eat and drink enough to maintain a balanced diet. Monitoring of people's food and fluid intake where they were at risk was incomplete and inaccurate.

### Is the service caring?

**Inadequate**

The service was not caring.

Staffing levels and the task-oriented culture at the home meant it was very difficult to foster positive, caring relationships between

people who lived at the home and staff.

Lack of adequate information about people had led to inconsistencies in the care delivered to people.

People's privacy was respected during personal care interventions, however staff were observed to discuss sensitive, personal information about people within earshot of other service users.

We found examples of people who has suffered distress and undignified treatment.

People and, where appropriate, their relatives were not routinely involved in making decisions about the care and treatment provided.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People and, where appropriate, their relatives had not been involved in planning care and, as such, people's individual preferences had not been explored or taken into account when care was planned.

Assessments of people's needs and associated care plans had not been reviewed regularly and did not reflect people's current care needs.

Activities provided within the home were minimal, as was access to the community. Staffing level had meant the activities coordinator had been used to deliver care tasks rather than activities.

The provider had not changed their practice in relation to issues raised in complaints and actions had not been identified to prevent similar concerns being raised.

## Is the service well-led?

**Inadequate**

The service was not well-led.

There had not been a registered manager in post for nine months.

There were not clear lines of accountability and responsibility at each level of the organisation. Staff were unsure about what was expected of them and leadership from senior members of staff was seen to be poor.

There was a lack of an appropriate governance and risk management framework and this resulted in negative outcomes for people who used the service.

The service did not operate effective systems to assess, monitor and improve the quality of the service provided.

The culture in the home was task rather than person focused. Poor practice went unchallenged and little was done to ensure that people received the safe, consistent and good quality care.

# Nazareth House - Northampton

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected the service on 1 and 2 March 2016. The inspection was unannounced.

The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and assessing whether statutory notifications had been received. A notification is information about important events which the provider is required to send us by law.

During the visit we spoke with twelve people who lived in the home and carried out observations in the home. We spoke with the relatives of one person and one visiting health professional. We spoke with eight members of care staff, two catering assistants, the head cook, the kitchen manager, three volunteers, the hairdresser, one senior carer, two team leaders and the manager.

We observed how care and support was being delivered in communal areas of the home and observed the interactions between staff and people who live in the home. We also completed a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of twelve people who used the service, medicines records, staff training records, seven staff recruitment files as well as a range of records relating to the quality and monitoring of the service.

Inadequate

# Is the service safe?

## Our findings

People were not protected against the risks of avoidable harm and abuse. Safeguarding policies and procedures were not consistently understood and followed in practice, this exposed people to the risk of abuse, neglect and omission in care because poor practice was not challenged or addressed.

Staff had a basic understanding of their role and responsibilities to safeguard people from the risk of harm and or abuse. They were able to talk about the different types of abuse and the signs to look out for however most were unclear on internal and external reporting processes. The majority of staff said that they would tell the person in charge if they had any concerns or if they saw anything that worried them. It was however worrying that a team leader outlined how they would immediately investigate any matter that was brought to their attention and failed to recognise that they would need to report the matter to the management team, the Local Authority safeguarding team and the Care Quality Commission (CQC), so that an independent investigation could be undertaken. Most of the staff spoken with were unclear about the role of external agencies in the investigation of safeguarding matters and did not realise that they could raise concerns directly with the Local Authority or CQC.

One staff member told us that they had used the internal safeguarding processes to raise their concerns about the way in which medicines were managed and they had concerns that some people were not always supported to take all of the medication that they were prescribed. They felt that this matter had not been taken seriously as nothing had changed and there continued to be poor practice in this area.

It was not possible to ascertain whether all safeguarding concerns or incidents had been report appropriately under the safeguarding procedures, this was because of the chaotic nature of the record keeping in the home. For instance medication records indicated that one person may have been given double doses of pain relieving medication; there were numerous occasions where it could not be confirmed whether people had received their prescribed medicines; care records indicated that one person had a grade 3 / 4 pressure ulcer which would have required a notification to CQC, however this information that was recorded was incorrect and it was confirmed that no one actually did have a pressure sore of that level. Staff told us of incidents where a person who lacked capacity to safely care for themselves in the community had almost walked to the main road before staff realised they had left the building. None of these instances were recognised as potential safeguarding concerns and had not been escalated internally or reported to CQC or the Local Authority.

