Mr Sanjay Prakashsingh Ramdany & Mrs Sandhya Kumari Ramdany

Waxham House

Inspection report

1 High Park Road
Ryde
PO33 1BP
Tel: 01983 564326

Date of inspection visit: 18, 20 and 25 March 2015
Date of publication: 11/06/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

The inspection was carried out on 18, 20 and 25 March 2015 and was unannounced. At our last inspection in January 2014 we found there were no breaches of regulation.

Waxham House is registered to provide accommodation for persons requiring nursing or personal care. Waxham House is a residential care home for up to 20 people. At the time of our inspection 17 people were living at Waxham House some of whom have physical disabilities or are living with dementia.

The service had 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.

At Waxham House care is provided on three floors. A lift and a stair lift are available for people to access the

Summary of findings

rooms on the upper floors. A dining room, lounge and conservatory are located on the ground floor. The garden was well maintained and people had access to the outside areas.

Care provided at Waxham House was not safe. When people were unwell short term care plans were not in place, and staff did not act quickly to ensure people received the care they required. This meant people's care needs were not always met in the most effective and safe manner. Some people's care plans were person-centred, whereas others were not. Risks had been assessed but some of these were generic and did not take into account people's individual needs and risks.

Pain assessment tools were not in place and this put people at risk of being given too much pain relief or not receiving pain relief when they required it. Systems for the management of medicines were not always effective.

Parts of the home had not been cleaned effectively and not all staff practiced safe infection prevention and control procedures. Not all staff followed the home's procedures to ensure people were protected from financial abuse.

Although people said they enjoyed the food, some people said they did not get enough choice. We saw that although a choice was advertised this was not always offered to people.

Although people said they felt safe in the home and that staff were respectful and helpful we observed that this was not always the case. We heard staff talking about people in a manner that was not always dignified or respectful. Some staff did not respect people's privacy by knocking before entering people's rooms.

The providers failed to monitor the quality of the care effectively or respond to some concerns about the care provided to people using the service. Staff had completed a range of training, however the providers did not arrange training in the care of people's skin when this had been clearly identified as an area of concern. At times the providers did not support staff. Staff said that the providers did not always respect their private time away from the home.

Staff knew how to identify abuse and act to report it to the appropriate authority. The registered manager followed safe processes to ensure staff working in the home were suitable to work with older people.

People felt involved in the way their care was planned and delivered. They were asked for their feedback on the service they received and their concerns were addressed.

The registered manager and most staff understood their responsibilities under the Mental Capacity Act 2005. Staff gained consent from people who could give it before providing care. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Whilst no-one living at the home was currently subject to a DoLS, the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the 2014 regulations. You can see what action we told the providers to take at the back of the full version of the 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?

Inadequate

The service was not safe.

Processes for pain management were not effective and medicines were not always accounted for. Some parts of the home were dirty and infection control measures were not adhered to by all staff.

Risks were not assessed and managed in a safe manner. Procedures to protect people from financial abuse were not followed by all staff.

Safe recruitment processes ensured staff were suitable to work with older people.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were not fully aware of all people's day to day needs.

Meals looked appetising, however, people did not always have access to suitable choices and on occasion insufficient food was available.

New staff completed a suitable induction and staff received regular supervision.

Is the service caring?

Requires improvement

The service was not always caring.

Some staff showed a kind and respectful attitude whereas others did not. Some staff did not show respect for people's dignity and privacy.

People were involved in decisions about their care and were assisted to be as independent as they could be.

Is the service responsive?

Inadequate

The service was not always responsive.

People's preferences were not always respected. Care plan reviews failed to show changes to people's care where this was required.

People had access to a variety of activities. People knew how to complain and were confident their complaints would be taken seriously.

Is the service well-led?

Requires improvement

The service was not always well-led.

The providers did not always support the management team and staff, or effectively monitor the quality of the service provided.

Summary of findings

Audits were carried out but did not always highlight areas of concern and therefore improvements to the service were not made.

The registered manager was known and liked by staff and people using the service. People felt confident in their leadership

Waxham House

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 18, 20 and 25 March 2015 and was unannounced. The inspection team consisted of three adult social care inspectors, a specialist advisor in the care of the elderly and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone elderly or with physical frailties or dementia.

