Nazareth Care Charitable Trust

Nazareth House - Cheltenham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Nazareth House – Cheltenham on the 20, 22 and 26 June 2018. Nazareth House - Cheltenham is registered to provide accommodation and personal care to 63 older people and people living with dementia. We carried out this inspection following concerns raised about the service by healthcare professionals.

At the time of our inspection, 55 people were living at Nazareth House - Cheltenham. Nazareth House - Cheltenham is based in Charlton Kings in Cheltenham. Nazareth House is a large building based on three floors. The home is attached to a chapel and accommodation used by the Sisters of Nazareth. The home has large grounds which people could enjoy, included a wooded pathway and extensive patio. Many of the people living at Nazareth House, chose the home to enable them to continue meeting their religious needs. This was an unannounced inspection.

We previously inspected the home on 17 August 2017 and rated the service as "Good". At the inspection in August 2017 we rated the key question 'Is the Service Responsive?' as "Requires Improvement" as we found additional improvements were required to ensure people's care plans were person centred to their needs. At our June 2018 inspection we found improvements had not always been made and sustained. We found multiple concerns relating to; the quality of care people received.

This is the fifth inspection of Nazareth House - Cheltenham where the service has been rated. At four of these inspections the service had failed to meet all the requirements of the relevant regulations. The registered manager and provider had not demonstrated that they were able to consistently meet the requirements of their registration and operate effective systems to ensure that Nazareth House – Cheltenham met the requirements of the Health and Social Care Regulations. Therefore we have rated the key question 'Is the service well-led' as 'Inadequate'.

There was a registered manager in place at Nazareth House - Cheltenham. The registered manager left the service shortly after our inspection, however was available on all three days of our inspection. A registered manager is a person who has registered with the Care Quality Commission 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 told us they were safe living at Nazareth House - Cheltenham. However, we identified shortfalls that impacted on people receiving safe care. People had not always received their medicines as prescribed. Care staff responded to people's changing needs and health and worked closely with people's GPs. However, they did not always document the support they provided people and did not always follow care plans to ensure people would always receive care that met their needs and kept them safe.

There were enough staff deployed to ensure people's health needs were being met but staff sickness had led

to shortages which impacted on people receiving person centred care, including access to baths when they wanted. We recommended that the service seek advice based on current best practice, around how to use staff most effectively.

People's privacy and dignity was not always respected and protected. Care staff did not always ensure people were cared for in private, by closing their bedroom doors. Care staff did not always effectively communicate with people living with dementia and did not always speak to people in a caring and compassionate way.

Staff felt they had the skills they needed to meet people's needs. The registered manager had no overview of the training their staff required. Staff told us they had not always received effective support including one to one meeting with their line manager, and there was no clear record of the support staff had received to aide their professional development. Care staff felt they had all the training and support they required to meet people's needs, however some care staff expressed concerns about staff practices.

The registered manager and provider had systems to monitor the quality of care people received at Nazareth House – Cheltenham however these had not always been effective. Audits were not always effective at identifying concerns in relation to staff performance, the support and training staff received and the management of medicines that we found. Following our inspection, the area manager and registered manager provided us with a list of actions they were planning to implement to drive improvements.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People did not always receive their medicines as prescribed. People were not always protected from the risks associated with their care.

There were enough staff deployed to meet the care needs of people, however staff sickness meant people did not always receive support with their personal choice or wellbeing needs.

People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff did not always have access to the training and support they needed to meet people's needs.

People were supported to make day to day decisions around their care, however records regarding people's capacity to make decisions, or when decisions were made in their best interests were not always clear.

Is the service caring?

Requires Improvement

The service was not always caring. Care staff did not always ensure people's privacy and dignity were protected.

People's personal independence and individuality was not always promoted.

Care staff knew people well. People enjoyed positive and friendly relationships with care staff.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care records were not always personalised or current to their needs.

People's well-being needs were acted upon to ensure people received the support of healthcare professionals.

People enjoyed their life in the home and had access to activities which met their individual needs.

Is the service well-led?

Inadequate

The service was not well led. The registered manager and provider did not operate effective systems to monitor the quality of the service. Concerns identified at this inspection had not been identified through the service's own systems.

