Veronica House Limited

Veronica House Nursing Home

Inspection report

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21 July 2016

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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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 20 and 21 July 2016 and was unannounced. On the day of our inspection, there were 28 people living at the home.

We carried out an unannounced comprehensive inspection of this service on 1 September 2015 at which a breach of legal requirements was found. This was because people's medicines were not always managed safely.

We carried out a further inspection on 7 March 2016 to look at how the provider had made improvements to their medicines management processes. At this inspection we found that although some improvements had been made, there still remained 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 or a physical disability.

Prior to our inspection, we were told that the registered manager had left the home. 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.

On the day of the inspection we were shown round by the manager of the home's sister home, who had stepped in to oversee the home whilst another manager was recruited into post.

People told us they felt safe in the home and were supported by staff who had been trained to recognise abuse.

People did not always receive their medicines as prescribed by their doctor. A number of concerns highlighted at previous inspections remained in place and had not been addressed.

A number of staff had been recruited without references being sought and management had failed to identify this as a concern.

Staff felt well trained to do their job, and were supported to attend specialist training. Not all staff benefitted from an induction process that equipped them with the skills to do their job.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards, but information relating to this was not reflected in people's care records and where some people had the capacity to make their own decisions, this was not taken into account.

People were supported to have a nutritionally balanced diet and adequate fluids throughout the day.

Staff were concerned that information was not always communicated to them in a timely manner.

People benefitted from access to a number of healthcare services such as their GP, the dentist and physiotherapy services.

Most people told us staff were kind and caring but not all people agreed with this statement. People's privacy and dignity was not always positively promoted.

A number of people told us they were not involved in the development of their care plan or asked how they wished to be supported. Care plans did not hold information regarding peoples likes, dislikes or preferences.

Activities were available but did not reflect the personal interests of the people living in the home.

People and staff had not been made aware and reassured regarding the recent management changes in the home. Audits that were in place did not fully reflect an accurate picture of what has happening in the home.

Staff were not confident that if they raised concerns regarding the running of the home, that they would be listened to.

We found three 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.

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 safe.

Not all actions identified at former inspections with regard to the safety of medicines had been taken and concerns remained. Medicines were not always given to people as prescribed by their doctor.

Staff had been employed without references being obtained prior to commencing in post.

People felt safe and confident that staff were able to protect them from abuse and harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff induction had failed to provide some staff with the skills required for their role.

Staff understood the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards, but there was little information available to them regarding the people this legislation affected.

People were supported to maintain good health and access a number of healthcare services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that they were cared for by staff who were kind and caring, but not all people agreed with this statement.

People's privacy and dignity were not always promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all people were involved in the development or review of their care plans. Care plans did not hold information that reflected people's likes, dislikes and preferences.

There was a system in place to investigate any complaints received.

Feedback had been obtained regarding the service but the provider had not always acted on the concerns raised.

Is the service well-led?

Requires Improvement

The service was not well led.

People and staff had not been made aware of the management changes in the home or provided assurances regarding this.

The provider did not have systems in place to monitor and assess the quality of care people received.

There were a lack of systems and processes in place to ensure the provider was meeting the regulations.

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.

This inspection took place on 20 and 21 July 2016 and was unannounced.

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

We reviewed information we held about the service and used this information in our planning of the inspection. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted representatives from the Local Authority to ask them for their feedback on the care provided by this home.

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.

As the registered manager had very recently left the home, we spoke with the manager of the home's sister home, who was overseeing the running of Veronica House whilst a new manager was appointed. We also spoke with the clinical lead, the provider, five care staff, the chef, the activities co-ordinator, 12 people living at the home and three relatives.

We looked at the care records of seven people living at the home, two staff files, training records, complaints, accident and incident recordings, safeguarding records, 13 medication records, home rotas,

and audits sent to the local authority.

