

Veronica House Limited

Veronica House Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 7 March 2016 and was unannounced. This was a follow up inspection in response to a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which took place on 1 and 2 September 2015. At this inspection, a number of concerns were raised with regard to the management of people's medicines. The provider had submitted an action plan in response to the concerns raised and at this inspection we examined the actions that the provider had put in place to determine whether the necessary improvements had been made. We found there were still a number of areas outstanding.

Veronica House provides accommodation for up to 52 people who require nursing or personal care, for younger or older people, people with a learning disability and or a physical disability.

There was a registered manager in post. 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.

There was also a new manager in post, who had recently taken over responsibility for the running of the home and had submitted her application with CQC to become the registered manager.

Improvements had been made in relation to how medicines were managed and administered to people. However, the provider remained in breach of Regulation 12.

More improvements were required in relation to the management of out of stock medicines. When medicines have been administered, refused or omitted records must clearly record this information in order for staff to ensure medicines are given consistently and safely.

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 consistently safe.

Actions had been taken to improve the safety of medicines but more improvements were required. The management of medicines stock levels was not effective and records of medicines administration charts were inconsistent. Protocols for administering 'as or when required' medicines were not always in place.

Requires Improvement ●

Veronica House Nursing Home

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.

The inspection took place on 7 March 2016 and was unannounced. The inspection was carried out by two pharmacy inspectors. The team inspected the service against one of the five questions we ask about services: Is the service safe? We only inspected the safety of medicines. This is because the service was not meeting this legal requirement.

The inspection concentrated on the safety of medicines. This was because at the previous inspection of the 1 and 2 September, the service was not meeting this legal requirement. During our inspection we spoke with three staff and the new manager. We looked at the medicine records of twelve people who used the service.

Is the service safe?

Our findings

When we inspected the service on 1 and 2 September 2015 we had concerns that people did not always receive their medicines on time. People's medical conditions were not always treated appropriately by the use of medicines and there was a lack of written protocols to inform staff on how to prepare and administer particular medicines. We saw that some medicines were not being stored correctly which could render them ineffective.

At this inspection we looked at the management of medicines and found that whilst some improvements had been made the service remained in breach of Regulation 12 and further improvements were needed.

People were not consistently getting their medicines as prescribed. We looked in detail at the medicines and records for twelve people living in the home. These showed that three people had been without some of their regular medicines. We saw that staff only ordered these medicines after the last dose had been given and no more remained in the home. We saw there were gaps in the administration records for some people and explanations were not recorded consistently for these omissions. There was a robust policy in place to address this but we were told this was not being followed.

Guidance for the administration of 'as required' medicines was not always available. This guidance provides information as to when it is appropriate to administer 'as required' medicine and ensures that people receive the medicines in a consistent manner, in order to meet their needs. There was insufficient information to show staff how and when to administer these medicines.

We saw that when people refused medicines for a number of days, there was no evidence that staff sought advice from the prescriber on how this may affect their health and well being.

Some people needed to have their medicines administered directly into their stomachs through a tube. Following the last inspection the service had obtained letters signed by the GP for three people receiving medicines in this manner authorising staff to give medicines via the tube. However none of the letters detailed which medicines were to be administered in this way and there was insufficient written guidance for each medicine to ensure that they would be given consistently in a way that was safe.

Medicines were being stored securely, at the correct temperatures, for the protection of people living in the home. Controlled drugs were stored and recorded correctly. However, we found that one medicine, with a limited shelf life when opened, was not dated on opening. This meant we could not be assured that this medicine would still be fit for use.

A number of staff spoken with told us that they had started a medicine training programme, but had not completed it and there was no evidence of competency checks for either the nursing staff or for care staff who administer creams.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People's medicines were not always managed safely.