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**
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

About the service: Veronica House is a residential care home that was providing personal and nursing care to 35 younger and older people at the time of the inspection.

People's experience of using this service:

There were a lack of effective systems and processes in place to assess, monitor and improve the quality and safety of the services provided. Regular audits were not taking place which would provide the management with reassurances that people were being cared for safely and in line with their care needs. Accidents and incidents were not routinely analysed and opportunities were lost for lessons to be learnt. People were not involved in the planning of their care and care plans seen held inconsistent information. Risk assessments were not always fully evaluated or were missing and daily charts were not completed consistently.

Staff had not received training in specialist areas such as epilepsy and had only received basic training in dementia care. Systems were not in practice to observe staff competencies in areas such as tracheostomy and/or peg feed care. Systems were not in place to provide management with the assurances that people were supported safely and effectively in line with their care needs.

Staff felt well trained and supported in their role. People were happy with the care they received and felt it met their needs.

Staff were aware of people's health needs and liaised with other health care professionals to support their wellbeing. People were supported where appropriate at mealtimes. People continued to be asked to make choices regarding meal times 48 hours prior to having that meal, despite inspectors previously being told this would change to 24 hours. Evening meal remained at 4.00pm giving rise to concerns that people who may not be able to communicate that they were hungry (and could ask for supper in the evening), going without another meal until breakfast the next day.

We were told people could ask for snacks in the evening such as toast, soup or biscuits, but not everyone spoken to was aware of this and there was no routine supper trolley in place which would alert people to these options.

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. Staff obtained people's consent prior to supporting them, but staffs' knowledge regarding which people were deprived of their liberty was limited.

People were well cared for by staff who treated them with dignity and respect and encouraged them to maintain their independence. People were supported to be involved in decisions regarding their day to day care decisions but were not involved in the planning of their care.

There was no documented evidence available to show that where complaints had been received they had been responded to and acted on appropriately.

People and staff were not involved in the running of the home. Staff had not received regular supervision or had not had the opportunity to discuss any concerns or issues they may have at team meetings. Staff did not feel able to contribute to the running of the service. Quality audits were not in place to assess quality of care or drive improvement in the service. The service had been without a registered manager since August 2018.

Rating at last inspection: Good published 5 January 2018

Why we inspected: Concerns regarding the governance of the service were bought to our attention by the local authority.

Enforcement : Action we told provider to take. Please refer to the end of the full report.

Follow up: We will meet with the provider following the publication of this report to discuss how they will make changes to ensure the rating of the service improves to at least Good. We will re-inspect Veronica House within our published timescales to what improvements have been made.

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

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 always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well led.	**Inadequate**

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 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by information received from the Local Authority. We were advised of concerns regarding the governance of the service and as a result of these concerns, the provider had agreed to impose a voluntary embargo on placements.

Inspection team:
The inspection was carried out by one inspector, a specialist nurse advisor and an expert by experience. An expert by experience, who has personal experience of caring for someone who uses this type of service.

Service and service type:
The service did not have a manager registered with the Care Quality Commission. The deputy had recently put in an application to become registered manager.

What we did: Prior to the inspection we looked at information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents which may have occurred. A statutory notification is information about important events which the provider is required to send us by law. We also spoke with representatives from the Local Authority and used this information as part of our planning. Local Authorities together with other agencies may have responsibility for funding people who use the service and monitoring its quality.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people would could not talk to us. We observed care and support

being delivered in communal areas and we observed how people were supported to eat and drink at lunchtime.

During the inspection, we spoke with 11 people using the service and seven relatives, to ask about their experience of care. We spoke with the manager overseeing the service and their deputy, the deputy manager, two nurses, five carers, the administrator and a chef. We looked at the care records for eight people, two staff employment related records and records relating to the quality and management of the service.