Requires Improvement

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. This meant the service was in breach of Regulation 12 of the Health and Social Care Act 2008. At our further inspection on 7 March 2016 to look at how the provider had made improvements to their medicines management processes, we found that whilst some improvements had been made, the service remained in breach of Regulation 12 and further improvements were needed. At this, our most recent inspection, we found that concerns regarding the administration of medicines remained.

We looked at the Medicine Administration Record (MAR) charts for 13 people and observed three nurses administer medicines to six residents. We found that medicines were not always managed safely.

We found that medicines were not always given to people as prescribed by their doctor. For example, one person had a pain medicine that was prescribed for external application three times a day but the records showed that in the last 17 days it had only been used as prescribed on six days. On all other days the medicine was given just twice a day. There is a risk that people's pain requirements will not be managed well and they will suffer unnecessary symptoms if medicines are not given as prescribed.

Records were not always clear enough to show how specific medicines should be given. For example, where people were prescribed eye drops, there was no record of which eye the drop should be used in. We looked at the guidance kept about medicines to be given 'when required'. Although there were arrangements for recording this information, we found it was not specific to individual's needs and was missing for some people. This meant there was a risk that care staff did not have enough information about what medicines were prescribed for and how to safely give them consistently and appropriately. One person told us that their skin was, "Very sore, it was never like this when I was at home". Care staff were responsible for applying some prescribed creams to people's skin. There was no information for staff on where the creams should be applied and in some cases there was no information on how often the cream should be applied. A record of administration was not always kept so it was not possible to confirm that these medicines had been offered to people or applied regularly.

For some people needing to have their medicines administered directly into their stomach through a tube, the necessary safeguards were not in place to administer these medicines safely. There were no written protocols in place to inform staff on how to prepare and administer these medicines and two staff members told us two different ways in which they administered these medicines. By not administering the medicines in the same way there is a risk that people's health and welfare could be affected. For those people who required medicinal skin patches, we found that staff were not following manufacturer's guidance when rotating the application of the patches, which could result in unnecessary side effects.

The provider did not have a system in place for recording medicine errors. This meant that there was no

evidence of learning from past mistakes and there was an increased likelihood that the same error could happen again and people were not protected against these risks.

This is breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People told us they received their medication on time. One person told us "It takes a while for them [staff] to come [when they press the buzzer] but I do get my medication on time" and another person told us, "If I need Gaviscon I press the buzzer". We saw that medicines were stored safely and at the correct temperature.

Staff told us that prior to commencing in post they had been asked to provide details of two referees and complete a check with the Disclosure and Barring Service (DBS). The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed. We looked at the personnel files of two recently appointed members of staff and found that references had not been obtained for one of them prior to them commencing in post. We raised this with the acting manager who immediately arranged to obtain telephone references for this person. We found that there were no references in place for a further five members of staff and only one reference in place for six members of staff. This meant that the provider did not have the checks in place to ensure they employed 'fit and proper' staff who were able to provide care and treatment appropriate to their role.

This is breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People told us that they felt safe in the home. One person said, "I'm not worried about anyone breaking in" and another person said, "Yes I feel safe". A relative told us, "It has a relaxing, safe environment".

We saw that staff had receiving training in how to safeguard people from abuse. A member of staff told us, "If I spotted some abuse I would report to senior, nurse, manager, CQC and safeguarding". However, we saw on one person's file that a member of staff had noted bruising on a person's shoulder but had failed to follow this up. We shared this information with the acting manager, who agreed to look into it. This meant that the provider could not be confident that all staff responded to safeguarding concerns consistently.

We saw that risk assessments were in place in order to assist staff in reducing the risks to people. A member of staff was able to describe to us the particular risks to one individual, the indicators to look out for and how they managed those risks. However, we also found in a number of instances risk assessments had not been completed for some people. For example, for one person, there was no risk assessment in place for their particular healthcare need. We raised this with the clinical lead and they agreed to rectify this.