Although most staff stated that they had received training in safeguarding people during employment either in this home or in their previous employment their understanding and competencies in this regard had not been assessed.

This was a breach of Regulation 13 (1) safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, visitors and staff told us there were not enough staff to provide the support to people and we

observed that there were not enough staff to meet the needs of people living in the home. The provider had not implemented a systematic approach to determine the number of staff and the range of skills required in order to meet the holistic and current needs of people living in the home. The dependency levels and care requirements of people were not taken into account when developing the rotas for individual units; instead staffing levels were based on the number of people living in each unit rather than on their care and support needs. In addition the role, skills and competence of staff had not been considered when developing rotas and the staff skill mix was insufficient to ensure that people received all aspects of their care in a timely and competent way.

The manager confirmed and records evidenced that there were two staff working in the capacity of team leaders and two staff in the role of senior carers; these levels are significantly (50%) lower than the number that had been identified by the provider as being necessary. Throughout our inspection we saw that these staff were rushing around from one area to another and that they were often covering a minimum of two areas and at times were covering the whole home. They held responsibility for key aspects of care provision including risk management, care planning, medication management, record keeping, oversight of care practices and for some aspects of staff supervision and management. However most of these responsibilities were not being achieved in a consistent way and this exposed people to unnecessary risk. A team leader said "There is not enough time to do everything; sometimes we only meet people's basic needs and even then they have to wait for staff."

We saw that staffing levels were impacting on most aspects of care provision and there were a number of areas where the quality and safety of the care provided were being compromised. In all units across the home we saw that people were only having their very basic personal care needs met and that at times they had to wait significant periods of time to be attended to. One staff member said "We just can't get to everyone at the right time and some have to wait a long time; it breaks my heart when I have to tell them they will have to keep waiting and to see them getting distressed".

On each unit within the home we saw that there were people who needed two staff members to safely attend to their personal care and movement and handling needs. The staffing levels did not allow staff to provide this level of care and at the same time ensure that other people in the general areas of the home were supported and supervised. We saw that calls bells were often ringing for long periods before staff were able to attend to them; we saw several occasions in all units where there were no staff visible and people had been identified as at risk falls. We observed occasions where people were in dining rooms eating food and where no care staff were present and people were identified as at risk of falls and choking. This put people at risk of unsafe care and treatment.

In one area of the home there were nine people were being cared for and all had care needs associated with dementia, including confusion, wandering and behaviours that may place them at risk. All required high levels of supervision to keep them safe. Three people regularly needed two staff to ensure safe movement and handling and to ensure that their personal care needs were safely met. During both days of our inspection two care staff were allocated to this unit and although a team leader administered medication no other support was available. We observed that both staff were often engaged in caring for people in their rooms and that other people in the unit were regularly left unsupervised or waiting for their care to be delivered. We saw that people in the general areas were wandering without supervision and others were becoming agitated and unsettled and there was no staff available to reassure them.

Staff in all units talked to us about their personal anxieties and frustration about not being able to care for people safely and in a timely way. "We can't support people in the way that they always need; we are so busy people have to wait; we can only do the basics but really we need to do more; we can't supervise or spent

time with people; it's very hard".

This was a breach of Regulation 18 (1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not consistently receive the medicines that they had been prescribed which exposed them to unnecessary risk of harm. The systems in place to manage medicines were fragmented and ineffective. Team leaders and senior staff were responsible for the administration of medicines within the home and all stated that they had received training to prepare them for this responsibility. However the practice that we observed and the records that were maintained highlighted a number of inadequacies in medicines administration practice.

Stock control practice and administration practice was unsafe. We found in several open offices where medicines were stored in open cupboards and fridges. There were no records of these medicines and staff showed little regard to the fact that these areas were easily assessable to staff and people living in the home, including those with dementia related needs. These medicines included medicines for pain relief; management of epilepsy and antibiotic medicines. Although these concerns were raised on the 1st day of our inspection we observed that six days later no effort had been made to ensure the safe and secure storage of medicines.