We reviewed the information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 16 of the 17 people living in the home and four relatives. We also spoke with the two providers, the registered manager, deputy manager, five care staff, a cook, a kitchen assistant and a housekeeper. We observed staff providing care and support to people in the lounge, conservatory and during the lunchtime meal in the dining room. We looked at care plans and associated records for 12 people living in the home and we looked at the records of care provided to three people recently deceased. We checked staff duty records, two recruitment files, records of complaints and accidents and incidents, medicine administration records, staff and residents' meeting minutes and the provider's policies, procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

People said they felt safe in the home. They knew who to talk to if they had concerns about safety and they felt confident that the registered manager would respond positively to their concerns. One person who had moved to the home recently said, "I'm much safer here".

Arrangements to assess and manage risks to people were not sufficient to protect people from harm and ensure they received appropriate care. For example, one person was at risk of developing pressure injury and plans to mitigate the risks were documented but were incomplete. One member of staff said the person should be supported to stand every three hours. The risk assessment did not refer to this and records relating to this were not always completed so it could not be confirmed whether the person was receiving appropriate support to move. The initial assessment for a person with diabetes indicated they had poor nutritional intake. Their dietary intake risk assessment did not include reference to their risk of hypoglycaemia as a result of them not eating sufficient amounts. A third person, who was registered blind, occupied a room at the top of a staircase. They were fully mobile and on two occasions had been observed outside of their room, once at the top of the staircase. The risk to the person had not been assessed and managed appropriately and as a result placed the person at risk of significant harm. We asked the registered manager to raise a safeguarding alert about this person which they did and the person agreed to move to a room on the ground floor before the end of the day.

Personal emergency evacuation plans (PEEP) for use in an emergency were generic and were not adapted to reflect the needs of the individual. For example, the PEEP for one person who was able to walk out of the building with the support of one staff, showed an evacuation chair with two staff should be used. As a result their exit from the building could be delayed unnecessarily. The lack of appropriate assessment and management of risk placed people at risk of unsafe care or treatment.

We found that the registered person had not assessed and managed risks to people's health and wellbeing. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Clear guidance was not always in place to ensure people received pain relief effectively. One person had a comprehensive pain control regime including three medicines that were administered regularly for pain relief. However there was no plan in place to guide staff when to administer a fourth medicine which had been prescribed in case of further pain as there was no pain assessment tool in use on a regular basis as recommended in national guidance.

Another person experienced chest pain associated with angina and had a spray to relieve the pain. A plan of action included the administration of an anxiety-reducing medicine. Their care plan did not state what the signs of anxiety were in order for staff to follow the plan effectively. The pain care plan did not include a pain assessment tool. Therefore staff would not be able to assess the amount of pain the person was in or how this could have been affected by the administration of the anxiety-reducing medicine. This meant the person was at risk of being left in considerable pain for a prolonged period because the severity of their pain was not assessed effectively.

Medicines records indicated controlled drugs (CD) were missing. For one person the number of tablets on the person's Medicines Administration Record (MAR) and in the CD record book did not match and meant 28 tablets of a controlled drug were unaccounted for. The registered manager told us they would investigate this.

We found that the registered person had not protected people against the risks of unsafe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection prevention and control procedures were not followed by all staff. We observed a member of staff holding soiled bedding and clothing close to their body without the use of personal protective equipment (PPE), disposable gloves and apron. The staff member told us they would only wear PPE "if someone had an infection". This practice did not follow the home's infection control procedures or the Department of Health Code of Practice on the prevention and control of infections and related guidance. This increased the risk of the spread of infection in the home. Some bedding was heavily stained brown and

Inadequate

Is the service safe?

dirty. Several toilet facilities had not been cleaned properly and a commode was heavily stained with a brown substance. The frame was rusting and soiled with a sticky substance. The lack of effective cleaning procedures failed to ensure people were cared for in a clean and hygienic environment.

We found that the registered person had not protected people against the risks of infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most other staff were observed to be wearing PPE appropriately. Other areas of the home were clean and people told us they were satisfied with the way their rooms were cleaned. Appropriate arrangements were in place to dispose of clinical waste. Staff used a colour-coded system for cleaning which meant areas of the home had their own designated cleaning equipment and this reduced the risk of cross contamination.

The registered manager said staffing numbers were based on people's needs and that the providers were open to employing more staff should this be needed. An internal audit of staffing levels had been carried out in September 2014 and following this additional staff worked the afternoon and evening shifts. Staff absence was covered by staff employed by the service working extra shifts and staff took turns to be on-call.