Requires Improvement

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

● Not all people had assessments of risk associated with their care. For example, an epilepsy care plan and risk assessment were missing from one person's file which would provide staff with the information and guidance needed should the person experience a seizure. Also, another person's mobility risk assessment held inconsistent and misleading information regarding the levels of support the person required, for example, staff referred to the person using a frame to support them but their risk assessment did not mention this. We saw that a number of bed rail assessments were not up to date and the incorrect oxygen levels were documented for a person. Staff were not provided with the most up to date and accurate details on how to support the people safely. Staff spoken with were aware of the risks to people but referenced the information held in care records, which were not fully up-to date and in some cases, had information that was missing or conflicting.

● Where actions had been taken to address risks, care documents were incomplete and audits in place had not identified these errors. For example, charts monitoring the frequency of moving people in their beds to prevent the development of pressure sores were incomplete but had been signed off by a senior member of staff. This meant the provider could not be sure that people were getting the pressure area care they required. Where one person's weight was monitored, no action had been taken to address a consistent weight loss over a 12-month period until a recent quarterly audit had picked up the concerns and a referral made to the dietician.

● Systems were not in place to formally observe staff practice and competencies in care delivery including when providing tracheostomy care. A member of staff told us, "I am confident providing tracheostomy care, but not everyone is and I'll try and work alongside those who aren't".

● The provider had failed to identify the PAT test on a blood pressure monitoring machine was out of date and had last been completed in 2017. We raised this with the provider who advised responsibility for testing of these machines had previously been done by the CCG and they were not aware of that the test was out of date. They made immediate arrangements to ensure the equipment was tested.

● A system was in place for staff to alert maintenance team to any areas of works that needed to be carried out. A fire alarm test took place during the inspection and weekly monitoring of water temperatures took place.

Learning lessons when things go wrong

● Accidents and incidents had been recorded but there was no analysis of the information recorded or evidence of lessons learnt. For example, we saw in January 2019 five individuals had experienced falls in the home. We saw in February 2019 three of the five individuals had experienced falls again. There was no analysis or recognition of the repeat of these events or assessment of possible actions to take following these events. Where people had suffered minor injuries following these accidents, there was no evidence of body maps being completed to indicate exactly where the injury was. Also, we noted on two separate

records instructions were to monitor people closely following a fall. The deputy told us, "I would expect people to be monitored every 15 minutes following a fall". Despite being told there was a form in place to record these events, there was no evidence that this was done or that monitoring was increased following the accident.

We were not assured that all reasonable steps had been taken to reduces risks associated with people's care and support. This constituted a breach of Regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.agree breach

Staffing and recruitment

● At the time of the inspection there were several staff vacancies including the post of registered manager and four nursing vacancies. Agency staff were being used to cover staff vacancies and efforts were made to use the same agency nurses where possible to provide continuity of care.

● People, staff and relatives all voiced concerns regarding staffing levels and staff's ability to respond to people's needs in a timely manner. One person told us, "Staff are golden, but they are stretched to the limit" and a relative said, "Sometimes they could do with a few more [staff] they are running around ragged". A member of staff told us, "When fully staffed it's ok, but there is a lot of staff sickness, but they do try and get agency in". During the inspection, we observed staff responding to people in a timely manner.

● There was a dependency tool in place to assess staffing levels but the manager overseeing the service felt the tool did not reflect the staffing levels needed and therefore additional staff had been placed on the rota. We saw on the dementia unit there were three staff on shift. However, two people on the unit were nursed in bed and required two staff to support them safely. This meant one member of staff would be left to support the remaining individuals, some of whom presented behaviour that may challenge. On the second day of the inspection we saw during the day only two members of staff worked on the unit as their colleague had been called to support another person on a hospital visit and additional support was not available. This meant people were not provided with the levels of support management had identified and staff told us they were unable to consistently respond to people's needs in a timely manner.

● We looked at two staff files. We saw satisfactory references and completed Disclosure and Barring Checks [DBS] prior to being employed by the service.