People told us they were not always responded to in a timely manner. One person described to us an incident when their room buzzer was stuck under their wheelchair, they said, "I told a member of staff who then went off and I was left for half an hour before they returned". Another person said, "Sometimes I have to wait, it's more difficult at night, sometimes I have to wait up to an hour". A member of staff told us, when asked if there were enough staff, "Yes and no. The rota counts seniors on, but they have to make sure the shift is running properly. We don't respond to people in a timely way. We could do with a 'runner' on each floor". Another member of staff said, "On occasions, no we don't have enough staff. On Fridays and Mondays when some people have pool therapy, it takes people off the floor and you see staff more and more stressed due to this". We observed that staff were very busy but did respond to people's needs. We discussed staffing levels with the provider who advised that any staff absences were covered by existing staff, with the occasional use of agency where necessary. We were told that the provider was responsible for assessing the

number of staff required in the home.

Requires Improvement

Is the service effective?

Our findings

Staff did not benefit from an induction which prepared them for their role. We spoke with a new member of staff who had been in post for a short amount of time. They told us their induction consisted of one day, looking at policies and procedures and some manual handling techniques. They told us, "When I came onto shift, a few people helped me out, I had to go round on my own. I do feel comfortable with some things, but not others. If I'm not comfortable I'll get someone else to help me". A member of staff said, "New staff who have not worked in care before are thrown in at the deep end. There is only one mentor, only level two qualified and they are never on the same shift as the new person". We were shown an induction pack that indicated areas of learning that were signed by staff to say they were happy to carry out a particular task and saw that arrangements were being made for new staff to study the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily life. The provider told us, "We tell staff not to sign [their induction] until they are happy". Despite this system being in place, the provider could not be confident that the induction was preparing staff for their role to support people appropriately and safely.

Staff told us that they had not received formal supervision and were therefore not given the opportunity to discuss their performance and learning in a formal setting with the manager. A member of staff told us, "Supervision is peculiar here. You are given a task and the senior watches you. My understanding of supervision is you meet with your senior and discuss good and bad points on both sides". We saw that this had been identified as an issue and training was being put in place for staff on this subject.

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 application 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us that staff obtained their consent prior to supporting them. One person told us, "I make my own decisions staff are really good". However, we saw for two people who had capacity, consent forms in their care plans had been signed by a relative. The acting manager told us, "The person has capacity, I don't understand why other people have made decisions on their behalf". The acting manager told us they would look into this immediately and if appropriate, arrange for the person to receive support from an advocate. Staff spoken with had an understanding of MCA and DoLS but not all staff were able to identify those people who were being deprived of their liberty. One member of staff told us, "There are quite a few DoLS applications in place" and was able to describe the reasons why an application was in place for one particular person. However, there was no guidance available for staff to instruct them as to why the application was in place, what it meant for that particular individual or the date that the authorisation

would need to be reviewed before it expired.

We received mixed reports from people regarding the care they received. Some people spoken with told us they considered staff to be well trained. One person told us, "They are alright here, I get good care" and another person said, "The staff are well trained, even the trainees are learning" but another person told us, "They could do with more training in looking after stomas" [stoma is an opening on the front of your abdomen which diverts urine or faeces into a pouch on the outside of the body]. Staff spoken with told us they had access to enough training to ensure they were competent in their role. A member of said, "I've had quite a few opportunities; I asked for training in two specific areas and it was arranged for me". We saw that arrangements were made for staff to attend specialist training, such as brain injury awareness and end of life care in order to support people's particular healthcare needs. The clinical lead explained to us particular training he had put in place for nursing staff in order to support a particular individual. They told us, "You need to know the implication of what you are doing".

At our inspection in September 2015, we highlighted concerns regarding communication in the home and at this our most recent inspection, we found those concerns remained. Staff spoken with told us that communication within in the home wasn't as effective as it could be. One member of staff told us, "It would be nice to be aware of events like taking people to hospital. I have been told half way through doing personal care that I am to go to the hospital, didn't seem to care that I was doing personal care". Another member of staff told us, "A lot of staff have told us they are not getting handover, so I devised a sheet with basic information for carers to have a quick glance at. The senior should share information with staff but a lot of staff complain that information is not always passed on".