We rated "is the service well-led" as inadequate due to the concerns found at this inspection and due to the inspection history of the service.

Care staff did not always have the support and communication they required. This had an impact on communication and referrals to healthcare professionals.

Concerns were not always effectively acted upon to drive improvements and reduce the risk of repeat concerns.

Nazareth House - Cheltenham

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 was 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.

This inspection took place on 20, 22 and 26 June 2018 and it was unannounced. The inspection team consisted of two inspectors. At the time of the inspection there were 55 people living at Nazareth House – Cheltenham.

We did not request a Provider Information Return (PIR) prior to this inspection, as we had brought the inspection forward following concerns raised by healthcare professionals. This is a form that asks the provider 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. We reviewed the information we held about the service, which included notifications about important events which the service is required to send us by law. We spoke with and sought feedback from a local GP and from local authority commissioners. We also spoke with a person who led a regular exercise session at the home.

We spoke with nine people who were using the service and three people's relatives. We used the 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 spoke with 15 staff members; including four care staff, a kitchen assistant, general assistant, housekeeper, four senior care staff, the activities co-ordinator, the maintenance worker, the registered manager and a representative of the provider. We reviewed 14 people's care files and associated records. We also reviewed staff training and recruitment records and records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

People felt safe living at the home. Comments included: "I'm safe here" and "I feel comfortable here, there is safety here". Relatives told us they felt their loved ones were safe living or staying at Nazareth House. One relative told us, "This is a safe place." However, we identified shortfalls that impacted on people receiving safe care.

People did not always receive their medicines as prescribed and we found at times people had missed dosages of their medicines. For example, we counted the stock of nine people's prescribed medicines to check whether people had received all their medicines in June 2018. We identified that since the beginning of June 2018 people had not always received their medicines as prescribed. Two people's prescribed pain relief medicines had been signed as given on two occasions, however these medicines were still stored in their monitored dosage systems. Another person's prescribed medicine, had not been given on one day. When we counted this person's prescribed medicine stock we found one dose more than was expected. This meant that people had missed their prescribed medicines and were placed at risk of their health and wellbeing being negatively impacted.

Additionally, care staff did not always take appropriate action when people's medicine stocks were low and needed to be replenished. One senior care staff member informed us that one person had not had one of their prescribed medicines on the 20 June 2018 as this was not in stock. They explained they had requested this medicine so that is was available for the next day and had received confirmation from the person's GP that this would not impact the person. We discussed this concern with the registered manager who explained that staff had identified the person would run out of this prescribed medicine, however prompt action had not been taken to ensure this medicine was available.

Where people's medicines were stored in boxes, care staff did not consistently follow recognised best practice. Staff did not always document when people's individual medicine boxes had been opened and an accurate record of people's prescribed medicine stocks were not available. This meant care staff and the registered manager would be unable to determine whether people had always received their medicines as prescribed or if maladministration of people's medicines had occurred.

These concerns meant that people's health and wellbeing could be placed at risk as they had not always received their medicines as prescribed. We discussed this concern with the registered manager who was unaware of all of the concerns we had raised. Following the inspection, the registered manager informed us they had sought the support of their community pharmacist to provide guidance and training to care staff.

People were not always protected from the risks associated with their care as their needs had not always been reassessed when they changed to ensure the care provided protected them from harm. For example, one person's needs had changed following an incident and admission to hospital. The person now required a period of bed rest to recover. The person's needs had not been reassessed to take into account the risks related to being cared for in bed, including what equipment was required to ensure the person's skin was protected from pressure area damage and the support they required from care staff with reducing this risk.

Since the person had returned to the home they had acquired a pressure ulcer. Care staff were aware of this concern and had made referrals to healthcare professionals to treat the pressure ulcer. However, at the time of the inspection pressure relieving equipment, including a pressure relieving mattress was not in place for this person. The registered manager informed us healthcare professionals had been contacted to provide this support, however this request had not been followed up to ensure this person received prompt professional input to prevent their skin from deteriorating.