The deputy manager told us they were covering a lot of care, cooking and housekeeping shifts. They said the reason for this was that some staff had left or were off sick. This meant they had not been not able to complete their deputy manager duties. In turn the registered manager was carrying out additional work which they had previously delegated to the deputy and this resulted in them not having time to update care records and monitor the care provided appropriately.

The procedure for protecting people from financial abuse was not always followed. One person said that a member of staff did "shopping for bits and pieces" for them, and other people living in the home, "all in their own time". We asked the registered manager if they were aware of this. They told us they knew the member of staff, bought scratch cards and birthday cards for one person, but was not sure of the arrangements to record this. No record was made of the transactions and receipts were not kept. This practice failed to follow the home's procedure and did not protect people from financial abuse.

We recommend the registered provider ensures procedures to protect people from financial abuse are effectively implemented in the home.

The registered manager made purchases on behalf of the majority of people living in the home. Their records showed the details of the transaction and people had signed to say this was correct. Receipts were kept and we checked the balance of monies kept for one person and this was correct.

The service used a Multi-Agency Safeguarding Policy and records showed this was adhered to when concerns were raised. All staff had completed safeguarding training as part of their induction and knew the signs of abuse and what to do if they had concerns about a person's safety. All staff were confident to report abuse and said they would contact either the local authority safeguarding team or the Care Quality Commission if they felt their concerns were not dealt with appropriately. However, they said the registered manager was always contactable and open to their concerns.

The registered manager followed recruitment processes that meant staff were checked for suitability before being employed in the home. This included an application form and interview, references and a check with the Disclosure and Barring Service (DBS).

Requires improvement

Is the service effective?

Our findings

People had mixed views on the food and drink provided in the home. Some people were happy with the food. One person said, "there is plenty to eat, and it's delicious". A relative said, "mum wouldn't eat before she came into the home; now she is". Other people were not as satisfied. Comments we heard were, "more breakfast, cornflakes and toast", "sometimes you look forward to it, sometimes it is edible", "sometimes they run out", and, "it's not hot enough".

Some food stored in the freezer was inadequately wrapped, or was stored in containers that were cracked or broken. Some foodstuff was not labelled to show the date it was frozen. The quality of the food could not be ascertained as there was no indication of how old the food was. The registered manager asked a member of staff to dispose of the foods that were unlabelled or inappropriately wrapped.

The member of staff who prepared the shopping list said the list was amended by the providers before the order was placed and lesser quantities were delivered than had been ordered. This meant there was insufficient food for all people living in the home and so staff used petty cash to purchase groceries to supplement the food provided in the home. On one occasion staff had brought food in from their home to supplement what was available in the home. There was no effective system to ensure adequate stocks of food where maintained in the home at all times.

People were not always offered a choice of food. A diary was used by staff to record people's choices for their main and evening meal but this had not been completed every day for all people in the home. We observed two people had provided their own food; one had accompaniments which were not available in the home, and another had purchased their own breakfast cereal, "because they don't have the one I like". One person was experiencing indigestion and we observed they had not eaten their main meal, complaining that it was, "tough". No alternative was offered to them to ensure they had had enough to eat. Although the menu stated there was a choice of dessert, ice cream with a sauce was given to everyone without asking if they wanted this. We heard people comment that they did not like sauce on their ice cream, and that the portion size was small. For tea, the menu stated quiche with either brown or white bread was on offer. The meal served was chicken nuggets and chips and no reason was given for the change.

People with specific dietary needs were not offered suitable alternatives to the main choice. The cook on duty was aware of two people who had diabetes but was not sure where their food intake was recorded. Staff told us people's food intake was recorded in their care notes but we found their nutritional intake was not recorded consistently. Therefore it could not be ascertained whether people who required a special diet were provided with appropriate meals.

We found that the registered person had not provided people with a choice of suitable and nutritious food. This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could choose where they wanted to eat their meal and we saw some chose to eat their meal in the dining room, conservatory, lounge or in their room. One person had been prescribed a fluid thickener due to problems with swallowing. Staff were aware of this and we observed the person had their drink appropriately thickened. Drinks were available to people throughout the home in communal areas and in people's rooms.

Staff did not know how to care for people with skin integrity issues. Three people living in the home in the last 12 months had been admitted to hospital with pressure injury. According to the provider's records, six people living in the home were at risk of, or had developed pressure injuries. When we spoke with a senior staff member they said it was nine people. One senior staff, who was in charge of a shift, was unsure how many people had concerns about their skin or how these were being managed. They said staff would document concerns in the shift handover record, however, they had not read the record themselves and were relying on other staff to note concerns. Staff were not effectively monitoring people's skin care and this placed people at risk of not receiving appropriate care and treatment.