People were complimentary about the food that was made available to them. On the day of our inspection, it was a very warm and we saw that people were provided with plenty of drinks to keep them hydrated and fans were placed in people's rooms and communal areas. One person told us, "The food is excellent, look it's just arrived and smell the mint sauce" and another person told us, "Quite good quality food and you can change your mind". We spoke with the chef who was aware of people's dietary needs, but there was little information available with regard to people's likes and dislikes. We saw that people were offered a choice of two meals at lunchtime, but were asked to make their choice two days beforehand. One person told us, "I am given choices of two meals, but I can't always remember what's for dinner on the day". We were told that people could ask for alternatives, but not everyone was aware of this. For example, one person told us, "I would love to have Caribbean food, I would love ackee and saltfish". We raised this with the chef who told us it would not be a problem to accommodate these requests and would look into the matter.

One person told us, "Staff are well trained and I can always ask to see a doctor" and relatives confirmed they were always kept informed of any concerns regarding their relative's health. A relative told us, "The slightest worry and they let you know, all of the staff are so pleasant and polite, nothing is ever too much trouble". People were supported to access a range of healthcare services, including their GP, dentist and optician and were supported to attend appointments where required. Where people required support from the Speech and Language Team (SALT) we saw that referrals were made and actions followed up on. A member of staff told us, "We work well with the physiotherapist and the SALT team. We get good support and can contact them with any queries". The clinical lead displayed a comprehensive knowledge regarding people's complex healthcare needs and how best to support them. Staff told us, and we saw evidence of the improvements in the person's health since being at the home. A member of staff told us, "[Person's name] is now off the PEG [where people are unable to eat and drink by mouth and receive their nutritional intake via a tube], and is able to support themselves at mealtimes".

Requires Improvement

Is the service caring?

Our findings

People told us that staff who supported them were kind and caring. One person told us, "Staff are kind and approachable, on the whole they are very good", another person said, "I can't praise them enough". A relative told us, "I will always be eternally grateful for what they have done for [person's name]" and another relative said, "They [staff] are very patient, [person] is kept clean and they know her very well". However, some other comments we received were not so positive and we referred these to the acting manager to look into individually. One person told us, "I just want someone to tell me why I'm here and I want them to listen to me. No-one is telling me why I'm here". We immediately arranged for the acting manager to speak to this person, to offer reassurance and support, which they did. On the second day of the inspection, we saw that the acting manager had responded to all the comments raised and the person told us they were happy with the actions that were being taken.

We observed that staff were caring when they supported people and when they had the opportunity, would sit with people and have a general chat with them, which people enjoyed. Staff were able to describe to us how they communicated with people using their preferred method of communication, for example by using signs or gestures. We observed a member of staff engaging in conversation with another person regarding the jewellery they were wearing, showing a genuine interest in what they had to say. Some people told us they felt listened to and that staff treated them with dignity and respect. One person said, "If you ask they [staff] will explain things" and another person said, "They [staff] will have a chat and a giggle and they always knock the door, staff are excellent". However, not everyone we spoke with felt the same way. One person told us, "I just want a little bit more attention, I have lost all of my liberty I can't describe it". This meant that the provider could not be confident that all people living in the home receive the same, consistent caring attitude from staff when being supported.

Although some people told us they were involved in the planning of their care, not all people spoken with benefitted from this experience and one person told us how frustrated they were and felt they were not being listened to when they spoke to staff about their care and support.

A member of staff told us, "We promote people's independence by asking them to do something themselves". We saw that people were encouraged to maintain their independence where possible. At lunchtime, we observed a member of staff supporting one person to eat their meal, and also conversed with other people in the room at the same time. The atmosphere was pleasant and friendly and the people living at the home enjoyed a laugh and a joke with the staff who came into the dining room.

