Veronica House Limited

Veronica House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 and 6 September 2017 and was unannounced. At our last fully comprehensive inspection in 20 July 2016 we found three breaches of legal requirements. This was because we continued to have concerns regarding the management of medicines, systems were not in place to ensure the appropriate recruitment checks were in place prior to employing new staff and there were a lack of systems or processes in place in order to ensure the service operated effectively and complied with the requirements of the regulations.

Following the inspection, the provider sent us an action plan, telling us how they intended to meet the legal requirements in relation to the breaches identified.

We undertook an unannounced focused inspection on 8 March 2017. That inspection was to check that the provider had followed their action plan and to check that they were meeting the legal requirements. At that inspection, we found that the areas for improvement identified on the action plan and in relation to meeting the legal requirements, had been met.

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 or a physical disability. At the time of the inspection there were 37 people living at the home.

There was a registered manager. 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 introduction of an electronic system for the recording and administration of medicines was not as effective as hoped and had created a number of problems for the service. Systems in place for the management of medicines could not demonstrate that people always received their medicines as prescribed.

People felt safe and were supported by staff who had receiving training in how to recognise signs of abuse and were aware of what actions to take should they suspect someone was at risk of harm.

People were supported by staff who were aware of the individual risks to them on a daily basis. Staff were aware of how to manage those risks and how to keep people safe. Where accidents and incidents took place, they were reviewed and lessons were learnt.

Staffing levels were based on the dependency levels of the people living at the home. The deployment of staff across the home was under review in order to ensure staff responded to people's needs in a timely manner.

Staff benefitted from an induction that prepared them for their role. Staff received specialist training in order to meet the needs of the people they cared for.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to have sufficient amounts to eat and drink and were offered choices at mealtimes that were tailored to their individual preferences and dietary needs.

People were supported to access a variety of healthcare professionals to ensure their health and wellbeing.

People were supported by staff who were kind and caring and treated them with dignity and respect. Staff were aware of people's preferences with regards to their care and what was important to them.

People were involved in the development of their care plan. Care plans included information which reflected people's likes and dislikes and family history.

People were supported to take part in a variety of activities that were of interest to them. The activities co-ordinator had a comprehensive knowledge of people and what was important to them and developed activities that were of interest to people.

People felt listened to and were confident that if they had any concerns or complaints they would be dealt with appropriately. Where complaints had been received, they were investigated and responded to and where appropriate, lessons were learnt.

People and staff had confidence in the registered manager and considered the service to be well led. Staff felt supported in their role and were confident that they would be listened to. Systems and processes were in place to monitor the effectiveness of the service provided. Where issues were highlighted, lessons were learnt and acted upon.

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 consistently safe.

A new system in place for the administration of medicines could not demonstrate that people received their medicines as prescribed. Deployment of staff across the home was under review to ensure people's needs were met in a timely manner. People felt safe and were confident that staff would keep them safe from harm.

Is the service effective?

Good

The service was effective.

Staff received an induction which provided them with the skills and confidence to meet people's needs. People were supported by staff who supported people in line with the principles of the Mental Capacity Act 2005.
People were supported to access a variety of healthcare services in order to maintain good health.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring and treated them with dignity and respect. People were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People were involved in the development of their care plans which reflected their likes, dislikes and preferences. People were supported to participate in a variety of activities that were of interest to them. Where complaints had been received, they were responded to appropriately.

Is the service well-led?

Good

The service was well led.

People and staff considered the service to be well led. Staff felt supported by their colleagues and the registered manager. Systems were in place to monitor the quality of the service provided.

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 checked 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.

This inspection took place on 5 and 6 September 2017 and was unannounced.

The inspection was conducted by one inspector, a pharmacy inspector and an expert by experience. An experience by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR). 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 reviewed information we held about the provider, in particular, any notifications about accidents, incidents, safeguarding matters or deaths. We asked the local authority for their views about the service provided. We used the information that we had gathered to plan what areas we were going to focus on during our inspection. We spoke with seven people who lived at the service and six relatives. We spoke with the registered manager, the provider, a nurse, four members of care staff, the activities co-ordinator, the chef and the administrator.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of documents and records including the care records of five people using the service, ten medication administration records, two staff files, training records, complaints, compliments, minutes of

meetings, activity records and programmes, surveys, quality audits and action plans.

Requires Improvement

Is the service safe?

Our findings

We saw at our last inspection, plans were in place to improve the service by introducing a new electronic system for the recording and administration of medicines. This system had been introduced but audits had identified that it was not as effective and efficient as the service had hoped. These concerns had been identified by the registered manager and at the time of this inspection, the service had returned to a paper system for the recording of medication and these new arrangements were currently being embedded.