Care staff did not always follow people's risk management plans to ensure people's assessed risks would be mitigated. One senior member of care staff told us that one person required repositioning every two hours, however not all staff we spoke with were aware of the required frequency. Repositioning records for the person had not always been completed consistently, with significant gaps in recording. There was no record of the frequency the person required support and if a senior member of staff had reviewed the records to ensure the person was being repositioned in accordance with their plan of care. This placed the person at risk of not receiving the care they required to protect their skin. We discussed this concern with the registered manager and area manager who informed us they would take immediate action to ensure the person's needs were met.

Some people were assessed as being at risk of malnutrition and weight loss. People's care plans identified that people required monthly weight monitoring (or more frequently). This would ensure any weight loss would be promptly identified so that plans could be put in place to reduce the risk of people becoming malnourished. We reviewed weight records for all the people living at Nazareth House – Cheltenham for 2018. Some people had not been weighed since February 2018. One person whose weight records showed they had lost a significant amount of weight from January 2018 to March 2018 had not been re-weighed prior to our inspection. There was no evidence that staff had identified and assessed the person's risk or the support they required to remain well nourished, or had checked whether the record was a false recording. We discussed this concern with the registered manager who told us care staff had raised concerns about the accuracy of the scales, however they agreed that all people should have been weighed as required.

The above demonstrated that people did not always receive appropriate safe care and treatment. People did not always receive their medicines as prescribed. These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Five people living at Nazareth House told us they felt there was not always enough staff to meet their needs in a timely manner. For example, two people felt they had to wait a period of time before their call bell was answered. Three people told us that they did not have baths as regularly, such as weekly or twice weekly as they required because staff were unable to assist them. Comments included: "I feel I have to wait"; "They don't always come quickly" and "I feel sorry for them."

Care staff told us there were enough staff deployed to ensure everyone received the care they needed to keep them safe, however felt workload and staff sickness meant they struggled to provide person centred care. Comments included: "We don't get a chance to sit and talk to people. It has an impact on residents"; "There is high sickness here, there doesn't seem to be a plan for this" and "We get everything done that we need to do. It is very busy."

We observed that there were enough staff deployed to assist people with their care needs. We saw people's requests for assistance were responded to promptly. However, we observed staff were often focused on getting care tasks completed and did not always stop to chat and engage. On two days of our inspection staff sickness had meant that the service was reliant on agency staff to provide safe staff numbers. While the amount of staff deployed were enough to maintain the safety of the service they were not as high as the

levels required by the provider, as noted in the staffing rota, for these shifts. The registered manager and area manager informed us that they were taking action to reduce the frequency of staff sickness.

We recommend the service seek advice based on current best practice, around how to use staff most effectively.

People were protected from the risk of abuse. Care staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "I would go to (registered manager)". Another staff member told us what they would do if they were unhappy with the manager's or provider's response. They said, "I am aware we can whistle blow, I can go to the (local authority)".

The registered manager had responded to any safeguarding concerns in accordance with local authority's safeguarding procedures. Since our last inspection the provider had ensured all concerns were reported to the local authority safeguarding team and CQC.

People could be assured the premises were safe and secure. Safety checks of the premises were regularly carried out. People's electrical equipment had been checked to ensure it was safe to use. Fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. Equipment to assist people with safe moving and handling were serviced and maintained to ensure they were fit for purpose.

People could be assured the home was clean and that housekeeping and care staff followed and recognised safe practices in relation to infection control. People and their relatives felt the home was clean. Care staff wore personal protective clothing when they assisted people with their personal care. Care staff told us how they protected people from the spread of infection. We spoke with the head of housekeeping who spoke confidently about the resources and staff that was available to ensure the home was clean.

Requires Improvement

Is the service effective?

Our findings

People told us staff generally were good at providing the support they needed. One person told us, "They do their best, but I do feel sorry for them." Another person said, "I don't always feel they're able to raise concerns, or to react." Two relatives praised the support the staff provided their loved one.

