Care Quality Commission

Nazareth Care Charitable Trust

Nazareth House - Manchester

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 – Manchester is a care home registered to provide nursing and residential care for up to 66 older people. At the time of inspection 65 people, some who lived with dementia, were receiving support.

People's experience of using this service and what we found
A lack of provider oversight impacted the ability of the service making the required improvements. The provider's inspection history demonstrated improvements had not been sustained and embedded.

Since our last inspection the provider had made limited progress in addressing the concerns, we found with the management of people's medicines. Although regular audits were taking place, these were not effective at highlighting the shortfalls and we found continued breaches of regulation during this inspection.

Systems in place were not effective enough to support the safe management and administration of medicines. This resulted in some medicines running out of stock and documentation connected to medicines was not always accurate. This placed people at risk of harm from unsafe practices in relation to the management of medicines.

Processes and systems in place to oversee the safety of the home were not always effective. The provider failed to ensure the home's three passenger lifts received their recent examination due to outstanding essential checks not taking place. The provider decided to suspend the passenger lifts until the works had been completed.

Sufficient numbers of staff continued to meet people's individual safety and support needs. A small number of agency nurses worked at the home, whilst two new permanent nurses awaited their final employment checks to be completed.

The provider carried out checks before staff commenced employment to ensure their suitability to work with people. People received support from a consistent staff team who knew them well.

Risks relating to infection prevention and control (IPC), including in relation to COVID-19 were assessed and managed. Staff followed good infection, prevention and control (IPC) practices. They had access to the required personal protective equipment (PPE), and they used and disposed of it safely.

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

Rating at last inspection
The last rating for this service was requires improvement (published 1 January 2020). At the last inspection we issued the provider with a warning notice for Regulation 12. At this inspection we found persistent issues connected to the homes medicines and the home remained in breach of regulations 12 and 17. At this

inspection improvements had not been sustained and the provider was still in breach of regulations. The service has deteriorated to inadequate.

Why we inspected
A decision was made for us to inspect, examine and follow up what improvements had been made since the last inspection in December 2019. Due to the COVID-19 pandemic, we undertook a focused inspection to only review the key questions of Safe and Well-led. Our report is only based on the findings in those areas reviewed at this inspection. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this 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.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to the management of medicines and good governance.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 six 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our safe findings below.	**Inadequate**

Care Quality Commission

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 Care Act 2014

Inspection team
The inspection was carried out by two inspectors, a medicines inspector and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience gathered the views of people during the inspection and spoke with relatives over the telephone while at the home.

Service and service type
This service is a care home. It provides accommodation and personal care to people living at Nazareth House – Manchester. The service had a manager registered with the Care Quality Commission. 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. The registered manager was not present during our inspection visit.

Notice of inspection
This inspection was announced. We announced the inspection two hours before we visited to take account of the safety of people, staff and the inspection team with reference to the COVID 19 pandemic. We visited the service on 15 April 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authorities with whom the service works. On this occasion the provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with six people who used the service about their experience of the care provided and four of the people's relatives. We spoke with nine members of staff including the registered manager, the regional manager, deputy manager, one nurse, two senior care workers and two care worker and a housekeeper.

We reviewed a range of records, some remotely by asking the provider to send us key information prior to meeting with them. We reviewed three people's risk assessments and multiple health and safety records. We looked at two staff records in relation to recruitment. A variety of records relating to the management of the service, including a number of audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection, 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. We issued a warning notice about this. Although some improvements had been made in this area, we were concerned to still find ongoing failures connected to the homes medicines systems for the third consecutive inspection. Therefore, the provider was still in breach of regulation 12.

• Medicines continued to not always be managed safely. People missed some doses of their prescribed medicines because there was no stock available in the home for them. One person did not have pain relief available to them for 10 days and another person waited 15 days for their prescribed cream because the systems for ordering medicines was not robust.
• One person was administered eyedrops, for a week, which were out of date. People were given some doses of medicines at the wrong times because the nurses did not follow the manufacturers' directions carefully. Other people were at risk of being given does of their medicines too close together because nurses failed to record the time medicines were administered.
• Records about medicines including creams were not always accurate and could not clearly show they were administered safely as prescribed. A system was in place to make sure that medicines administered in a patch formulation were rotated safely but staff failed to rotate them in line with the manufacturers' directions.
• Written guidance was in place when people were prescribed medicines and creams to be given "when required" but the guidance was not personalised, and staff did not have the information to tell them when someone may need the medicine. When medicines were prescribed with a choice of dose there was no information about which dose to choose.
• Information was missing to help staff give medicines which needed to be given covertly (when medicines are hidden in food or drinks) or via a PEG (percutaneous endoscopic gastrostomy tube) safely.
• Most medicines were stored safely but medicines requiring cold storage had not been stored safely. The fridge temperature had been over the maximum recommended temperature for over two weeks.
• Waste medicines and oxygen were not stored safely in line with current guidance.
• The provider contacted us after the inspection and told us that, in response to our findings, they had implemented an action plan to improve medicines management in the service. We have not been able to test the effectiveness of the provider's action plan and we will review this at the next inspection.