We looked at how medicines were managed by checking the medicine administration records (MAR) for ten people, speaking to nursing and care staff and observing a medicine administration round. We found recording deficiencies with some of the administration records, which meant they were not able to demonstrate that people were receiving their medicines as prescribed. The provider was not taking into account the transfer of medicines from one medication cycle to the next. This meant that without an accurate starting point the integrity of the administration records to evidence people were receiving their medicines correctly was not possible. Discrepancies between some liquid medicines and the administration records meant that we were unable to tell whether these particular medicines had been administered correctly. We also found that staff initials were missing from the administration records of inhalers and topical medicines so we were unable to establish if these medicines had been administered as prescribed. We saw that records for the application of creams and moisturisers were inconsistently completed and were unable to demonstrate that these topical preparations were being applied as described. We found one person had only received half of their prescribed dose of a medicine used to treat epileptic seizures for 12 days due to an error on the MAR that had not been identified by the service. We saw that systems and processes were reviewed to reduce the risk of this incident re-occurring in the future.

Staff were knowledgeable about the people they were looking after and when to administer 'as required' medicines. Where people were administered pain relief patches, there was evidence to support that these were applied safely and that people's pain relief would be well controlled. Where people received their medicines directly into their stomach through a tube, staff were provided with all the necessary information to ensure these medicines were administered safely.

We saw that medicines were kept securely and at the correct temperature. For example medicines requiring cool storage were being stored at the correct temperature and so would be effective in treating the conditions they had been prescribed for.

One person told us, "I have never felt unsafe. Staff all take care of you, there have never been any problems with my medication" and another said, "I feel safe because I am looked after." Relatives told us, "I visit 3 times a day 90% of the time there are enough staff. I always feel [person] is safe here" and, "Mum's things are safe everything you bring in is logged nothing has gone missing."

People were supported by staff who understood the potential types of abuse people were at risk of and their responsibility to report and act on any concerns. Staff had received training in dealing with abuse and were provided with a handbook with information on how to raise concerns. One member of staff told us, "Any

safeguarding I would phone CQC and inform the manager." We noted that where safeguarding concerns had been raised, they were responded to and acted on appropriately and saw that the registered manager worked in partnership with other stakeholders in order to keep people safe from harm.

People were supported by staff who were aware of the risks to them. For example, a member of staff described how they supported a person, "[Person] can stand with assistance, but there has to be two members of staff." They went on to explain that the person wore glasses, but still required guidance and reassurance when mobilising, adding; "Sometimes [person] gets frustrated and doesn't understand, so it's how you tell them [how to mobilise]." Care plans held detailed risk assessments that were regularly reviewed by a named nurse. This meant that reviews were carried out by staff who were aware of people's history and what actions had been taken previously to keep them safe.

We saw where accidents and incidents took place they were recorded and acted on appropriately. For example, where one person had suffered a fall, risk assessments were reviewed and equipment purchased to lessen the risk and a sensor mat was placed in the person's room [with their permission] to alert staff.

One person told us, "They [care staff] do the job but you have to wait when you ring the bell" and another said, "Some [care staff] are good, some bad you ring the bell it can take half an hour it's worse at night they change over at seven and you can wait a couple of hours." The person's relative was in the room and they agreed with this statement. Another relative observed, "They have a lot of agency staff and they tend to leave them [agency staff] in the lounge; there isn't much interaction from some of them." We also observed this and reported this back to the registered manager. We observed that communal areas were always staffed. All people spoken with told us it took staff a long time to respond to call bells. A member of staff told us, "There are enough staff but there could be more." The registered manager told us one of the challenges he faced was ensuring staff were spread across the home to ensure the communal areas were always manned by staff. They told us they were looking at different ways of deploying staff more effectively across the home.

The registered manager told us they had recognised the need to recruit more staff and in response to this there was an active recruitment campaign in place to recruit more staff to the home. Staff vacancies for night staff were being filled by existing or agency staff who were familiar with the service. The registered manager told us, "We are trying to keep agency staff to a minimum." There was a dependency tool in place to assess staffing levels. The registered manager told us, "Ultimately we will increase our staffing as our numbers increase. We would like to recruit more people and have been spending one day a week for the last five weeks recruiting."

All staff employed by the service had the appropriate checks in place, including two references, prior to commencing in post. We saw that systems and processes were in place to ensure people were supported by staff who had been assessed as being appropriately experienced and skilled in order to meet their care needs.

Good

Is the service effective?