People were not always supported by staff who were skilled and supported to meet their needs. For example, four members of staff raised concerns regarding the training and skills or care staff working in Nazareth House. They raised concerns to us regarding staff practices in relation to medicines, training, dignity, dementia care, infection control and moving and handling. One member of staff told us, "I am not always confident all staff are following good practice to prevent infection.'' Another member of staff said, "I'm really worried about the medicines" and "There is a lack of professionalism." We discussed the training provided to staff with the registered manager who informed us they were unaware of the provider's expectations in relation to mandatory training, this meant they had limited overview of the training needs of care staff. The provider informed us that their policies informed staff of the training they should receive, however this had not been followed by the registered manager.

Healthcare professionals had raised concerns regarding moving and handling practices of staff prior to our inspection. We asked the registered manager for a record of the moving and handling training staff had completed. The training record showed some staff had not had access to refreshment training in relation to moving and handling since 2011. They might therefore not be aware of current best practice in relation to moving and handling. The registered manager and area manager informed us that three staff had been trained to provide moving and handling training to staff, however at the time of our inspection these resources were no longer available. The area manager was aware of this and support was due to be provided by a senior member of the providers management team.

People living with dementia did not always receive effective care and support as staff did not always have the required skills to support people appropriately. For example, we observed three members of care staff who provided support to people living with dementia. On two of these occasions staff did not speak with people while assisting them with their dietary needs. One member of staff was supporting a person who was walking with another person. The staff member refused to let the person sit down when they wished to do so and did not understand the reasons for the person's anxieties, the person became more anxious with the support they received, becoming visibly upset. Training records for staff had identified these three members of staff had not received training in relation to dementia. We discussed dementia training with the area manager and registered manager, they informed us they would review the training needs of staff.

Care staff did not always feel as though they received sufficient support to enable them to fulfil their roles effectively. The registered manager had a limited overview of which members of staff had received supervision (one to one meeting with their line manager or observational meetings). Supervision records we reviewed showed that some members of staff had not received a supervision in 2018 and no members of staff (who had been employed at Nazareth House longer had received an appraisal (a meeting which sets the goals of the staff member and the expectations of the service). Senior care staff informed us they were

responsible for providing supervisions to their teams, however they expressed this was something that they did not have the time to provide. One senior care staff said, "It's been really stressful. Since the Head of Care left, seniors have had the extra responsibilities." Another senior told us, "Supervisions have been sporadic. We're meant to do them with staff, we haven't had the time, we've snowballed." This meant staff had not received the opportunity to routinely discuss their development needs and concerns so that prompt action could be taken to provide them with any training and support they might need.

Care staff and senior staff felt they had not always received the support they needed from the registered manager or the provider. Comments included: "It has got worse since the Head of Care left. We're not getting the help"; "We've never had anything from (provider), there is no level of support from them. (registered manager) is good, she's up against a lot, she gets stressed, we've lost morale" and "I haven't had supervision for a while. It would be nice."

Where supervisions had taken place these were not always effective in addressing their concerns or the needs of care staff. For example, one member of staff had requested training in relation to management skills and leading staff. This had been discussed at a supervision in January 2018. The member of staff told us during our inspection, "I've never had any training in management, I have asked for it." Another member of staff had raised a concern regarding the conduct of staff in their supervision in July 2017. We discussed this concern with the registered manager, they were unaware of this as the concern had not been passed to them. The provider informed us that training was available for the development of leadership skills for staff, however the registered manager had not acted on these systems.

The above demonstrated that care staff did not have access to effective training and supervision dedicated to help them develop and meet the needs of people. These concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and knew to promote choice when supporting people. The 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care and nursing staff understood and respected people's rights to make a decision. Staff explained how they embedded the principles of the MCA into their practice. Comments included: "We do our best to provide people a choice, it's important, we wouldn't want to be without choice" and "One person can't tell us what they like to eat anymore, however we know them. If they didn't want to eat then they would refuse."

At the time of this inspection a number of people were being deprived of their liberty within the home. 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). The registered manager was aware of their responsibilities to ensure where people were being deprived of their liberties that an application would be made to the supervisory body. Where people were living under DoLS this was not always reflected in their care plans. Records relating to the reason for DoLS were not always clear, however care staff and the registered manager were able to discuss the decisions which had been made and people's legal rights were being protected. We discussed these concerns with the registered manager and area manager who informed us action would be taken to ensure where decisions were being made in people's best interests this would be clearly documented alongside an assessment of their capacity to make a decision.