Medication administration records (MAR) had not been appropriately completed and there were many examples where people were prescribed medicines to be given on a regular basis yet the records and staff were unable to confirm whether these medicines had been given or not. There were examples where MAR records had been completed to confirm medicine had been given yet the staff themselves told us that this was not correct and that the medicines had not in fact been given. We observed staff signing for medicines before they were administered, in one instance the MAR had been signed for however the person refused to take the medicine. Staff told us that the same person regularly refused their medicines yet the MAR sheet did not record these refusals. A team leader told us that although they recognised that this was not safe or appropriate practice, that this was common and the way it was done. They failed to recognise the risk to people when medicines records could not be relied upon to aid monitoring or review of people's health care needs.

One care staff had been so concerned about medicine practice in the home that they had made an internal safeguarding alert in this regard. They told us that practice had not however improved and that they regularly found medicines on the floor or in people's clothing. We were informed that a relative had found medicines in an administration cup in their relative's room. Their relative had a dementia related condition and was dependent on staff to administer their medicines. When they looked at the medicines their concerns increased as the tablets were not their relatives prescribed medicines. Prior to our inspection we had received information raising similar concerns with us about the way in which medicines were being managed.

Care staff told us that at least one person had their medicines administered crushed and added to their food as the person concerned would otherwise refuse their medicines. There were no assessments, records or authorisation for this person to have their medicines administered in this way and a team leader we spoke with told us they were not aware that any person living in the home had their medicines administered this way.

On both days of our inspections we saw that the morning medicines were not administered to some people until late morning. This meant that the time frame the administration of medicines was not in line with the

frequency prescribed and that people's health related needs were at risk of inappropriate management. A team leader told us that this was the normal pattern and that they were unable to get to some people earlier due to the pressure that they were working under.

This was a breach of Regulation 12 (2g) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities)

People were not supported by staff who managed, assessed and reviewed risks associated with their care and treatment. There was a range of basic risk assessments in place, however, most risk assessments did not contain a level of risk rating, what actions needed to be taken or reduce or mitigate the risks identified and risk assessments were not reviewed; in some cases for nearly 24 months.

Peoples changing needs had not been identified in risk assessments and this left people at risk of unsafe care and treatment. Some people who required support with mobilising and changing position did not have safe handling procedures in place to guide staff on how to safely support people and what equipment had been assessed as appropriate for that person. One team leader who told us they were a moving and handling assessor confirmed that they had not completed any safe moving and handling assessments on a person who required full support to get out of bed and change position with the use of a hoist and an appropriate hoist sling. The team leader said "I know there should be a plan in place but we just don't get the time to complete them."

People who had been identified at risk of falls were not monitored and on many occasions over the two days of inspection were able to wander the building without staff being aware of their location. Falls risk assessments had not been updated after people had recent falls and accident and incident records evidenced that care plans and risk assessments had not been updated after incidents and no further action had been taken. Where actions had been taken by staff to reduce the risks to people i.e. crash mats on the floor when the person was in bed, these actions had been implemented by the individual staff member rather than a planned, consistent approach or agreed plan of action.

One team leader we spoke with said that they were not aware that any members of the management team reviewed accident records to monitor for any trends in incidents. The manager confirmed that at this point in time there was no overview and no active monitoring of accidents and incidents although the computerised records system that is in place does have the capacity to provide an overview.

Staff informed us that some people were at risk if they left the home independently, we saw that these people were not being regularly monitored or appropriately supported. We saw on many occasions' people who were at risk standing near the front door of the home and no staff in the vicinity. The door opens with a push of a button. We were aware of an incident before the inspection where a person who was at risk of leaving the home independently because of their lack of awareness of safety had left the home and managed to reach a neighbouring property before staff were alerted from a member of the public. The manager has informed us that action has been taken to address the issue with the easily accessible front door and the risk this can pose for some people; however it has been six weeks since the first reported incident and this area of concern remains and puts people at risk of harm.

This was a breach of Regulation 12 (2a)(b) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities)

Records confirmed that robust and appropriate recruitment practice was followed and staff only commenced working in the home when all references, checks and processes had been completed. Staff we

spoke with confirmed they received all the appropriate checks and could not commence working at the home until these were in place.

Inadequate

# Is the service effective?

## Our findings

People were not supported by staff who understood their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments had not been completed for people who may have been unable to consent to their care and treatment, best interest meetings had not been held with people's relatives and those involved in their care support to record that care and treatment was being delivered in their best interests.