Using medicines safely

● We looked at the medication records of 18 people and found numerous gaps in signatures which meant the provider could not be confident that people received their medicines as prescribed. We saw that appropriate protocols were not always followed for example, creams and lotions in some rooms had been opened but not dated. There was no daily record check in place of controlled drugs.

●We saw for one person the dose of a medication had been increased by their GP. The service had experienced problems in getting the new prescription issued by the GP, resulting in a delay of approximately 12 days. We spoke with the person who was aware of the delay and told us they had not suffered any ill effects because of it. The absence of this medication meant this person was at an increased risk of poor health.

● There was an action plan in place to address several concerns regarding medication, including the auditing of medication administration records for missed signatures. The deputy manager was able to show us the actions they had taken to date to improve this area of the service and this work was currently ongoing.

Systems and processes to safeguard people from the risk of abuse.

● People told us they felt safe and relatives and staff spoken with agreed with this. One person told us, "They [staff] use the hoist, they know how to use it I feel safe in it, the staff are competent".

● Staff spoken with had received training in how to recognise signs of abuse people may be at risk from and were aware of their responsibilities to report and act on concerns.
● Where safeguarding concerns arose, the provider had responded and acted on the concerns appropriately, including reporting them to the local authority and putting in measures to keep people safe.

Preventing and controlling infection
● Staff had received training in infection control and confirmed they had access to protective personal equipment such as gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● At previous inspections of the service people were asked to choose what they would like to eat 48 hours before they had their meal. We raised this as a concern and at our last inspection in September 2017 we saw this had changed to 24 hours before and we were assured this would remain in place. However, at this inspection we found that despite assurances, this had reverted to 48 hours. One person told us, "I have to make a decision 48 hours before I have the meal. Can you remember what you chose 48 hours ago? I know I can't. I don't mind them asking 24 hours before, but it's not good asking 48 hours".

● At our last inspection we also shared a person's concerns regarding the timing of the evening meal which they felt was too early at 4.00 pm. At this inspection, two people raised concerns regarding the timing of the evening meal. One person told us, "I think lunch is too early and should be a 1.00 pm and tea is too early at 4.00 pm. You don't have breakfast tile 7.00 am or 8.00 am. It's a long time to wait". We asked if they had raised this concern previously with management and they told us, "I've been raising it for the last three years and it hasn't changed" adding, "I'm used to being hungry in the evenings now". We looked at this person's care records and noted they had lost a considerable amount of weight in the last 12 months. These weights were being recorded but no action had been taken to address this. The person told us they were concerned about their weight loss as well. The person's weight loss was not picked up until very recently, when a quarterly audit of people's weight was completed resulting a referral to the dietician being made for this person.

● We were told people could ask for snacks in the evening such as toast, soup or biscuits, but not everyone spoken to was aware of this and there was no routine supper trolley in place which would alert people to these options.

● A relative told us, "I bring [person] soup and biscuits and things for them to eat, they don't really like the food, we have meetings [with management] and I talk about the food, but nothing happens".

● We saw where people had specific dietary needs, for example required a diabetic diet or meals to be pureed, this was adhered to. We spoke with a member of the kitchen staff who informed us that care staff kept them informed of people's dietary needs and preferences.

Staff support: induction, training, skills and experience

● The manager overseeing the service was not able to demonstrate they had checked the competency of care and nursing staff to ensure they were equipped with the skills needed and were applying these into practice.

● Staff told us they had not received regular supervision or an annual appraisal which would provide them with the opportunity to discuss their learning or any concerns they may have.

●Staff had access to a variety of training modules through e-learning and were expected to keep up to date

with their training. A training matrix was in place to provide management with an overview of staffs training. However, it was noted no staff had received training in how to support people who lived with a diagnosis of epilepsy, despite several people living at the service being diagnosed and receiving medication for this condition. Since the inspection, we have been told that this training has commenced. Staff who supported people who lived on the dementia unit told us they had only received 'basic' training in this subject. The manager overseeing the service told us the provider was currently looking at sourcing additional training in this area.