Above was the evidence of a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and Treatment.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Aspects of the homes safety had not been addressed in a timely manner. Safety testing connected to the homes three passenger lifts had not been completed in a timely manner. The home decided shortly after the inspection to suspend the three passenger lifts until the works were complete. The passenger lifts are now back in order.
• The home undertook regular fire evacuation drills. However, the level of detail recorded from each evacuation drill was brief and didn't detail the outcome of the drill. Assurances from the management team after the inspection confirmed they would revisit the evacuation process.
• Risks were continually assessed and were safely managed. People's needs and abilities were assessed before they moved into the service. Potential risks to each person's health, safety and welfare were identified and known to staff.
• Accidents and incidents appropriately reported and recorded the necessary details. A monthly analysis was completed which provided an overview and enabled the provider to monitor what was happening in the service.

Staffing and recruitment
• There were enough staff to meet people's needs.
• The home was fully staffed in line with the tool used by the provider to calculate safe staffing levels. When possible, existing staff covered any shortfalls. At the time of the inspection the home was in the process of recruiting two permanent nurses, who were awaiting their final checks. In the meantime, they were using a minimal amount of agency staff to cover staff shortfalls.
• People told us there were always staff around to meet their needs. People we spoke with said they did not have to wait long for assistance. One person told us, "I could not survive if I couldn't live at Nazareth House. I just press my call bell and staff come straight away, I have panic attacks regular, and they calm me straight away."
•The provider and registered manager continued to follow safe recruitment practices to ensure that staff employed to work with people were suitable for their roles.

Systems and processes to safeguard people from the risk of abuse
• The registered manager and staff understood their responsibilities to keep people safe from abuse.
• Records showed that staff recorded and reported allegations of abuse to the appropriate safeguarding authorities. Outcomes were fully documented and included lessons learned, which was shared with all staff groups.

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 meeting shielding and social distancing rules.
• 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 accessing testing for people using the service and staff.
• 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.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. 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, there was a lack of proper oversight of the service, auditing and checking processes were not sufficiently robust. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service continued to be in breach of this regulation.

• In reaching our judgement whether Nazareth House – Manchester was well-led, we took into consideration issues identified at this inspection and the inspection history of the home. Continuing issues found at this inspection, together with the inspection history of the service and a failure to make enough improvements, showed the service was not well-led.
• Although the provider had auditing systems in place, we found some areas had been overlooked, which did not provide assurances the provider or registered manager had good oversight of the home.
• Previous recommendations made to the service to improve and embed quality monitoring systems had either not been implemented or sustained. This was the third consecutive inspection where we have identified shortfalls with the home's medicines and outstanding works connected to the safety of the home.
• Audits did not always effectively identify the shortfalls we found. For example, the medicines audit failed to identify the systemic issues found at this inspection.
• Environmental checks had not identified potential risks to the homes three passenger lifts and that essential works were outstanding.
• The most recent regional manager quality assurance checks in April 2021 did not explore the issues noted above and the regional managers were reliant on the data provided by the home managers. Therefore, no formal analysis or assessment was taking place to show how the provider was assuring themselves the systems in place were effective.

The provider failed to ensure there was a robust governance system in place. The checks, audits and systems in place were not used effectively to identify shortfalls, errors and omissions was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• Staff spoke positively about working at the home, comments included; "Yes they [management team] have been very supportive", "Definitely feel supported. If you have a problem, you're not worried about going to see the manager or the nurses. It really, really helps" and 'Yes I feel supported 100%. I can go to management no matter what, straight away, no issue."
• Relative meetings had been impacted upon by the COVID-19 pandemic. The registered manager informed us that an annual quality assurance questionnaire was due to be sent to people and their relatives and representatives seeking feedback about the service. Resident meetings were still taking place.
• Relatives we spoke with were happy with the service provided. One relative said, "I can't fault any of the staff from reception to carers to the manager."
• People and relatives told us they felt able to raise concerns and make complaints. We received feedback on various experiences of how these had been addressed.
• There was a statement of purpose and a service user guide. These gave people details of the facilities provided at this care home. These explained the service's aims, values, objectives and services provided.

Working in partnership with others
•The service was working in partnership with others. When people's health had deteriorated, the provider referred them to the relevant healthcare professionals.

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 provider had a complaints policy and procedure. Complaints the provider received were investigated and responded within the provider's required timescale. When mistakes were made this was acknowledged, apologised for and improvements made.
• The provider had met their registration regulatory requirements of notifying CQC of events when they happened at the service, this was a previous issue at our last inspection. The provider's inspection rating was displayed as required.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the safe and proper management of medicines.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there was a robust governance system in place. The checks, audits and systems in place were not used effectively to identify shortfalls, errors and omissions.

The enforcement action we took:

Warning notice