Our findings

A relative said, "All the staff I have seen appear to be properly trained" and another said, "They [care staff] seem to know what they are doing." Staff told us they felt well trained and competent in their role. We saw that as well as the mandatory training, staff were offered additional learning opportunities in order to meet people's specific needs, such as epilepsy. We saw that arrangements were in place to teach staff 'break away' techniques when supporting people who may become agitated or aggressive. This meant staff could be confident they would be provided with the training and support that would equip them with the skills required to meet people's needs on a daily basis. We saw and staff told us there were systems in place to ensure staff received the most up to date information about people in order to meet their needs safely and effectively. A member of staff told us, "In handover you find out what's happening. There is a booklet in people's bedrooms as well, it tells you what people like, dislike, their medical history, etc."

People were supported by staff who benefitted from an induction that prepared them for their role. The registered manager told us the induction for new staff had been redesigned with a view to providing more support for staff to encourage them to remain at the service. We saw the new induction pack and process in place included a handbook providing staff with information to assist them in their role. There was a policy of new starters being able to shadow colleagues for as long as deemed necessary. New staff wore different colour uniforms to the rest of the staff to remind people that they were new in post. Induction included a mixture of online and practical training and being introduced to the people living in the home. One member of staff told us, "They [management] want us to get used to people across all floors. I've never had an induction like this before, I'm really enjoying it."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that staff had received training in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People told us staff obtained their consent prior to supporting them and we observed this. Staff were able to demonstrate an understanding of the need to consider people's ability to give consent and what may be considered as a restriction of their liberty, but some staff did require some prompting on the subject. We saw that prior to applications to deprive people of their liberty; best interests meetings had taken place. A number of applications for people using the service had been submitted and authorised by the supervisory body, in this case the local authority.

At our last inspection, people were asked to choose what they wanted to eat, 48 hours before they had that meal. At this inspection, this had changed to 24 hours before. We saw people were supported to make

choices at mealtimes and pictorial menus were in place for those people who were unable to tell staff what they would like to eat. One person told us, "The meals are good" and we observed people enjoying their lunch. Another person told us they thought the evening meal was planned too early (at 4.00 pm) resulting in a long time between evening meals and breakfast. We discussed this with the registered manager. They told us that they had not received any concerns regarding this and during the evening people had access to snacks staff were able to provide them with. However, they took on board the comments and told us they would look into the matter.

The provider told us in their Provider Information Return [PIR] that people were consulted with regard to the menu choices on offer. We saw that the chef had worked in collaboration with the activities co-ordinator in order to gather more information regarding people's mealtime preferences. We saw this information was then incorporated into menus in order to provide people with a variety of choices of food that were tailored to their preferences. The chef was aware of people's individual dietary needs and preferences and there were systems in place to accommodate these. For example, for those people who were at risk of choking and required their meals to be pureed, their meals were prepared freshly and efforts made to present the food to make it appear more appetising.

People told us they were supported to maintain good health by having access to a variety of healthcare services and we saw evidence of this. For example, their GP, chiropodist, opticians and physiotherapist. We saw where one person was at risk of weight loss, referrals had been made to a dietician and the advice provided was followed. A relative told us, "I was concerned about person's weight. They had got the GP and the dietician involved and they've kept me informed." Staff spoken with were aware of people's healthcare needs and how to support them to maintain good health. One member of staff told us, "[Person] is here for rehabilitation. They see the physiotherapist and can stand with assistance. They have problems with their sight; and sometimes they get frustrated so you have to be clear when supporting them."

Good

Is the service caring?

Our findings

One person said, "It is very nice here and if I am truthful they [staff] look after you well and feed us well." People spoke positively about the staff who supported them and we witnessed many instances of staff speaking to people in a kind and caring manner, sharing a laugh and a joke and enquiring after them. For example, we observed a member of staff greet a person enthusiastically saying, "Did you have your hair cut? It looks smashing!" Another member of staff was aware that a person went out with friends for lunch and asked them about this. We saw one person being encouraged to eat at lunchtime and the member of staff was persuading them kindly. A relative told us, "[Person] has come out of their shell here. We are all very happy the way they have come on."

People were supported to be actively involved in making decisions about how they spent their day. One person told us, "You can have a bath or shower every day if you want one, they know everything about you." We saw for people who were unable to communicate verbally, alternative systems of communication were in place such as picture guides. For example, for one person, photos had been taken (with their permission) of them demonstrating different gestures and what they meant. This meant that staff were able to communicate effectively with the person and also respond to their requests for assistance and or support. We observed that people were dressed appropriately for the time of year, many were wearing jewellery or scarfs and had had their hair done. This meant that people were supported to maintain their individuality when it came to their appearance.

