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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 1 and 2 September 2015 and was unannounced. The inspection was carried out by two inspectors and a pharmacy inspector. The home was registered on 2 April 2014 and this was their first inspection.

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

There was a registered manager. 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 the registered manager was on leave and we were shown round by the Clinical Lead.

Summary of findings

People and their relatives told us that they felt safe in the home. Staff were aware of the risks to people living at the home but risk assessments were inconsistently reviewed and care plan paperwork was not always completed in a timely manner.

People did not always receive their medicines on time. People's medical conditions were not always treated appropriately by the use of their 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.

Staff were concerned about being able to respond to people's care needs in a timely manner due to staff sickness levels and the number of new people being admitted to the home.

Staff felt well trained to do their job and supported by the registered manager. Staff spoke positively about the training they received and the induction process.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what this meant for people living at the home.

We saw that people were supported to have a nutritionally balanced diet and adequate fluids throughout the day and were offered a choice at meal times. A pictorial menu was being developed to assist people in making their choices.

Communication systems across the home were not consistently applied which meant people's needs were not always effectively met.

People were supported to access a number of healthcare services such as their GP, the dentist and optician. However, this was not always applied consistently across the home.

People and their relatives told us that staff were kind and caring and helpful and treated them with dignity and respect. We saw instances where staff spoke warmly to people, using their preferred method of communication and offered reassurance when required.

People told us that they were not involved in their care plan and had not been asked how they wished to be supported. Activities were available but were not person centred and did not reflect the personal interests of people living in the home.

There was a procedure in place for staff to follow when investigating complaints, but it was not evident that this process had been followed.

People were not asked for their views of the service and the provider's own quality audits had failed to identify a number of areas of concern that were highlighted during the inspection. This meant that issues which could affect people's experience of the service were not being routinely identified and addressed.

We found one breach 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People had not received their medicines at the right time or in the correct way.

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

Staff were safely recruited to provide care and support to people.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff were trained and supported to ensure they had the skills and knowledge to support people appropriately and safely.

Communication across the home was not consistent to ensure staff had the most up to date information in order to meet people's needs.

People were supported to have enough food and drink and staff understood people's nutritional needs.

The registered manager and staff understood the principles of the Mental Capacity Act 2005 (MCA).

Requires improvement

Is the service caring?
The service was caring.

People told us that they were cared for by staff who were kind and caring.

People's privacy and dignity were promoted.

Good

Is the service responsive?
The service was not consistently responsive.

People were not involved in the development or review of their care plans.

People were confident that if they raised any complaints they would be dealt with; however lessons learnt were not taken forward to improve the delivery of care.

Requires improvement

Is the service well-led?
The service was not consistently well led.

People spoke positively about the registered manager and the management team.

Audits in place had failed to identify a number of areas that required improvement.

Requires improvement

Veronica House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 2 September and was unannounced. The inspection was carried out by two inspectors and a pharmacy inspector.

The registered manager was on holiday on the day of the inspection and we were shown round by the clinical lead.

Prior to the inspection, some concerns had been raised regarding the administration of medication in the home. We therefore decided to include a pharmacy inspector in our team to assist with the inspection process. We looked at notifications that had been received from the provider about deaths, accidents and incidents and any safeguarding alerts that they are required to send us by law. We also spoke with representatives from both the Local Authority and the Clinical Commissioning Group (CCG) in order to obtain feedback on the care provided by this home.

We spoke with eight people who lived at the home, two relatives, the clinical lead, the owner, the in-house trainer, the chef, the activities co-ordinator and five care and nursing staff.

We looked at the care records of 10 people living at the home, two staff files, training records, complaints, accidents and incident recordings, safeguarding records, policies and procedures, medication records, home rotas, staff supervision records, quality audits and surveys.

Requires improvement

Is the service safe?

Our findings

One person told us, "Yes I've just had my medicines" but a relative commented to us, "My relative has never had their morphine on time". We observed that some people did not receive their medicines as they should have. For example, one person had not had their four times a day antibiotic capsule for a whole day. We found two people had been prescribed an antibiotic which needed to be administered on an empty stomach. Staff were not aware of this and as a consequence people were receiving them with or just after their meals, which meant the antibiotic would not work properly. We also found an antibiotic eye drop had been administered for a longer period than was recommended and as a consequence this practice could place this person at risk.