People's needs were assessed before moving to the service. These assessments provided an overview of people's needs to enable senior care staff to implement care plans. Assessments included information in relation to people's nutritional needs and needs around their personal hygiene and mobility needs. The care plans provided staff with basic guidance on the person's dietary preferences and how they should be supported with their day to day needs.

People's care plans reflected their diversity and protected characteristics under the Equality Act. People's sensory needs had been identified and staff were prompted to make sure people had access to equipment to ensure their continued independence. For example, staff checked people's hearing aids to ensure they were in working order and glasses were accessible. People's religious needs had also been clearly documented including the support they required to meet these needs.

People had access to health and social care professionals. Records confirmed people had been referred to a GP, continuing healthcare professionals, occupational therapists and physiotherapists. Additionally people were supported to attend appointments when required (such as when families were unable to escort their relatives to appointments). People's care records showed relevant health and social care professionals were involved with people's care.

Care staff were supported to learn from incidents and accidents to make improvements to people's care and support. For example, accidents or near misses were reviewed alongside healthcare professionals and guidance provided to staff to ensure people's health and wellbeing needs would be maintained.

People spoke positively about the food they received and felt improvements were being made to the quality and variety at mealtimes. Comments included: "It's good, I would like more variety for supper, it's usually just sandwiches" and "I like the food, it's got better." Care staff supported people to have access to food and drinks throughout the day. On the third day of our inspection temperatures were high. Kitchen and dining room staff ensured fresh drinks were in communal areas and people's rooms. Care staff were aware of the importance of prompting drinks to ensure peoples risk of being dehydrated were reduced.

People received diets which met their dietary needs. For example, one person required a pureed diet. We saw this person had specific meals to meet their dietary needs. Where people received pureed diets, the food was presented so people could see the individual colours. We observed one member of care staff take time to explain what was on the plate so the person was informed of the contents of their meal.

The premises were suitable to people's needs. Adjustments were being made to the home to increase access to two of the home's units. Changes were also happening in areas of the home to aid the support people received. The provider and registered manager had identified that changes were required to ensure the building was appropriate to meet people's needs.

Requires Improvement

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff employed at Nazareth House - Cheltenham. Comments included: "We think they go the extra mile. The attitude of the staff is great"; "I really do feel the staff are caring and try their best"; "I enjoy talking to them, I haven't been here long, they're all nice" and "I think most of them are lovely."

However, people's privacy and dignity was not always respected. For example, on the first morning of our inspection we observed three people were receiving personal care in their bedrooms with their doors open. People walking through the corridors including staff, other people and visitors could see and hear the care being provided. This did not uphold people's right for privacy and dignity.

On the third day of our inspection, one person was supported to go to the toilet in their bedroom. They were assisted by a member of care staff who did not close their en-suite bathroom door and their bedroom door. The person was anxious and could be heard from the corridor. The staff member did not seek to reassure the person. The staff member supported the person to their armchair. Once the person had sat down they placed a footrest in front of the person and against the person's wishes. This unsettled the person and when the member of care staff left, the person tried to get up from the chair however due to the foot rest was unable to. The person was left anxious and unsettled as their choice was not respected.

Care staff did not always engage with people in a respectful way. For example, during lunch on the second day we observed one member of staff approach a person from behind as they were sat at a dining room table whilst moving to the side. The staff member said "(person's name) behave." The person did not react to this and after a few minutes stood up and left the dining room.

These concerns were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People enjoyed positive relationships with each other and care staff. For example, we observed many friendly conversations between care staff and people. Two people enjoyed a lively conversation regarding the weather and the best ways to stay cool in heat. The atmosphere in the home was often friendly, inviting and lively in the communal areas with staff engaging with people in a respectful manner.

Where possible, staff encouraged people to spend their days as they wished, promoting choices and respecting people's wishes. For example, people could spend time in the home's grounds, enjoying the patio or attending the chapel. Some people stayed at Nazareth House – Cheltenham to enable them to continue to meet their religious needs. We observed people being supported to go to religious services. Where people were unable to attend a service, pastoral support was provided to them in their room.