The registered manager said some staff were "petrified of making a mistake" about people's skin care. They had

Requires improvement

Is the service effective?

several times requested the providers arrange training in this area of care for all staff but this had only been agreed recently. The providers failed to ensure staff had the skills they required to care effectively for people with skin care concerns.

We found that the registered person had not ensured staff were supported with appropriate training to carry out their duties. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were up to date with other training and records showed they had completed a range of courses appropriate to their role in the home. A new member of staff said they had completed a full induction and shadowed other staff. They said this had equipped them to be confident to provide care alone. Staff said they were not expected to undertake duties on their own until they felt able to do so. New staff's performance was reviewed regularly to check their competence. A clear plan was in place for staff development and this was discussed with staff regularly at supervision meetings. Where actions were identified a plan was produced and actions were followed up. When staff raised concerns the registered manager addressed these. Each member of staff had an annual appraisal where areas for improvement were identified and the registered manager provided support to staff to assist them to make the improvements.

People spoke positively about the care they received and said that staff knew how to care for them. Another person commented, "you don't need to tell them what to do; they already know".

People had access to healthcare when they needed it. People said they were seen by a GP when they were unwell. One person said they had not felt well for a few days. They had seen a GP and staff were monitoring their condition. Another person told us they were not eating much and they were expecting a GP visit that day to discuss their indigestion. On the day of our inspection we observed staff took action to call paramedics when a person was having difficulty breathing. Records showed people were visited by healthcare professionals regularly and staff contacted the GP and District Nurse for advice when necessary.

We observed staff approaching people and asking for their consent before they undertook any aspect of care and support. Most staff were familiar with the principles of the Mental Capacity Act (MCA) 2005. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decisions that affect them. The MCA was part of the training for all new staff and all staff we spoke with understood how the MCA affected their work. Staff said that if people were having difficulty making decisions they would contact their next of kin, their GP and other relevant people to help them make a decision in the person's best interests. One person's care plan showed a mental capacity assessment had been carried out and this was documented appropriately.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager understood their responsibilities in regard to DoLs. They had sought appropriate advice in relation to one person and had acted accordingly. People were free to leave if they wanted to.

Requires improvement

Is the service caring?

Our findings

Most people spoke fondly of staff and praised their kindness. One person said, "I couldn't wish for better". Another person had recently returned from a hospital stay. They said, "I am so glad to be back; the carers are extremely kind". Another person said staff were particularly kind when assisting her in the care of her legs. They said, "they do it well and we chat". Relatives were similarly complimentary about staff, saying, "nothing is too much trouble", and, "it's all positive". One person said they felt some staff, "just want to get the job done".

People's privacy was not always respected by staff. On four occasions, whilst talking with people in their rooms, staff entered the room without knocking. On two occasions the member of staff did not greet the person, or let them know what they were doing in their room. When staff did knock, they entered the room without waiting for the person to answer. This practice could compromise people's dignity and failed to show respect for people's privacy. One person was observed sitting in the lounge with a catheter bag in full view. This failed to protect their dignity, or promote a pleasant and homely environment for other people in the lounge.

Over the lunch time period we observed two staff serving people in the dining room and conservatory. Both staff were task focussed, with little interaction with people. They placed food in front of people without any conversation with them and did not stay in the dining room whilst people ate their meal. The member of staff who cleared tables at the end of the meal made no attempt to talk with people other than to assist them to move with minimum discussion. This task focussed approach did not promote a friendly and homely environment for people. Several times during the day we overheard conversation about people's individual mealtime and care and support needs taking place in the kitchen where care staff and kitchen staff congregated. The conversation, could be overheard by people sitting in the dining room. These conversations were not respectful and did not protect people's privacy and dignity.

One person had been provided with adapted cutlery which helped them continue to eat independently. The layout of the dining room discouraged sociable conversation as the three tables were set against the walls. This meant most people sat with their backs, or sideways, to the centre of the room. We observed a little conversation between four people on one of the tables. The providers said they would look into the options and discuss these with people who used the dining room to eat their meals.

One member of staff volunteered information about a person using the service. They did not speak about the person's care needs in a dignified way. This showed a lack of respect for the person.