The provider told us in their Provider Information Return (PIR) that the home now had an open visiting policy, giving consideration to meal times and visitors spoken with confirmed this.

People were supported to maintain their independence where possible. One member of staff described for one person, how important it was to get the balance right when providing support, at the same time ensuring people were able to retain the skills they had. They told us they had considered how they were supporting the person and questioned their practice. This meant that staff were mindful of their role in people's daily lives in supporting them to be as independent as possible.

All people spoken with told us that staff treated them with dignity and respect and we observed this. One person said, "They [staff] asked me how I like my tea; they are all very good, very respectful, so far so good!" We saw one person was supported to the bathroom. The member of staff reassured the person they would be standing outside the bathroom door and told us, "[Person] likes me to stand on guard so that no one walks in on them." Staff were able to provide us with examples of how they maintained people's dignity when supporting them, one member of staff told us, "I will always knock before entering a room and will then ask, 'is it ok for me to come in?'"

We saw that people were supported to access advocacy services should they wish to have someone act on their behalf. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes.

Good

Is the service responsive?

Our findings

We saw people were involved in the development of their care plans. Care plans included information about people's history, their likes and dislikes and how they liked to spend their time. A relative commented, "The last home [person was living at] closed at short notice and it was a difficult time. But they [staff] made a real effort here to help [person] settle. The nice thing is it has that personal touch that has surprised me."

We noted that care records had recently been transferred to an electronic system and all staff were being provided with their own dedicated tablets to enable them to make contributions to care records. We saw that people's care plans were reviewed on a regular basis by their dedicated key worker, but people and their relatives were not routinely involved in these reviews. We discussed this with the registered manager who told us that this was an area that was being looked into and plans were being made to invite relatives to the reviews of their loved one's care. People and their relatives told us they could speak to the registered manager at any point to discuss any issues or concerns they may have.

The provider told us in their Provider Information Return [PIR] that people, families and friends were involved in putting together 'My Life Story's' which provided staff with a variety of information regarding people's likes, dislikes, hobbies, how they wished to live their lives now and in the future. Staff spoke positively about these files and the information provided within them.

Meetings took place which provided people and their relatives the opportunity to discuss any issues or ideas they may have. For example, we saw that families had asked for access to their loved one's electronic care records and this had been provided in line with data protection requirements. We noted menus had been amended and updated to include people's particular preferences, a member of staff told us, "People are pleased when they see something in particular on the menu that they have asked for."

People were supported to take part in a variety of activities which they told us they enjoyed and we observed this. One person told us, "She [activities co-ordinator] is very good. We see her every day, she comes and does all sorts and asks us what we want to do to keep us motivated and active." A relative commented on the positive impact the activities co-ordinator had had on their loved one and told us, "They have got [person] to join in and they would never even come out of their room at the other place."

Working with the chef, the activities co-ordinator had asked people not only what they liked to eat, but their favourite recipes or meals that had been prepared by them or relatives that evoked happy memories. These menu choices were then incorporated into the menus. The activities co-ordinator told us this had worked well and people had started to recognised particular items on the menu that they were fond of. For example, one person had a particular name for a stew which they were pleased to see make an appearance on the menu.

We saw that there was a noticeboard that displayed a variety of activities that were taking place every day. In addition to this, there was a monthly karaoke night, where one person enjoyed conducting the pub quiz before the singing started. The activities co-ordinator told us, "We try and create an atmosphere, like if you

were down the pub, put out beer mats and provide plates of sandwiches. We want to do more of this, it's nice to do things people enjoy doing and are good at."
We saw when new people came into the home, they and/or their relatives were asked to fill in details of activities they enjoyed, this included not just what people currently enjoyed doing, but what they enjoyed a year and a decade ago and also what they would like to do in the future. The activities co-ordinator said, "It's useful for staff and agency; gives them a little guidance." This meant that information collected on what was important to people was used to create activities that helped fill people's lives and provide meaning to their days. We saw for those people who were cared for in bed, activities came to them. There were a variety of rummage boxes people could look through, each with their own theme, for example, there was one with a holiday theme, which had items of interest for people to look at and talk about. There was another for cleaning which contained dusters and ornaments. Other people enjoyed the shoe cleaning box. The activities co-ordinator told us, "These things just help people touch base with reality; it's what they used to do before they came here."