People were supported to maintain their personal relationships. We observed people enjoying time with their relatives within the home and using the home's gardens. One person told us how they liked to walk around the grounds as well as spend time out of the home with their family. People's relatives told us they

could visit at anytime which was important for people maintaining their personal relationships.

People were able to personalise their bedrooms. For example, people displayed decorations or items in their bedroom which were important to them or showed their interests in their bedrooms. For example, one person's room contained photos of their family and people who were important to them. Another person had a number of possessions they had brought from their own home.

People where possible were supported to make decisions around their care and treatment. For example, one person's care plan clearly documented their views and also their wants and wishes regarding their end of life care. This person had also made a decision that they required resuscitation in the event of cardiac arrest. This decision was clearly recorded in the person's care plans.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in August 2017, we found people's records were not always current and contemporaneous and we rated this key question as "Requires Improvement". At this inspection we found that improvements regarding people's care records had not been sustained. We also found that people did not always receive effective person centred care.

People's care assessments were not always current and cotemporaneous. For example, one person's care assessments did not reflect the support they required in relation to their mobility needs. For example, their care assessments stated they required the support of two members of staff and a hoist as they were no longer able to stand and had been unable to do so since January 2018. However, care staff informed us that on a daily basis they assessed the needs of the person, as the person could mobilise using a stand aid with the support of a member of staff. This had not been recorded in people's care assessments and staff therefore did not have up to date information about the care people required.

Each person had a key worker who was responsible for updating and reviewing their care and risk assessments. A number of the files we reviewed had not been reviewed and updated in accordance with the provider's policies. For example, one person's plans had not been reviewed for three months prior to our inspection. The provider had identified this concern during a quality audit on 4 June 2018 and had included an action in their action plan to ensure people's records were current.

People's mental capacity assessments to make significant decisions and best interest decisions where they did not have capacity regarding their care at Nazareth House had not always been clearly documented. For example, the service met with a person's family and GP and a best interest decision was made not to actively treat the person in future. However there was no clear mental capacity assessment which identified the person lacked capacity. Additionally where people had bed rails in place there was not always a recorded assessment of how consent had been sought for these, particularly as they could be seen as a restraint.

People's care records were not always personalised. For example, for three people there was limited information in relation to their life histories, their interests or hobbies. This meant there was often limited information for care staff to use to understand the wellbeing needs for people, particularly those people living with dementia.

These concerns about people's records were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care and support which was personalised to their needs. One person was currently on bed rest. There assessments had not been updated to provide guidance on how staff should meet their wellbeing needs. For example, the activities and engagement they should provide the person. Care staff and the registered manager told us they had identified that the person was "feeling low" and at risk of social isolation, however there was no evidence of actions taken to ensure this person was protected

from the risk of isolation or clear guidance of how this person was to be supported. Care staff were unaware of how to assist this person to protect them from the risk of social isolation.

One person was supported with walking within the home. We observed on two occasions a care staff member assisting them by pulling on the persons mobility aid. While this did not place the person at risk of falling, it made them agitated. The member of staff did not work at the person's pace and did not promote their independence and choice. We raised this concern to the registered manager and area manager who informed us they would take action to address this concern.
We observed on all three days of our inspection that people who required wheelchairs to mobilise around the home, spent the majority of their time in wheelchairs. People's care records did not show if this was the preference of people to stay in these wheelchairs whilst away from their individual rooms. We discussed this with the area manager who informed us they would look into these concerns to ensure people were being offered choice.

Three people informed us that they did not always receive the support they required for their wellbeing needs. For example, all three people told us they liked to enjoy baths, with one person telling us they liked to enjoy a bath in the morning. They said, "I would like to have a bath twice a week, I rarely get one weekly." Care staff informed us that they were unable to assist people with baths when they required. One member of staff said, "We don't give them the baths when they like, it has an impact on people."