Some people consented to their day to day care and treatment and we saw some staff offering people choices and explaining what they were doing or what was going to happen next; however this practice was not consistent. We saw people who were not given a choice about whether they wanted to leave the dining table and with no conversation were taken away to another area of the building. We observed meals taken away from people at the dining table with no discussion about whether they had finished their meal. We saw another person who was moved in a wheelchair to a lounge area and again, no conversation was held this person and the person was placed in such a way that they were left looking at a wall rather than being positioned so that they could interact with others or watch the TV. The person was left like this until another member of staff noticed and turned them around and had been given no choice in this matter.

We observed a person who was resting in bed be interrupted by a maintenance person and an external contractor measuring the floor space in the bedroom. This person was not asked if the people could enter the bedroom, no conversation was held with this person and their consent was not sought to carry out the activity they were undertaking. At one point it was noted that the contractors clip board was placed on the persons bed, again without any discussion or apology given to the person concerned.

People who staff told us were at risk of leaving the building unaccompanied did not have mental capacity assessments in place to evidence that the person did not have capacity to keep themselves safe outside of the building. They explained that they would not allow these people to leave or would support them to return if they did leave the building. No DoLS authorisations for these people had been submitted to the Local authority to assess and evidence that people needed to be deprived of their liberty, that it was in their best interest and it was the most least restrictive options available. The provider was not acting within the law of the Mental Capacity Act 2005 and associated codes of practice.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

This was a breach of Regulation 11 (1) need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had received training on how to provide safe treatment and care for people and records confirmed this; however, the staff did not effectively apply the knowledge and skills gained when carrying out their roles and responsibilities. Staff had received training on the safe handling of medicines but did not administer medicines safely, record accurately on the medicine administration records or use the appropriate codes for when medicine wasn't administered. Staff confirmed and records showed that staff had received training on safeguarding people from abuse. However, it was clear that some staff did not know the correct procedures for reporting their concerns and in some cases did not recognise that their concerns needed to be reported. Staff told us that at times they did not act on their concerns as they did not want to get other staff into trouble. This put people at risk of harm and unsafe care and treatment. A team leader confirmed they had received training on assessing the safe handling of people; however, they had failed in their duty to assess and record the safe handling procedures for at least four people.

People were not supported by staff who received guidance and support and formal supervision. Staff at all levels told us that supervision had not taken place for a long time; some staff more than eight months previously and in other cases people could not remember ever receiving supervision to assess their competencies and receive support and guidance . There had not been a manager in post for eight months and this had impacted on the opportunity for staff to receive formal or informal supervision. Team Leaders who supervised other staff told us they were aware that they should be supervising staff and completing competency assessments of their care practice but said they didn't have the time. One team leader said "I know what we should be doing but we never get the time to sit down with staff and offer supervision; any spare time that we do have is spent helping in other areas of the home with caring for people." Staff appraisals were not in place consistently for all staff.

The negative culture of the staff working in the home, the lack of leadership and the addition of not enough staff to support people resulted in poor care practices that had become unchallenged. Although staff had received training on all of the provider's mandatory training courses they failed to put this in to practice on a daily basis, failed in their duty to provide supervision and support and assess the competency to ensure standards were maintained.

This was a breach of Regulation 18 (1) (2) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to have enough to eat and drink. We saw at lunch time on both days of our inspection that some people were only given half a glass of juice which was a small wine glass. People were not offered more to drink and some people had their drink removed from the table without being asked or encouraged to drink more. Drinks were not readily available in communal areas of the home. We observed meals taken away from people without people being asked if they had finished their meal. On one occasion we observed care staff place a dessert in front of a person who appeared sleepy and did not attempt to waken the person to ask if they wanted their dessert it was assumed that they didn't want it and it was taken away again.

There was no systematic method in place to consistently identify those people who were at risk of not eating and drinking enough. Although we saw that Malnutrition Universal Screening Tool (MUST) were in place within most people's case files we found that these had not always been completed appropriately. Where the assessment had been completed the risk scores had not always been totalled or used to formulate a focused care plan. None had been reviewed or updated to reflect peoples changing needs and many failed to reflect the current needs of people living in the home.

Records relating to people's daily intake of food and fluid were not consistently completed and staff told us that records could not be relied on as an accurate record of people's food and fluid consumption. Daily food and fluid monitoring charts revealed that one person at risk of not eating and drinking enough had eaten one biscuit, one piece of cheese and 200ml of fluid in a 24 hour period. Another person also at risk had recorded they had eaten one sandwich, one piece of cake and 200ml of fluid in 24 hours. Staff did not believe these records to be accurate but were unable to ascertain what the person had eaten or drank.