Staff were able to describe to us how they treated people with dignity and respect when supporting them with their personal care, for example, by ensuring curtains and doors were closed or covering people with a towel. A nurse told us how she ensured staff treated people with dignity and respect. She told us, "I will observe practice and make sure the person is covered appropriately". However, we also saw that when people were receiving their physiotherapy, there were other people in the room who were also having their hair done. This meant that people's dignity and privacy was not always respected consistently.

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.

Requires Improvement

Is the service responsive?

Our findings

Whilst some people living at the home had been involved in the planning of their care, others had not. Care plans were very clinical, but there was very little information that had been gathered regarding people's likes, dislikes, preferences or aspirations. One member of staff commented, "Unless you know the person, or have been here a long time; you wouldn't know anything about them from the care plan". We looked at a number of care plans and then spoke to people and their relatives. What people and their relatives told us about themselves was not documented in their care plans.

We spoke with the activity co-ordinator who was new in post. She told us that she planned on a weekly basis activities for people in the home and was trying to develop and extend opportunities for people beyond the home. One person told us, "They don't understand my spiritual needs I can't go to church because I'm in a wheelchair". The activity co-ordinator confirmed that there were no current community connections with local schools or faith groups. The acting manager told us, "We are trying to steer away from bingo and are planning some other activities. We had a Black Country Day, and we are arranging small day trips – it's about working out what people like to do".

Some people were able to share with us their hobbies and interests and tell us about activities they used to enjoy and participate in. However, as information regarding people's preferences and individual likes and dislikes had not been gathered, there were no timetabled activities in place that would include these interests. One person told us, "I wish someone would tell me how I'm doing, I don't have the strength to do activities". One member of staff told us, "Some people like dominoes and the ball man and a dancer have come in. We've been taking people out recently. Activities aren't individualised enough, [person's name] can't see very well, yet they get him to play cards. There's no person centred activities".

We were shown a booklet entitled 'All about me' that had been introduced into the home when it first opened, with the intention of gathering information about people, their life history and likes and dislikes. We found a completed copy of this booklet held on a person's care file. We shared this with the activities co-ordinator, who told us she was not aware of it and understood that she wasn't allowed to see the contents of people's care plans. We were told the former manager had replaced this with another document entitled 'Memory diary' but we saw that the questions were aimed predominately at women who had lived through the war. This meant that the information gathered was only relevant to a small minority of people living in the home.

We observed there were no traditional memory aids in the home such as clocks or calendars which would assist people with their memory and daily routines. People were completely reliant on staff telling them the date and the time.

People spoke with told us they knew the process to follow if they wished to raise a complaint, but had never had cause to complain. We saw that there was information on display regarding complaints, comments and compliments and a complaints folder was accessible to people in the main entrance to the home. We saw that a complaint had been responded to in a timely manner but there was no evidence that it had been

dealt with to the satisfaction of the complainant. Staff were unable to locate any further information regarding this and told us that the former manager had been involved in this process. A member of staff commented, "If there was any complaints I wouldn't know anyway as there's a lack of communication".

We saw that a meeting had been held for people living at the home and their relatives earlier in the year and that surveys had also been sent out for completion. The response to the survey was mixed. There were a number of positive responses to the questions asked, but also a number of responses that indicated that people had not been involved in the planning of their care and reviews of their care. One person had written on their survey that they had raised issues with the former manager and the clinical lead and whilst some had been actioned, others had not been followed up. They also added that they had to keep asking and reminding staff to ensure certain things got done which had already been agreed to. There was no evidence to show that actions had been taken in response to the findings of the survey.

Requires Improvement

Is the service well-led?

Our findings

We saw that 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. For example, not all the concerns regarding medication, which had been highlighted in our previous inspections in September 2015 and April 2016 had been addressed. The provider had failed to ensure the requirements of the action plan that had been submitted had been met. The systems in place to ensure that the provider's recruitment processes were followed were not robust. The provider had failed to gather all available information to confirm the staff they were employing were of good character. We were told that when the former manager had been appointed, they had taken responsibility for these areas but the provider had not ensured that these actions were met.