People had access to newspapers and there was a video library that people could access to watch particular films either in the privacy of their room or with others in the lounge areas. The activities co-ordinator had a comprehensive knowledge of the people living at the home and what they enjoyed doing. When it came to reading or watching films, she was aware of the genres people enjoyed and was able to support them accordingly. She told us she was constantly looking for more creative activities for people to get involved in and enjoy and we saw evidence of this. Links had been made with local schools who were involved in a history project and arrangements were being made for some people to visit the schools to watch a play.

We saw that people's diverse needs were accommodated in a variety of ways. We saw that care was taken to support people in celebrating their chosen faith and offers of assistance were provided. For example, one person enjoyed having religious passages read to them and others enjoyed the Church of England service that took place on a weekly basis. Outside visitors also provided activities for people to enjoy including weekly exercise, tai chi, and a virtual sensory experience which was carried out by a visiting physiotherapist. There was access to a minibus that was currently shared with the provider's sister home and plans were in place to raise monies to purchase a minibus solely for the use of Veronica House.

People told us they felt listened to. Meetings took place providing people with the opportunity to raise any concerns and share their points of view. We saw there was a system in place to log, investigate and respond to any complaints received. We saw that where complaints had been received they had been investigated and responded to appropriately and actions taken, staff spoken to where appropriate. There was information on display providing people with details how to raise a complaint .There was a complaints and compliments folder on display which held many compliments, such as, "Thank you for taking care of my mom with compassion and kindness" and "Thank you for looking after [person] so well."

Good

Is the service well-led?

Our findings

One person told us, "[Registered manager's name] is marvellous, always accommodating, I can ask to see him anytime." A relative told us, "I always have a sense that someone is responsible here all the time to sort things out" and another said, "I would recommend it here to anyone, yes definitely." We received many positive comments regarding the registered manager's ability to manage, lead and support staff in a way that ensured people's needs were met. Staff told us they would recommend the home to other people and considered it to be well led. A member of staff told us, "I actually asked if my Mom could come here. The carers are lovely, [Registered Manager's name] listens, it's well led. He observes what's going on, asks questions and asks how you are feeling. The owners too, always ask how you are." We observed that the registered manager had a visible presence in the home. A relative commented, "The manager is very visible and approachable."

People were supported by staff who were aware of their roles and responsibilities. The registered manager had a comprehensive knowledge of the people living in the home. This in turn enabled them to discuss with staff the needs of the people living at the home and the support staff required to meet those needs. For example, we saw that additional training was sourced for staff to assist them to meet the complex care needs of a person. Further, we saw that guidance and training was provided in how to support the person safely, ensuring staffs safety was considered at all times. We saw that staff induction had been developed in an effort to provide additional support to new staff with a view to reducing the problem of staff retention. Staff spoke positively about the teamwork in the home and there was a culture amongst staff to support each other. One member of staff told us, "Staff are supportive, not clicky at all, I don't feel like an outsider" and provided an example of how they were welcomed by colleagues. Another said, "This is the first time I've been in a care job and I've found the manager very approachable." These examples meant that the registered manager had worked with staff to create a working atmosphere that was supportive so that staff felt they could approach their colleagues or manager for support and know it would be there for them.

The provider told us in their Provider Information Return [PIR] that staff were encouraged to raise any concerns they may have and we saw evidence of this. Staff told us they felt supported and listened to. They spoke of the changes the registered manager had introduced into the home and the positive impact this had had. One member of staff told us, "Staff have had to take on changes and [registered manager] is really patient and gives staff the time. It's nice to be listened to. [Registered manager's name] still listens to everything you have to say, always says 'my door is always open' and it is."

The service was led by a registered manager who had a clear vision for the service. We saw that the local authority and Clinical Commissioning Group [CCG] were actively in contact with the provider with a view to purchasing more care. The registered manager was mindful of the impact this would have on staff and people in the home and was actively recruiting new staff. There were a number of plans in place for the future of the service, such as creating a dedicated unit to provide dementia care. The registered manager was working with the providers to assess the existing environment and how it could be improved upon in order to meet the future plans for the home. We saw that people had been involved in the re-naming of the

different areas of the home and their involvement in the future development and quality of the service was an ongoing theme through meetings and surveys seen.

We saw there were a variety of audits in place to assess the quality of the service provided. For example, audits looked at the environment, infection control and catheter care, to name but a few. Audits were completed on behalf of the local authority and where accidents and incidents took place, they were analysed for any trends. Where audits had identified areas for improvement, action plans were in place. For example, the registered manager had identified the problems with the new electronic medication system through their own audits and the decision to use this system was quickly reversed and lessons were learnt.

The provider had a history of notifying the Commission of any events that they are required to by law. We saw that the provider had on display their rating poster from their previous inspection, which they are required to do so by law.