Records showed that another person who was identified at risk of not eating and drinking enough at risk ate one sandwich, one piece of cake and 200ml of fluid; again staff were unable to be sure if this was a true reflection of what the person actually consumed. There were no records for these two people that documented why and when they were identified as being at risk of poor nutritional and fluid intake; staff told us they were because they had been unwell.

It was clear and staff confirmed that no-one had any oversight of people's nutritional intake and there was no system in place that could provide assurances that people's nutritional and hydration needs were being met; this put people at risk.

Kitchen staff were knowledgeable about people's dietary needs and knew if people required their food to be pureed if they had difficulties chewing or swallowing food, meals were fortified with high calorie foods such as cream and butter for those people who were identified as requiring this extra nutrition. The kitchen staff relied on their own knowledge of people and from guidance from care staff about people's dietary needs; this information was not written down for kitchen staff to refer to and there was a risk that kitchen staff were not informed about peoples changing dietary needs.

This was a breach of Regulation 14  Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, staff and records showed that people living in the home had access to healthcare professionals. One person said "I am registered at the local doctors surgery and I can see my doctor if I need to." We spoke with a visiting district nurse who visits the home but not on a regular basis, they told us that staff appeared to know people's care needs and staff were always approachable and friendly. However due to the inaccuracies in peoples care records and the poor monitoring of peoples overall health needs we were unable to be confident that people were referred to health professionals in a timely manner.

Inadequate

# Is the service caring?

## Our findings

People were not always treated with kindness and respect, we did however see some genuine moments where individual staff treated people with kindness and compassion and engaged in conversations and activities that were meaningful to people.

Most care staff knew the people that they were caring for well and could tell us about their care needs and how they liked to receive their care and support. However, all grades of staff told us and we observed that staff did not have the time to spend with people to ensure all of their needs were met.

People were not always listened to and they told us this was a regular occurrence. One person made a statement after lunch which any member of staff regardless of grade or position should have responded to; however, there were two care staff in the room and no one responded to the person's statement. We were immediately concerned by what the person said and the risks involved and asked the person to clarify what they had said, they told us "I was only joking; I just say things sometimes to see if any staff are listening to me; and as always they are not." The same person was asked at the end of lunch if they had finished their meal, they responded that they had, they then went on to say that they couldn't finish the meal because they felt a little unwell; however, as the person said yes the staff member just withdrew the person's plate and walked away without responding to the rest of the conversation which was clear for everyone to hear.

Meal times were task focussed and staff did not enhance people's experiences by making it in to a social and interactive time of day. In one area of the home the dining room was a large room with tables set out in a way that didn't encourage people to have conversations with other people that lived there. There was no atmosphere, no-one was chatting and engaging in conversations and the staff walked by people's tables were not acknowledging them or making the experience a positive event. In another smaller area of the building we observed a similar experience of no atmosphere, no conversations and it appeared to be a sombre experience for those people living at the home. The dishwasher was positioned in a kitchenette and was quite loud when it was in operation and while people were eating their meals all that could be heard was the sound of the dishwasher. We did observe some positive and caring interactions from the kitchen assistant in this smaller area of the building that was observed to be welcomed from the people dining in this area of the building.

During our inspection we observed care in all areas of the home and saw a number of occasions when care staff failed to treat people with care or dignity. We observed that one person was sitting in their bedroom and that there was a very strong odour associated with incontinence in the room; we saw that they were visibly agitated and unsettled. A member of care staff told us that they due to work pressures this person had been heavily soiled before staff could attend to their personal care needs and that they were now so agitated that they were struggling to cooperate with staff attending to their needs. The care staff told us that they had dressed the person in their day clothes but that they had not been able to wash or attend to their personal care.

One person who had just had their personal care needs met was brought into the lounge area and moved

into a lounge chair. We observed that staff did not talk to this person and that they left the area without ensuring that the person had their hearing aid fitted. The person tried several times to get staff attention and was waving the hearing aid seeking their help; the care staff in the area did to notice or respond. Eventually the activities coordinator attended to the person and fitted the hearing aid for them.