●People were supported by staff who received an induction that prepared them for their role and included opportunities to shadow more experienced staff.

Staff working with other agencies to provide consistent, effective, timely care

Supporting people to live healthier lives, access healthcare services and support

● Systems were in place to share information and communicate with other services

● People had access to a variety of healthcare services to help them maintain good health, including their GP, dentist and optician.

● The service monitored people's health care needs but did not consistently act on issues identified. For example, for one person there had been an increase in their agitation which had been raised at a meeting with senior staff on 11 September 2018. There was no evidence available to demonstrate any follow up action with health care professionals regarding these concerns. We discussed this with the deputy and found that some medical intervention had taken place earlier this year, but there was no evidence that further appointments had been followed up.

Ensuring consent to care and treatment in line with law and guidance

●The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We saw that conditions for one person were being met, but staff spoken with were not aware of who had a DoLS in place.

● People told us staff obtained their consent prior to supporting them and they were in control of their care.

● Staff described to us how they obtained people's consent prior to supporting them. These discussions demonstrated that staff encouraged people to make their own decisions and that staff respected these.

Adapting service, design, decoration to meet people's needs

● The environment was accessible and spacious. People had personalised their own rooms. The manager overseeing the service expressed their concerns regarding the decoration of the dementia unit and talked of plans to improve the environment for people living there.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●Prior to offering support, people's needs were assessed to ensure the service was able to support them effectively and safely. We found the protected characteristics under the Equality Act had been considered when planning people's care, including who was important in their lives.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

People spoke positively about the caring nature of individual members of staff and we observed several caring interactions between staff and people living at the service. However, we also found that the provider's lack of systems did not always support the service to be fully caring. This can be demonstrated by the concerns found in other areas of this report.

Respecting and promoting people's privacy, dignity and independence

● One person told us an agency nurse had refused to carry out a particular procedure (that management had understood they had received training for), for a female resident. A male member of staff had stepped in and carried out the procedure. The person told us, "It was a bit embarrassing". We were advised the agency member of staff no longer worked at the service following this incident. Other people spoken with told us staff treated them with dignity and respect and we observed this and told us generally their preferences for male and female carers were observed.

Ensuring people are well treated and supported; equality and diversity

● People told us they felt staff did not always have enough time to spend with them. One person said, "Staff are helpful they are very stretched they come in a turn you and rush off" and another commented, "Generally [the care] is good, but there are not enough staff, they never had any time to chat, they have no time to spend with you". Staff spoken with also raised concerns regarding having enough time to spend with people. One member of staff told us, "I feel only essential care can be given".

● All people we spoke with told us they were treated with kindness and we observed people had positive and warm relationships with the staff who supported them. People spoke positively about the staff. A relative told us, "They [staff] look after [person]; they are good girls and they know [person] and look after them really well".

● Staff showed a caring nature when talking about the people they supported. We observed a number of interactions between staff and people living at the service, which demonstrated their caring nature. Staff passed the time of day, enquired with people how they and their loved ones were and were generally well informed when it came to recent events people had been involved in.

Supporting people to express their views and be involved in making decisions about their care

● Staff were aware of what was important to people and ensured they supported them to express their views and maintain their independence where possible regarding their day to day care. People told us they had not been involved in the planning of their care and people's choices were not always respected. For example, in relation to the times people wanted to eat their meals. One person told us, "I don't really feel like tea at 4.00pm. it's a long, long time until breakfast". Relatives told us protected mealtimes had recently been introduced without consultation and many people and relatives were unhappy about this

arrangement. These concerns had been raised at a recent relatives' meeting and were being considered by management. A person told us, "I don't like these protected meal times, I like my daughters to stay. We talked about it at the meeting". We observed staff offering people choices regarding where they sat, what they wanted to watch on television or listen to on the radio, or an activity they wanted to participate in.