We looked at how controlled drugs were managed and found that people's medical conditions were not always being treated appropriately by the use of these medicines. We found that five people had been prescribed a pain relief medicine that had to be administered every 12 hours. We found that the nursing staff were not aware of this and had not been administering the pain relief medicine every 12 hours as prescribed. We spoke to a relative of one of the people who had been prescribed this medicine and they informed us that their relative was in a "terrible state when they came to visit them at 11:30am in the morning as the capsules had not been administered, it should have been administered at 10.00am." We also found from the records that the next morning's capsule was not administered as the service had none in stock. We also found a person had not received a prescribed medicine for two days because the home did not have any of the medicine in stock. We spoke with this person and they told us, "I am ok; I have had to go and buy some drugs to tide me over".

We reviewed six medicine administration records and found that people's medical conditions were not always being treated appropriately by the use of their medicines. For example, we found gaps in some people's medicine administration records which had not been identified by the service. We saw two records that lacked a staff signature to record the administration of the person's medicine or a reason documented to explain why the medicine had not been given. We carried out an audit and found that the gaps demonstrated that the medicines had not been administered.

We found that the provider did not have a robust system for recording where analgesic patches [used for pain relief] were being applied to people's body. The provider was unable to demonstrate that the application of these patches was being rotated to avoid complications to people's health, as per the manufacturer's guidelines. We also found that a person that had been prescribed a seven day analgesic patch had not had the patch changed for nine days. This was quickly rectified once the omission had been brought to the attention of the nursing staff.

We found that the provider was not ensuring that medicines were being stored correctly to ensure the safety of the person. For example refrigerator temperatures were not being monitored on a daily basis and as such we saw sensitive medicines such as insulin were inappropriately stored. The provider was advised to obtain new supplies of the insulin and discard the current stock so that people received their medicines in a safe way.

Some people needed to have their medicines administered directly into their stomach through a tube. The provider had not ensured that the necessary safeguards were in place to ensure medicines were administered safely and there was insufficient guidance in place for staff on how to prepare and administer the medicines. We were particularly concerned that the staff were dissolving the contents of a capsule in water prior to administration when the manufacturer's guidance only advised that the contents of the capsule could be dissolved in orange juice.

We found that the registered person had not provided care and treatment in a safe way for service users. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they felt safe in the home. One person told us, "Staff are cheerful and they are helpful; they keep me safe at night and they keep the light on". Another person told us, "I feel safe enough, the security is good".

Staff spoken with confirmed that they had received training in respect of keeping people safe and were able to tell us what they would do if they suspected someone was at risk of abuse. One member of staff was able to describe to us an incident where they had raised a concern, they told us, "I reported it straight to the nurse". Another member of staff

Requires improvement

Is the service safe?

was able to describe to us how they had raised concerns regarding a particular individual when they returned from hospital. They told us, "I reported my concerns to the senior and the nurse. I felt listened to".

Staff spoken with were able to tell us about the risks to some people living at the home and how they managed those risks. For example, one person was able to tell us how a particular individual was at risk of developing pressures sores, they told us, "We make sure [person's name] is in the right position and is turned every two to three hours so that they don't get sores on their back". We saw that the clinical lead had introduced a new monitoring record to manage this.

We saw that people's files held basic risk assessments that covered risks such as falls, manual handling and nutrition. However, the management of risk was not always consistently reviewed and we saw this had an impact on people's safety. For example, we saw one risk assessment state that the person was independently mobile. We observed this person was being nursed in bed and staff confirmed to us that they were to be checked every two hours for turning.

We saw that when accidents and incidents had taken place they had been reported upon and information regarding this was passed onto staff at the next handover and also written on a communication board. However the clinical lead told us that if accidents and incidents had taken place they were not confident that they were always updated in the care plan. This meant that people were at risk of not receiving the most up to date and appropriate care required.

People and their families told us they thought the staff worked very hard. We asked people if they thought there were enough staff to support them. One person told us, "I love it here, the staff are really good but there are not enough of them and they're over worked. I know not to ring the call bell during handover; I end up waiting 30 minutes for someone to answer". Another person told us, "I don't have to wait too long" [after pulling the call bell] and a relative commented, "Is there ever enough staff? They do well I think". We observed staff responding to call bells as soon as they were free.