We observed that a person living in the home who was being cared for in bed was disturbed by a maintenance person and an external contractor. They entered the person's bedroom without knocking, gave no explanation or introduction and commenced measuring the bedroom for carpets. Whilst doing so they pulled the tape measure across the person's bed and placed their clip board directly on the bed. They did not converse with the person who was in bed at any stage and then left the room without giving any form of explanation or apology to the person.

We observed that one person was approached from behind by a member of the care staff team; they proceeded to place an apron on them. The staff member did not inform the person what was going to happen and as the apron went over their head it became caught in the person's mouth; the care staff was not aware of this until the person called out in distress.

One member of staff was referring to people by the equipment that was being used to care for them i.e. hoists; we asked for clarification from the staff member whether they were referring to a piece of equipment or to a person, they confirmed they were talking about people.

It was clear from our observations that some poor practice was a direct result of not enough staff to support people with their care needs; however, the culture of the staff team and the lack of leadership impacted so greatly on people who lived at the home that the staff did not recognise how task focused and uncaring their actions had become.

This was a breach of Regulation 10(1) Service users must be treated with dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

# Is the service responsive?

## Our findings

The assessment and care planning processes in place were disorganised, inaccurate and left people at risk of receiving inconsistent or inappropriate care.

Although there were a range of risk assessments available within the home we found that these had been poorly completed and failed to guide staff in the consistent provision of safe care. Where care plans were available we found that they did not describe people's current needs or how these should be met. Four peoples care needs had changed so much in the previous twelve months that the care plans in place for these people had no resemblance to the person's current abilities or care needs. For example the care plan stated that they were mobile when in fact they were unable to walk, were dependent on hoists and wheelchairs and in some cases could not stand without staffs support. Numerous staff at different grades confirmed that the records we were reviewing were the most up to date records available; however they all acknowledged that the care plans did not reflect people's current needs or the way which they were currently cared for. Staff told us that they did they cared for people in the best way that they knew. However this meant that care was provided based on individual staffs instincts or perception of how to care for the person concerned rather than on an agreed and consistent plan of care.

Some people had life history books which should have contained information which would help staff have a better understanding of people; however, we found that most books had only been partially completed. We brought this to the attention of different grades of staff and they told us that they never referred to these books to help guide them in delivering person centred care; two staff said they knew they were there but said they had never had time to read them or to help a person add more information to them.

Staff were observed to be working in a task orientated rather than a person centred way; they showed little attention to the people's choices in relation to care provision and we saw many examples where care was provided without interacting with or involving the person in anyway. This meant that people did not always have their needs responded to in the way they preferred or in a way which considered their individual needs or preferences. A person sat at the dining table when they had finished their lunch told us, "I dread the day when I can't do things for myself and I am treated like other people in here; this person next to me will still be left at this table in an hours' time until staff decide to move them away from table, they won't ask to be moved because they know the staff are too busy." We observed that the person had been seated at the dining table for a total of nearly two hours before they were moved away from the table; not by care staff but by the activities coordinator who noted that they were still sat at the dining table. Another person told us "I can't get out on my own anymore to go for a walk; if I ask the staff they tell me they are too busy or they will take me outside in the summer."

People's care needs were not kept under review to ensure that any changes in their health and wellbeing were recognised and responded to. People who were at risk of developing pressure sores and general health deterioration were put onto the 'red tray system' and staff told us that this indicated that the person needed to be monitored carefully with their nutritional intake. However there was little evidence to confirm that these people received the level of monitoring and support they needed. Staff did not have a clear overview

of people's observations and records were poorly maintained, inaccurate and could not be relied upon.

This was a breach of Regulation 9(1)(2)(3) Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were inconsistencies in how people's concerns and complaints were dealt with and learning from complaints had not been embedded into the practice of the home. People said that they were aware that they could raise a complaint however stated that as there had been so many changes to staff and management that there was no focal point to do so and they were not confident that they would be listened too.

A member of care staff told us that a family member of person living with dementia had complained about the way their medicines were managed yet the same issue kept occurring. However the staff member had not formally escalated this to the management of the home so that the matter could be formally addressed. They said that the family would inform management when they were ready to do so and failed to recognise their responsibility to escalate this matter.