People's preferences such as the time they wanted to get up or go to bed, were not always recorded or respected. One person said they could get up and go to bed at a time of their choosing and staff assisted them to do this. Two people told us staff got them up out of bed at a time that did not suit them. One person said they preferred to be woken around 8am. However, they said they were sometimes woken between 6 and 6:30am. They had not been told why they were being woken so early. They further told us they would like, "a tipple" of red wine with their lunch, which had been their habit before they moved in to the home. Their food and drink preferences were not included in their care plan. Another person told us, "I like to get up at 9am but they get me up at 7am which puts me off my breakfast as it's too early. About 9:30am would be ideal". People's preferences were not respected.

We found that the registered person had not ensured people's privacy, dignity and preferences were respected. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed one member of staff interacted with people often and spoke in gentle and patient tones. They frequently smiled as they worked, and when they gave people their lunchtime meal they spoke with each person briefly. They told us they had time to talk with people as they supported them throughout the day.

One person told us when staff were assisting them with a bath, "it's all very dignified". We observed part of the medicines round and saw the member of staff was sensitive to people's individual needs. A person who was using oxygen said they were "a bit out of breath". The staff

Requires improvement

Is the service caring?

member administering their medicines said, “take your time; there’s no rush, get your breath back first”. They then sat with the person, holding their hand, until they were ready to take their medicines.

A key worker arrangement was in place. This meant a member of staff regularly talked with the person they were assigned to, discussing aspects of their care and updating their care plan. People we spoke with said, when they wanted to be, they were involved in decisions about their care. Care records showed people were involved in reviews of their care.

People felt involved in the running of the service. They took part in quarterly residents’ meetings. One person, when referring to suggestions made in the meeting said, “they’re not bad at acting on it, and following up on issues”. People expressed confidence in the registered manager and other staff. One person said, “they always come round and talk to everybody”.

People had the equipment they required to enable them to move about the home without summoning help from staff. We observed people moved around the home throughout the day, and staff offered support, if it was needed, but respected people’s right to refuse this.

Inadequate

Is the service responsive?

Our findings

Most people told us their needs were met in a way that suited them. We observed the staff shift handover and people's current needs were discussed at the meeting.

Staff were familiar with some people's day to day needs and how to meet them. Other people's needs appeared to be less known and acted on. One person had lost a significant amount of weight. A staff member told us the person was not on a weight loss diet. They knew the person was not eating a lot but their food intake was not monitored. Their care records indicated they should have a diabetic diet but there was no evidence that the person was provided with a suitable diet, and kitchen staff were unaware of the person's dietary requirements. Records also indicated the person had continence needs which had not been assessed and managed, and a grade two pressure sore. Their care records stated that these conditions should have triggered a malnutrition risk assessment but this had not been done.

We looked at the records relating to three people who had recently died. We found that when people became unwell staff did not always act quickly enough to address their changing needs. For example, one person's records showed they had "slipped off the chair onto the floor." They were assisted up and found to have no apparent injuries or pain. Five days later their records said, "Unable to weight bear this evening". On the days following, records showed the person's condition deteriorated and they required the support of three staff to mobilise. No falls care plan had been developed to ensure staff were aware of the best and safest way to assist the person to mobilise. By the time staff sought healthcare advice the person's health had significantly deteriorated. The person self-administered their insulin. When they became ill staff did not monitor whether the person was medicating appropriately and so when the person became unable to inform staff about their medicines staff could not ascertain the appropriate amount of insulin to give them. No record had been made of the person's normal blood sugar range and so when staff tested their blood sugar they would be unable to know whether this had been affected by acute illness or not.

Another person was recorded as losing weight and their care plan stated staff should weigh the person monthly. However, their care record showed they had not been weighed since 7 January 2015 and nothing was recorded about the person's favourite foods which may have encouraged them to eat more.

People's care records were not person-centred and did not evidence individualised care was provided. Care plans were reviewed every two months. However, we found that frequently "no change" had been recorded, when people's needs had changed. For example, where a person had previously had a fall, their support plans had not been updated to ensure they had sufficient support measures in place to try and prevent further falls. Another person had been living with a diagnosis of schizophrenia. There was no care plan related to the mental health needs of the person. They had also been diagnosed with an enlarged prostate and there was no care plan relating to the risks and care needs of a person with this condition. When the person had been diagnosed with a UTI no care plan had been produced to support their comfort, or to encourage the person's hydration level. People's care plans did not reflect their current needs and care plans were not updated with information that was necessary to provide responsive care and support.