We discussed staffing levels with both the clinical lead and a number of care and nursing staff. All spoke with voiced frustration that staff sickness levels had had an impact on staff being able to do their job. The clinical lead confirmed that attempts had been made to provide cover for staff absences from their other home, and when she had requested additional staff, the management had responded positively. However, staff sickness, coupled with a number of new people being admitted to the home meant they were always trying to play catch up. One member of staff told us, "No matter what, there's always someone off sick. Today I was told to help at breakfast and support someone one-to-one at the same time – you can't do both" and another member of staff told us, "People are safe here, but I have asked for more staff. I feel I can't do my job properly". We discussed this with the provider, who acknowledged they were aware of the problem regarding sickness levels and were working hard to support staff. We were told that staffing levels were assessed by the registered manager and management team and this involved ensuring the skill mix on each shift met the needs of the people living at the home. We saw that agency staff were used to cover nursing vacancies

Staff spoken with confirmed that before they commenced in post all the necessary checks had been put in place, including checks with the Disclosure and Barring Service (which provides information about people's criminal records). We looked at the files of two members of staff and noted that the provider had a robust recruitment process. This meant that checks had been completed to help reduce the risk of unsuitable staff being employed by the home.

Requires improvement

Is the service effective?

Our findings

People we spoke with told us that they were confident that staff were able to care for them and meet their needs. One person told us, "They know how to look after me" and another said, "I'm sure they know how to look after me". We received mixed responses from family members with regard to the care their relatives received. One visitor told us that they felt their relative had all their care needs met and spoke positively about their relative's treatment in the home, whilst another raised a number of concerns which resulted in a safeguarding referral being raised in respect of this person.

Staff told us that they considered themselves to be well trained to do their job. For example, one member of staff was able to describe to us how particular training ensured they supported the healthcare needs of one individual in the home. They described an emergency situation which they had had to deal with and told us, "I kept calm and my training came into play and it was okay; I knew what to do".

We saw that there were good links with the local college. Regular meetings took place in order to assess and plan staff training which was relevant to each individual's role. A member of staff told us that they felt well equipped to do their job once their induction was over. They told us, "If you need any help you just say, I went to college as well and worked alongside two people before I started. I wasn't pushed in at the deep end". Staff told us that they usually received supervision every six months and a yearly appraisal and that they were happy with this arrangement as it gave them the opportunity to discuss any issues or training needs.

People's needs were not always effectively met as communication systems were not consistently applied across the home. For example, weekly handover sheets were in place that provided staff with up to date information regarding the people living in the home. The nursing staff conducted a daily verbal handover with senior carers who, in turn, were responsible for cascading this information to the remaining staff group. One member of staff commented, "Sometimes it's good [communication], other times they forget to tell us things" and another member of staff told us "Other day I came on shift and there were two new people and I hadn't been told about them. Their names weren't on the board. It has happened a few times". This meant that there were no guarantees that staff were given the most up to date information they required in order to meet the needs of the people living in the home.

Staff spoken with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what this meant for people living at the home. We observed that staff obtained the consent of people before they provided them with support and people spoken with confirmed this, one person told us, "They always ask me first [before providing support]". A relative told us, "They obtain [person's] consent as far as I know". We were told that there were no applications to deprive people of their liberty. However, we saw that in some people's care files a checklist had been completed to check that people were not being deprived of their liberty.

People spoke positively about the food on offer and we observed that they enjoyed their meals. One person told us, "The food is marvellous, I like the steak pie". Staff spoken with were able to tell us about people's individual dietary needs. We saw evidence of people being referred to a dietician following concerns regarding their diet. Staff were able to tell us and records showed how this was followed up and advice was taken from the Speech and Language Team [SALT]. We were also informed that arrangements had been made to meet with representatives from the SALT in order to discuss menus. We spoke with the chef and saw that there was a three week menu in place and we were told this was put together using information from assessments, families and service users. There had been identified a need for a pictorial menu and this was being worked on to assist people when making their choices at mealtimes.

People told us and their families confirmed that if they felt unwell, they were able to ask to see their doctor. They also confirmed they were able to see other healthcare specialists such as the dentist and the optician and we saw evidence of this in people's care records. We saw that there was a hydrotherapy pool for those people required physiotherapy and that two people in the home were currently funded to make use of this facility. A relative described to us how the registered manager had supported their family member. They told us, "The manager got in touch with the hospital and got it sorted. The nurses always explain what's happening and I'm confident they would ring me if there was a problem". However, another relative

Requires improvement

Is the service effective?

spoken with described a very different experience with the home. They told us their family member had been ill and night staff had requested a visit from the doctor. They told us, "[Person's name] went a whole day without seeing a doctor. Their own doctor came out the next day and prescribed antibiotics". This meant that people within the home were at risk of receiving inconsistent levels of care, depending on which area of the home they were being cared for in.

Good

Is the service caring?