Where complaints were formally brought to the attention of management we saw evidence that they had been investigated and responded to, however we saw that practice did not improve and the same issue continued to occur. For example a complaint had been received about lack of support when someone was transferring to a new bedroom and how pictures had not been positioned on the wall and the television had not been tuned in. We saw that the same issues were being experienced by a person who was newly admitted to the home and although they had been living in the home for four weeks these matters had not yet been addressed

We saw a plan of activities displayed in various parts of the home. The included quiz nights, craft activities, bingo and musical entertainment. There was a recently appointed activities coordinator in post who was motivated and had a range of ideas to involve people in planned activities. However, we saw that the activities coordinator was often busy responding to peoples care needs because there were no other staff in the vicinity to respond to people. People did not always get involved in activities because the lack of care staff available to support them. One person told us "We don't get told what activities are happening, how can I join in when I don't know about it." Care staff told us about a musical entertainer who comes in to the home on a regular basis and said that people really enjoy the session. Throughout the two days of our inspection we saw long periods of time where people were not stimulated and no activities were offered, the activities coordinator told us "I can only be in one place at once and I can't manage too large a group because there is no other staff available to support with the activities."

Mass was held daily in the homes own chapel; we observed that some people were supported to mass although it appeared to be that it was only those people who could attend without staff support. One person said "I would like to go to mass but the loop system (Assists with people hard of hearing) is either not switched on or doesn't work so I don't go anymore." We asked the person if they had given this feedback to staff and they said "How many times do I have to tell people for them to listen; I've given up and just keep myself to myself now."

Inadequate

# Is the service well-led?

## Our findings

The service had been without a registered manager for eight months. A manager had been appointed to the role and had been working in the home for approximately four weeks prior to our inspection. An application had been submitted to the Care Quality Commission to appoint this person as the registered manager. All staff we spoke with said they were hopeful that the new manager would be a positive addition to the team and felt that they would be able to lead the service to deliver better outcomes for people.

The registered provider had failed to implement effective governance systems or processes and had not effectively assessed, monitored or driven improvement in the quality and safety of the care being provided in the home. Although the providers own internal processes have identified concerns about the adequacy, safety and quality of care they had failed to take the necessary action to drive improvement and secure compliance in relation to the regulatory requirements. This meant that people living in the home were exposed to unnecessary and unacceptable levels of risk.

Internal audits completed in January and February 2016 identified that significant improvements were required in relation to the documentation, record keeping, accident monitoring, staff supervision practice, medicines management, completion of mental capacity assessments and the need for consent to care to be recorded and evidenced. However the overall grade applied was adequate and although action plans had been developed to drive the improvements required; the actions had not been taken and had been carried over from one month to the next. During our inspection on 1 and 2 March 2016 we identified that these matters remained unaddressed. Our inspection findings shown systemic failings across most of the systems and processes in the home; there were failings in all areas of the home and the approach to the delivery of care lacked compassion and empathy for the people living at the home.

It was evident that the absence of a registered manager had resulted in a break down in the operational and managerial infrastructure and oversight of the home. Staff were providing care based on their personal knowledge and instincts, there was no overarching vision about the way in which care should be provided and this impacted on the safety, quality and continuity of the care provided to people in the home. Risk management and risk mitigation systems and processes were not being utilised in day to day practice and people were being exposed to unacceptable and unnecessary levels of risk and harm. Risks to people had not been appropriately assessed, monitored, reported or recorded and the risk of reoccurrence was high.

Staff were not receiving the supervision, direction or structure that they required to provide good care and many of the staff told us they were unhappy and discontent with the way in which the home was being managed. Although they felt supported by their colleagues they were consistent in their view that the senior management of the service was not listening or taking their concerns seriously. All grades of staff were working under a great deal of pressure and there was no evidence that the adequacy of the staffing levels had been considered based on the needs and dependency levels of people currently living in the home. This was having a direct impact on the adequacy of the care provided to people living in the home and was fundamental to many of the regulatory failings identified at this inspection.

Staff, people living in the home and their relatives talked about the lack of managerial stability, the impact on staff turnover and the lack of coordinated and safe care. People felt that there was no focal point in terms of raising concerns. Staff who had tried to utilise the internal reporting processes to alert the management to poor practice in the service, reported that they had not been listened to and that the poor practice reported continued unchallenged.