● Staff were able to describe how they offered choices to people who were unable to communicate verbally, for example by observing people's body language in response to questions asked. One member of staff told us, "[Person] sometimes gets frustrated as I cannot always gauge what they are trying to say, so I get them to write it down for me and then it's lot easier for us both".

● We saw that advocacy services were accessed for people who required this additional level of support. 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

Responsive – this means we looked for evidence that the service met people's needs
People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● Care and support plans were not consistently completed and did not provide up to date information that staff required to support people. Information was missing, or inconsistent and had not been reviewed. For example, we noted one person's care plan lacked information on how to transfer them [ie from bed to chair]. For another person, we saw that there was a lack of information regarding how to support a person when they became agitated or distressed. Management had identified care plans were in-complete but progress was slow in addressing these concerns.
● People told us they had not been involved in the development and review of their care plans.
●Staff spoken with knew people well, but the knowledge they held about how to support people in line with their needs and preferences, was not reflected in people's care records and therefore not all staff would be aware of this information. For example, one person's care record stated staff should carry out regular safety checks every 30 minutes or less if a person became agitated. The care plan failed to describe how the person showed their agitation which would assist staff in recognising events which may lead to the person putting themselves or others at risk. The deputy was able to tell us the behaviours the person displayed when agitated and what staff should do to protect themselves and others, but this information was not documented in the care records.
● There was an activity co-ordinator who worked across the service to support people to take part in a variety of activities that were of interest to them. Noticeboards across the home indicated the planned activities that were taking place on a daily basis. We observed the activity co-ordinator arrange an activity with a small group on people. They asked people what they would like to do and offered a number of choices. They also checked with people before they switched the television off and asked them if they would like some music in the background. We observed people enjoy the interaction and it was clear they had a good relationship with the activities co-ordinator, who they welcomed with open arms. It was clear that the activities co-ordinator had a positive impact on the people living at the home. One person told us, "The activities could be better; music would be nice, we have karaoke but it doesn't meet my needs. I asked at the meeting and it was all noted so we will see". A relative commented, "When [activities co-ordinator] isn't here, nothing happened, they [staff] just leave them in their rooms it's like the place comes to a standstill, especially at weekends".

Improving care quality in response to complaints or concerns
● We saw there was a folder in place to record any complaints received. We noted the last complaints recorded were when the former manager was in post. At that time the complaints were recorded and responded to appropriately. Since the departure of the registered manager, there were no complaints recorded despite people telling us they had raised concerns. A relative said, "I sent in a complaint on 17 March, I still haven't had a response". We spoke with the manager overseeing the service who recalled speaking to the relative and told us they had arranged a meeting with them but there was no record on file of the actual complaint or the any response to it.

End of life care and support

- There were systems in place to provide end of life support to those who required it.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care

● The lack of oversight of the service including the lack of effective audits in place meant that areas for action were not routinely identified. For example, staff were expected to complete daily charts to evidence that people had received their personal care, had been repositioned on a regular basis if nursed in bed and had been provided with sufficient food and drink. However, we noted these forms had not been completed consistently and they contained a number of errors or gaps. Further, many of these forms had been signed off by the senior member of staff on shift as being acceptable. For example, we saw that handwritten charts for one person identified they had been turned on their left side at 3.30 pm and remained on their left side until 10.00 pm at night. The senior responsible for auditing this form had signed this off with no comment. Duplicate electronic recordings of the charts had said the person had been turned at 7.16 pm but did not say which side they were on. Therefore, systems and processes in place to ensure the quality of the service were ineffective as they had failed to identify these errors.

●The manager overseeing the service described the care plans as 'appalling' and told us they had come to this conclusion in September 2018 and had been given the task, with another colleague to address their concerns. However, at the time of the inspection, only eight of the 35 plans had been re-written and there was no formal system in place to ensure staff had read and understood the new content.