People did not always receive personalised care that meet their individual needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People enjoyed engagement and activities with the activity co-ordinator. People told us there were things for them to do living at Nazareth House. Comments included: "Oh I don't feel bored" and "I enjoy going there. (activity co-ordinator) is very good." The activities co-ordinator offered a regular programme of activities and also spent time individually with people who could not attend the group sessions. Regular exercise classes were taking place and we heard many examples of how this had helped people to remain active, strengthened their mobility and reduced their risk of falling.

Staff were responsive to people's changing needs. For example, one member of senior care staff took effective action to assist two people on the first day of our inspection. One person had had an accident and the member of staff took appropriate action to call paramedics. The member of staff was also concerned another person was anxious. They arranged for an immediate GP visit, which occurred. One GP told us, "The care is genuinely very good, they contact us if they need support."
People' relatives spoke positively about the end of life care their relative received at Nazareth House – Cheltenham. They told us, "They were always asking if there was anything more that they could do. We've been so happy. There was always so much for (relative) to do."

People knew how to make a complaint if they were unhappy with the service being provided. One person said, "I know who the manager is, I'd say if I was unhappy." Information of how to make a complaint and key contacts were available throughout the home. The registered manager told us they had not received any complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

There was a registered manager at Nazareth House - Cheltenham. A registered manager is a person who has registered with the Care Quality Commission 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. The registered manager left the service shortly after our inspection, however was available on all three days of our inspection.

This is the fifth inspection of Nazareth House - Cheltenham where the service has been rated. At four of these inspections the service had failed to meet all the requirements of the relevant regulations. While improvements had been identified at our August 2017 inspection, these improvements had not been sustained. While the registered manager and provider had identified a number of the concerns we had identified prior to our inspection, actions at this time were still ongoing and had not been fully implemented and evaluated to ensure people would always receive safe and effective personalised care. The registered manager and provider had not demonstrated that they were able to consistently meet the requirements of their registration and operate effective systems to ensure that Nazareth House – Cheltenham met the requirements of the Health and Social Care Regulations. Therefore we have rated this question as 'Inadequate'.

Audits had not always been effective at identifying concerns and driving improvements. For example, medicine audits carried out in May 2018 and a provider audit carried out in June 2018 had not identified concerns in relation to the administration of people's prescribed medicines. These audits had identified issues in relation to gaps in people's medicine administration records and the storage of people's topical creams. However, the medicine audit had not identified that people had not received their medicines as prescribed and that good practice had not always been followed to ensure stock checks would support staff to determine whether people had received their medicines. Therefore, prompt action had not been taken to protect people from the risk associated with not receiving their medicines as prescribed.

Audits in relation to people's care plans and visual observations carried out by management had not been carried out since March 2018. We discussed this issue with the registered manager who informed us that these audits had not been carried out. The provider's action plan from their 4 June 2018 visit identified that people's care records required reviewing however had not identified issues around the records being current or cotemporaneous. Therefore these audits had not always been effective at identifying concerns to help drive improvements.

The registered manager had no overview into the training and support care staff received. The registered manager explained that all training completion dates and supervision dates needed to be logged onto an electronic record system and the registered manager and administrator had access to complete this task. However, this had not occurred. Senior care staff informed us they had not been able to carry out staff supervisions. The registered manager had no system in place to identify shortfalls in supervisions not being completed. The registered manager was unaware of the providers mandatory training requirements to enable them to monitor staff's compliance and take action to arrange the required refresher training when

needed. They showed us an email from April 2018 which stated this information would be provided. When asked they informed us they had not received a further email, or requested one in response.

Where audits had been carried out, effective action had not always been taken when shortfalls had been identified. For example, the most recent provider audit in June 2018 had identified that people's prescribed topical creams were not appropriately stored safely. During our inspection we found that prompt action had not been taken following this audit and people's topical creams were still be stored in people's rooms, against the providers expectations.

Effective action had not always been taken in response to concerns raised to the registered manager. For example, we were informed that a member of staff had left the service following a concern over poor practice. While action had been taken in response to the concern, the registered manager and provider had not investigated to see if other practice issues or concerns were occurring across the home. During our inspection we identified issues which had been discussed through supervisions to this member of staff, however had not been raised to the registered manager or provider for investigation. There was no evidence these concerns had been investigated in accordance with the providers policies or that the registered manager or provider had identified that their supervision process had not always been effective in identifying and responding to concerns which could negatively impact people's care.