Our findings

People living at the home told us that the staff who supported them were kind and caring. One person told us, “Staff are cheerful and they are helpful” and another person said, “The staff are nice”. A relative spoken with described to us the care their family member received, they told us, “They always speak to [relative] as a person, staff are very caring and treat [relative] as a human being”.

We observed that people were spoken to kindly and respectfully. We saw one person use picture cards to communicate with staff. The staff member responded to this, and used the cards to communicate to the person, as well as talking to them in a calm and reassuring manner. We saw where people required support from only female or male carers, that this was provided. We saw that people were addressed by their preferred names or their titles and with respect. One person had identified that they liked to wear a particular item of clothing and we saw that they were supported to do this.

Staff spoken with were able to tell us about how they got to know people. One member of staff told us, “We can go and access the care plans at any time and read the ‘about me’ information on file; I find it helps to understand people”. They were able to describe the particular cultural needs of one individual living in the home and how they had spoken to their family in order to gain more information. Another member of staff told us, “You need to build relationships with people so that they can trust you; you give up a bit of information about yourself and they might tell you something”.

We saw that visiting was flexible to take into consideration people’s emotional needs for example when visiting relatives who were very poorly. People told us that their families visited often and relatives spoken to confirmed they could visit at any time, apart from mealtimes as those were protected.

We were told that people could access advocacy services should they wish someone to act on their behalf, but at present no –one living at the home was using this service.

We saw that before staff entered people’s rooms, they knocked and spoke to the person to tell them who they were and what they were doing. A member of staff told us, “I always give people a choice, ask them when they want to get up, whether they want a shower or bed wash”. Another member of staff told us how they maintained people’s privacy and dignity whilst supporting them with their personal care. They told us, “I shut the door, cover the person with a towel or clothing as soon as they are washed – I support them, I don’t take away their independence”. A relative told us, “I can’t praise them enough; [relative] is treated with dignity”.

Requires improvement

Is the service responsive?

Our findings

People spoken with and their relatives told us that they had not been involved in their care plan or asked how they would like their care delivered. One person told us, "No I haven't met with anyone" (to discuss their care plan). A relative told us, "No, we weren't involved in the care plan" and another added, "No I haven't met with the staff; no one has asked any questions". In care files looked at, we saw consent forms were in place for people to sign when they had discussed their care, but these were inconsistently completed. We saw care plans were not being consistently reviewed and therefore not updated.

We spoke with one person who had recently arrived at the home. We saw they became upset that their lunch was too much for them to eat. They told us, "They keep giving me large meals when I only want small, they are going to speak to the chef again and hopefully he will get the message". We spoke to this person the following day and they confirmed to us that their meal that day was a smaller portion, which they were pleased about.

Staff spoken with were able to provide us with some information regarding how people liked to be supported and their likes and dislikes, particularly those people who had lived at the home for some time. For example, one member of staff told us, "I always ask if people want the television or radio on; I know [Person] likes to catch up on the soaps at the weekend". However, for new people to the home, there was little information available to staff with regard to this. We saw care files held a document which people and their families were encouraged to fill in called 'All about me' but many of those looked at were not completed and if they were, the information was not incorporated in the care plan. One member of staff told us, "We can access care plans at any time and look at the "All about me" in people's files – it helps me understand people" and another member of staff told us they had suggested a visual menu to be put in place as they noted a number of people had difficulty reading the small print on the written menu.

One person told us about an activity they enjoyed, they said, "The ball man comes in; it's a bit of fun". We were told that activities took place three times a week. We observed one activity taking place in a lounge area. The people sitting in the lounge were from a very wide age group and the activity was focussed more at the older people than the younger people. We spoke to the activities co-ordinator who told us how she tried to meet the needs of the people living at the home. She told us, "It's difficult to cater for everyone as they all have different abilities. People like [person's name] need one to one with me to do things they like but I'm limited on time; it can be frustrating". Other staff spoken with told us that they thought there should be more activities, one member of staff told us, "Monday, Thursday and the weekend there's nothing happening; if I get chance I try and work my way round people and involve them in a conversation" and another added, "We try and get everyone together downstairs so people don't have to look at the same four walls". This meant that people were not being supported to follow their interests which would in turn enhance their quality of life.

People spoken with told us that if they had a complaint they would be confident that it would be dealt with. One person said, "I'm sure they would listen if I complained" and a relative told us, "I've no complaints and I know I would be listened to if I did; I know the head nurses and the owner and his wife".