Records relating to peoples care and treatment were not kept securely. Three offices were left unattended and unlocked on regular basis over the two days of inspection. In these offices we saw open and unlocked cupboards which contained people's confidential care records. In addition the records relating to the care and treatment of people were not fit for purpose. Records were not up to date and did not reflect people's current care needs. Four peoples care records were viewed, we saw that their care needs had significantly changed; some records showed that people were able to mobilise with the use of walking frame, however, their needs had changed so significantly that these people were now reliant on assistance of hoist to mobilise and change position. Care records did not reflect this change of needs. Multiple staff confirmed to us on the two days of the inspection that these were the most up to date records; however all told including team leaders told us that they simply did not have the time to update people's records and were not surprised about our on our inspection findings.

Staff and the manager confirmed that there was no overview of accidents and incidents to monitor for any trends or regular occurrences. We saw that there was no evidence that accident and incident records had been reviewed by any senior staff or members of the management team. We viewed accident and incident records with no recorded action taken including the option of updating care plans and risk assessments or referrals to other appropriate bodies.

Staff meetings were not planned and staff told us they could not remember when the last meeting was. Two staff told us that previously when staff meetings had been organised they didn't attend them because they found them to be of no interest. Minutes of staff meetings were not available upon our request on the days of the inspection, however we have been informed that minutes are available from a team meeting in December 2015.

The registered provider had a system in place to receive feedback from people using the service, their relatives and staff. The last time feedback had been sought was five months prior to our inspection and had been prompted by the previous registered manager. Although this highlighted some positive comments from relatives about the care and support their loved ones received at the home we could not be confident that this is how people felt about their care and support now. Feedback from the staff team in the survey nine months ago demonstrated that only 25% of the staff thought that morale was high in the team. We saw no evidence of completed actions to address the issue of low morale in the staff team.

The provider had failed to ensure that there were clear lines of responsibility and accountability at all levels. Leadership was poor and staff were not fully aware of what was expected of them. Care staff told us that other staff on the same grade did not respond well to advice and direction and "did their own thing" resulting in a divide between staff members. We were told of two occasions where staff had left their shift early which left the service short staffed and staff told us that on a regular basis groups of staff left the building at the same time for a cigarette break which again left people unsupported. Team leaders appeared to have limited leadership skills and did not direct staff accordingly; however, the team leaders themselves received no direction or regular support and guidance.

The culture of the staff working in the home was poor; and the negative culture in the home was so widespread that it impacted on all aspects of care provision and on all of the people who lived in the home.

Staff were not challenged on their behaviours and attitudes and this led to a continued and sustained negative environment for people to live in.

This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home was supported by a volunteer who supported people with baking, craft activities and provided opportunities for social interaction with some people who lived in the home. The provider worked closely with The Princes Trust and they provided volunteers which were currently being used to also support people with social activities.

Meetings were held with 'The friends of Nazareth House' which consisted of a group of people who were relatives, Sisters and interested parties who discussed social activities planned throughout the year, ideas for fundraising and future projects. Minutes of these meetings were available.

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<br><br>The provider did not ensure that the care and treatment of service users must were appropriate, met their needs or reflected their preferences. Regulation 9 (1) (2) (3) |

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider did not ensure that service users were treated with dignity and respect. Regulation 10 (1) |

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider did not ensure that care and treatment of service users was only provided with the consent of the relevant person. Regulation 11 (1) |

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not have systems in place to |

assess the risks to the health and safety of service users receiving the care or treatment and did not do all that was reasonably practicable to mitigate any such risks. Regulation 12 (2a and2b)

And

The provider did not ensure that there were proper and safe management of medicines. Regulation 12 (2g)

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Service users were not protected from abuse and improper treatment as the provider did not have sufficient processes in place for staff to recognise and report suspected abuse. Regulation 13 (1) |

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The provider did not ensure that nutritional and hydration needs of service users were met. Regulation 14 (1) |

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not assess, monitor and improve the quality and safety of the services. Regulation 17 (2a)<br><br>The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (2b) |

| | |
|---|---|
| | The provider did not maintain secure records relating to service users. Regulation 17 (2di and ii)<br><br>The provider did not seek and act on feedback from service users for the purposes of continually evaluating and improving such services. Regulation 17 |

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's assessed needs. Regulation 18 (1) |

**The enforcement action we took:**

We imposed conditions on the provider's registration to prevent any further admissions and placed the service into special measures.