● Following the departure of the former registered manager, a number of systems and processes that were in place to provide an oversight of the service had not been continued. For example, a formal end of shift report which would provide an oversight of what had happened at the service during a 24-hour period had not been completed since they left. This meant that systems to monitor the service and care provided were not being used effectively to ensure people's safety.

● Systems had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. There were a number of failings in several areas which should have been addressed through the operation of robust systems of governance, audits and monitoring. Accidents and incidents were not being analysed, care plans and risk assessments were not completed or were missing, staff competencies had not been assessed and staff supervision sessions had not taken place.

● Audits had failed to identify a risk assessment was missing [on a staff file] where a concern was raised on a DBS check. We raised this with the deputy manager, who followed this up and found it had been done but not placed on the file.

● Staff were not provided with the opportunity to have a one to one discussion with management regarding their training and care delivery and any concerns they may have. Staff competency checks were not taking place which would provide management with reassurances that people were being supported safely and in line with their care needs.

● There was an action plan in place that had been developed alongside the local authority following the

voluntary embargo on placements that was in place.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 agree

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● Since the departure of the registered manager, no staff meetings had taken place which included all staff. Staff were not aware of what as happening in the home and what the plans were for the future. There was a general theme amongst the staff spoken with, all said, "I don't know what's going on" [with regard to the service]. We saw the minutes of the last staff meeting for senior staff that had taken place in October 2018. We were told plans were in place for a full staff meeting in May 2019.

●Staff surveys had not taken place which would provide staff with the opportunity to voice any concerns they may have. Many staff described staff morale as low and cited a number of reasons, including the introduction of 14 hour shifts and the failure to recruit to the registered manager's post. A member of staff said, "Staff morale is low. No one wants to do a 14-hour day". Staff told us they felt supported, but not listened to and were also concerned regarding the failure to recruit full time nurses but were complimentary of two of the agency nurses who had been block booked to work at the service. They told us they felt reassured when these staff where on duty. We saw efforts were ongoing to recruit to the vacant posts.

● There was no system in place to provide management with an overview of the day to day culture and delivery of care at the service. Further, there was no system in place to share information with staff regarding the vision for the service and ongoing management arrangements.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The service had been without a registered manager since September 2018. The registered manager of the provider's sister service and their deputy, had been given responsibility by the provider to oversee both Veronica House and the provider's sister service. The deputy had recently returned to post and had applied to become registered manager of the service.

● Staff were aware of their roles and responsibilities and were complimentary of their colleagues when working together as a team to meet people's needs. However, a lack of ownership by some staff to complete some paperwork appropriately or check for errors meant the provider could not be confident the service being provided was safe and effective.

● The provider had met the requirement to display their most recent rating on their website and within the home.

● There was an electronic recording system in place to store care records but not all staff had received training on this.

● The provider had failed to ensure staff had received the appropriate training which would provide them with the necessary skills to meet the needs of the people they care for and support.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Surveys had recently been placed on reception for visitors to complete. Nine had been completed and a meeting had very recently taken place to discuss the concerns raised and respond to people's concerns, for example, regarding protected mealtimes.

● People living at the service had not been asked to complete surveys and the lack of reviews of care taking place meant that people were not being given the opportunity to have their voice heard. People told us they

had previously raised concerns about the timing of the lunch and evening meals but that things had remained the same.
Staff told us they felt supported, but not necessarily listened to. Staff supervision sessions were not taking place and there had been no staff meetings.

Working in partnership with others
● The provider was working alongside the local authority quality team in order to improve service delivery and was providing weekly updates on the actions being taken.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We were not assured that all reasonable steps had been taken to reduce risks associated with people's care and support.

The enforcement action we took:

We placed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient and inadequate systems in place to monitor and improve the quality of the service.

The enforcement action we took:

We placed conditions on the provider's registration.