Two staff members raised concerns regarding medicine administration practices within Nazareth House. They both informed us these concerns had been discussed with the registered manager, however they were unaware of the action that had been taken and they were still concerned. We identified that people were not always receiving their medicines as prescribed. We made the registered manager aware of these concerns. The registered manager confirmed they were aware of staff concerns regarding the administration of medicines prior to our inspection. On the third day of our inspection the registered manager took action over these concerns. One staff member told us, "I've gone to (registered manager) a number of times, nothing gets done." Staff were confident in using the provider's whistleblowing and concerns process however concerns had not been addressed by the registered manager to ensure effective action was taken to ensure people received safe care and treatment.

People told us the staff required more support and raised frustrations that they were not always informed of changes within the home, such as building work promptly. Staff employed by the provider felt they had not received effective support which had an impact on their wellbeing, skills and ability to carry out their roles successfully. Comments included: "We are being squeezed, it's not sustainable. I worry about burnout"; "There is a big pressure on us. Staff are stressed. We're not getting the help we need. Staff are too scared to go to (registered manager)" and "We don't get the support we need. Morale is low."

Healthcare professionals and care staff felt there was not always effective communication regarding people's needs. Staff comments included: "Communication needs to improve, things get forgotten" and "Communication just isn't there. I made my own communication book." One healthcare professional told us, "Communication can be challenging. There is no consistency in the communication between staff. Staff are not always aware. I keep my own book now to ensure things are picked up." The registered manager informed us they were aware of concerns as staff did not coordinate referrals and the actions required, such as healthcare professional referrals or making requests for peoples prescribed medicines.

One healthcare professional discussed how their practice worked with staff regarding the management of people's prescribed medicines. These actions had a positive impact on the management of medicines on the ground floor and we found people were receiving their medicines as prescribed. These changes however had not been taken forward by the registered manager and staff on the first floor to drive improvements.

The registered manager provided us a copy of the engagement survey of people and staff. The survey of people carried out in March 2018 identified people did not always feel there were enough staff, did not know who their key worker was and didn't have choice over what they could eat. Whilst these concerns had been identified by the provider, there were no record of the actions the service were planning to take in response to these concerns to ensure people's concerns were listened to and acted upon to improve the service. Concerns regarding staffing and the variety of food were still raised by people living at Nazareth House – Cheltenham.

People were supported to express their views through resident meetings. Minutes of the last meeting were available within the home. The last meeting was carried out in June 2018 and people felt the food required further improvement and that a larger evening choice would be appreciated. One person raised concerns in the February 2018 and June 2018 meeting about diabetic food. It was not always clear the actions the registered manager had taken in response to these concerns and therefore was difficult to ascertain if these systems had been effective in responding to people's views to improve the service they received.

Quality assurance systems had not always been effective in identifying shortfalls, making and sustaining improvements to the service people received over a period of time. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the area manager provided us with a list of visits the provider had arranged to Nazareth House – Cheltenham for support. This included a quality audit in June 2018 and support in relation to medicine management competencies, policy changes and quality audits. The provider informed us they had recently become aware of concerns within the service and were aiming to take action, including the recruitment of a new head of care. The area manager was new in post, however assured us of the action they would take to ensure improvements within the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care that meet their individual needs and preferences. Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment. People did not always receive their medicines as prescribed. Regulation 12 (1)(2)(a)(b)(e)(f)(g).

The enforcement action we took:

We issued a warning notice to the provider informing them they must be compliant with the regulation by 31 August 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had not always been effective in identifying shortfalls, making and sustaining improvements to the service people received over a period of time. Regulation 17 (1)(2)(a)(b)(c)(e).

The enforcement action we took:

We issued a warning notice to the provider informing them they must be compliant with the regulation by 30 September 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Care staff did not have access to effective training and supervision dedicated to help them develop and meet the needs of people. Regulation 18 (2)(a).

The enforcement action we took:

We issued a warning notice to the provider informing them they must be compliant with the regulation by 30 September 2018.