We saw that accidents and incidents had been logged inconsistently and had not been analysed. This meant the provider was unable to identify possible trends or lessons learnt to reduce the possibility of a reoccurrence of the incident, and the acting manager confirmed this.

The lack of audits and quality assurance systems throughout the service, meant that there were no opportunities to learn from medication errors or any other concerns that had been raised. Where surveys had been completed by people using the service, there was no evidence to suggest that any of the issues raised had been acted upon. People's care plans were detailed in respect of their clinical needs, but there was little or no personalised information available. Paperwork that had been established to obtain personalised information about people had been changed but was not being used. No one had taken responsibility to follow this up in order to ensure that people received a service that met their individual needs. The induction in place for new staff did not equip them sufficiently with the skills they required to confidently support people. This, coupled with a lack of formal staff supervision and staffs' reluctance to voice their concerns to management meant that the provider was not able to obtain an accurate picture of the service they provided or be assured that they were providing a safe, quality service. This lack of monitoring of the service by the provider, meant that they were not aware of the concerns that had come to light during the inspection.

This is breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The acting manager told us that she was not aware of any specific audits that were taking place, but she was able to show us a weekly audit that was completed and sent to local authority commissioners. She informed us that through her own investigations, she had uncovered that the information it contained was not a true reflection of what was happening in the home, for example, it did not highlight some medication errors she had identified and the number of wounds being cared for was documented as three when in fact there were five. We saw that she was working to correct this information to provide the local authority with an accurate representation of the home.

The registered manager left the home the week before the inspection took place. People told us they were not aware that the manager had left. People told us they thought the home was well led, but staff spoken

with disagreed with this. One member of staff told us, "Morale is not good, there have been so many changes in a short period of time. At the moment it's a bit hit and miss and all over the place. I'm not confident that if I raised concerns with a director, that they would be acted upon". Another member of staff told us, "There are staff meetings, and you can voice concerns but sometimes I think, should I bother?" Despite this, staff told us they enjoyed their job and found it rewarding. One member of staff told us, "I love the rehab side of the job and seeing how people progress. Staff are good, if you can help each other they will, it's a friendly place to work". Another member of staff said, "I love all the service users; there are some nice characters here".
The provider told us that a formal announcement had not been made advising people that the manager had left. She told us, "Word has got round and people have come and asked us. We have been so busy we haven't got round to telling people". Staff also told us that an official announcement had not been made. One member of staff told us, "I've not been officially told about [former manager's name]. Relatives keep coming up to me about it, they've heard the rumours, it's difficult, knowing what to say". On the second day of our inspection, we were told that letters were being sent out to people advising them that the former manager had left and what arrangements were in place for cover.

Staff told us that the former manager had introduced a lot of change into the home, but staff did not always receive an explanation as to why the changes were taking place, which led to confusion and also some of the changes not being implemented.

The acting manager was currently managing both Veronica House and the home's sister home. She told us she had met with the providers and agreed how she would divide her time between the two homes whilst work got underway to recruit a new manager. She told us she had asked the clinical lead for information regarding each person living at the home and their needs and was awaiting this information. We discussed with her the challenges that lay ahead and the areas she had already identified that required some work. She told us, "The care plans are immense and they are a bit repetitive, I'm trying to review a couple every day". She also told us that she planned to invite staff to become 'champions' in certain areas of learning, such as end of life care, and dignity and respect. This would mean that people would benefit from being supported by staff who had received additional support and training to ensure people received consistent, quality care.

The acting manager told us that a survey had been sent out to staff following the departure of the former manager asking them what they wanted and how they felt. She told us, "We want to see what people think and how we can move forward".

We saw that the provider had on display their ratings poster from their previous inspection, which they are required to do so by law.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust processes in place to ensure they employed people of fit and proper character.