We saw that the home had received one complaint earlier in the year and an acknowledgement letter sent out. However, we could see no evidence of an investigation taking place or the outcome of the investigation. We spoke to the clinical lead about this who was able to locate a copy of the investigation, but was not sure if the complainant had received a response to their letter. We saw that a full investigation had taken place which identified lessons to be learnt, one being, 'Nurses and seniors have now been instructed to ensure that on admission as much information relating to service users' day to day routine to ensure care is structured to maintain their routine'. However, we found that this was not the case and people told us that they were not consulted on their daily routine when they first arrived in the home. This meant that despite a complaint being investigated and lessons learnt identified; these actions had not been put in place and acted upon.

Requires improvement

Is the service well-led?

Our findings

The registered manager was responsible for this home and another which was located close by. The majority of people spoken with told us they knew who the manager and the owners were and considered the service to be well led. A relative told us, "They seem trustworthy here and well organised. I find them ok". One member of staff told us, "The manager visits every day and always speaks to the residents. If you can't speak to the manager you can speak to other people" and another staff member said, "I think it has potential to be well led I know the owners want only the best for everybody".

Staff told us that they felt supported and listened to. One member of staff told us, "It's friendly, management are approachable". Another member of staff told us, "The manager and the clinical lead are approachable; I've reported things to them and they have dealt with it". They told us they were aware of the home's whistleblowing policy and were confident that if they had to raise any concerns they would be dealt with.

All staff spoken with were clear about the vision for the home, to provide end of life care in one part of the home whilst providing care and support for younger people in the rest of the home. Staff described to us the difficulties involved in providing care to a group of people with diverse care needs. The clinical lead told us, It has been quite difficult because we are mixing elderly people with dementia, with people who are really vulnerable". However, staff acknowledged that management had responded to this and were looking at different ways in which to support staff to ensure they were able to meet people's care needs. We saw that attempts had been made to address the issues highlighted and that some staff from their other home had been moved across in order to share their knowledge and expertise. One member of staff acknowledged, "It's not that it is run incorrectly, it's just a different client group with different needs". They told us that they felt the recent changes that had been introduced had made a difference and added, "It's very early days, but it is better".

We saw that staff meetings took place and staff were encouraged to take part. One member of staff told us, "It works well. We have regular meetings for nurses, seniors and carers and share what we have learnt", another member of staff said, "Staff meetings take place; you are expected to join in and they listen to us. You have to stand up and put your point across." Another member of staff commented, "If we think there's a better way that things can be done we can speak to the manager; we work as a team and we will do it together". They told us of the changes in staff allocations had very recently taken place and said, "Allocations were altered last Thursday, it's very early days but it is better".

We observed that the clinical lead had a visible presence in the home and was able to provide us with detailed information regarding the people living there.

Staff spoken with were aware of their roles and responsibilities and those of their colleagues. However, we noted that care records were not always updated in a timely manner and were not always reviewed, which could lead to staff following unsafe practices and not delivering the correct care and support people required.

Staff told us they had supervision every six months and spoke positively about the mentoring system that was in place for new staff. However, the clinical lead had not received supervision since commencing in post in December 2014. She also told us that the nursing staff had not received supervision, although she had observed the nursing practices of some staff and records seen confirmed this. We saw that there was a supervision matrix in place but the clinical lead confirmed to us that she was unsure who she was responsible for providing supervision for.

We saw that the oversight of risks was not robust and the lack of records regarding this meant people were still at risk. For example, we saw individual learning had taken place in response to accidents and incidents, but this information was not always transferred to people's care files. We saw that where people needed to be turned every couple of hours there was no system in place to monitor the recording of this. We saw that there were inconsistencies with regard to the completion of monthly risk assessment audits and for some people living at the home, these had not been completed at all. We discussed this with the clinical lead and were told that because new people had been admitted to the home they had fallen behind with this work.

We saw that the registered manager had in place a number of quality audits, for example, accident and incident, care plans, complaints, nutrition and medicines. The medicines audit had failed to highlight the issues raised during the inspection. A monthly audit was completed by the

Requires improvement

Is the service well-led?

registered manager which gave an overall score. We saw these audits had highlighted some issues but no action plans were put in place to manage these. The last audit had been completed in June this year.

People were not involved in the running of the home nor asked their opinion of the care provided. They told us they had not been invited to attend any meetings or complete any surveys about the quality of the service. The clinical lead informed us that ideally surveys would be given out prior to a resident's meeting and any responses would be followed up at the meeting. However, she told us, "We haven't had any residents or relatives meetings as yet due to the turnover of residents".

This section is primarily information for the provider

Action we have told the provider to take

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

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