The Coroner's report of September 2014 stated that staff at Waxham House failed to recognise when a person was at risk of infection when prone to sacral sores. One of the providers, who was a health professional, had personally carried out an audit of people with skin conditions. However, this was not done until six months after the Coroner's report and following complications associated with pressure injury with at least one other person living at Waxham House. This action was not taken in a timely manner to ensure people received appropriate care and treatment.

We found that the registered person had not ensured people received person-centred care so that their individual needs were met. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A programme of activities was advertised and we observed one of these in progress. Around 10 or 11 people participated in the activity. People told us they enjoyed the variety, which included arts and crafts, some exercise

Inadequate

Is the service responsive?

activity and music. An activities co-ordinator was employed on four days of the week, and the registered manager told us that from April, day trips are arranged. People said they enjoyed these and were looking forward to the better weather when these would start again. A good number of people were independent and were observed to be reading, or doing jigsaws or a crossword puzzle. One person rarely came out of their room and staff respected their preference.

One member of staff told us that processes had changed, and that staff were now expected to complete daily records of people's care at the time it was provided, and not at the end of the shift. We observed they were doing this after they had assisted a person to the toilet. However, we observed later in the day, care staff completed people's daily care records at the end of their shift. This included details of what people had eaten and drunk, and what creams had been applied to them in the morning. This could result in the inaccurate recall of details relating to people's care, as some people had multiple creams applied to different parts of their body. We found records were inconsistent when referring to people's nutrition, hydration and the application of creams and some of the people in the home were at risk of malnutrition or had skin care concerns.

People told us they knew how to complain and had received written information on the process. All the people we spoke with were confident complaints would be responded to and that action would be taken in a timely manner. The registered manager made a record of all complaints received. The record showed they responded appropriately to address the complaint and took action to improve the service and prevent recurrence of the issue.

Requires improvement

Is the service well-led?

Our findings

People using the service spoke positively about the registered manager. They knew them by name and people commented, "they are very hard-working", "always available" and, "she comes round and talks to everybody". The culture appeared to be well-established and friendly amongst people using the service and staff.

The registered manager, and the deputy manager, had a programme of audits they followed throughout the year. Whilst the most recent audits had identified improvements needed, and these had been addressed, they had not highlighted the breaches of regulation we identified on our inspection and noted in this report. Therefore the audits were not always effective in monitoring the quality of care provided and showing the improvements needed in the home.

The registered manager had been asked by the providers to support and provide training to the manager at another location which left the deputy manager in charge of Waxham House for a period. The deputy manager told us that, at times, they were "overwhelmed" and "not confident" about their work in the managing of the home. Management meeting minutes confirmed this was the case. As a result the registered manager had an excessive workload as they had taken back duties they had previously delegated to the deputy. This meant they had not always been able to ensure care plans were reviewed and updated in a timely manner and effectively monitor the service and take action where necessary. A suggestion box in the communal area allowed people to make suggestions for improvements to the service. One suggestion had been made in January 2015, "could staff wear name badges". One person we spoke with said they had, at times, trouble remembering staff names. At the time of our inspection the suggestion had not been acted on. The registered manager said they had not had the time to implement the suggestion.

One of the providers said their monitoring of the management team was "informal". They said they visited the home two or three times a week and always consulted the registered manager although we could not find evidence to support this. No formal arrangement was in place to discuss the quality of care provided in the home and to address concerns. The provider later gave us a copy of minutes from meetings held in 2014 and 2015, however, the registered manager did not have a copy of them. The registered manager said they had "not had time to do everything". Other staff also said they did not feel supported by the providers and sometimes their private time was not respected, for example, when they were contacted about non-urgent matters in the evenings when they were off duty.

The providers did not take appropriate action following the registered manager's attendance at a fire safety seminar in December 2013. The registered manager passed on to the providers recommendations to improve the safety of people in care homes in the event of a fire. A fire risk assessment was carried out in November 2014 and a fire safety inspection in February 2015 resulted in a Notification of Deficiencies.

The registered manager had asked the provider to arrange training for staff to care for people with skin care concerns. Staff knowledge in the area of care and support was known in September 2014, however training had not been arranged until March 2015.

The service was not effectively monitored for quality and areas of concern or improvement were not addressed in a timely manner.

We found that the registered person had not effectively monitored the quality of care provided at the home and taken timely action to address concerns. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they respected the registered manager and the work they had put in to improve the service. One staff member said the registered manager was, "really approachable". Staff also commented that the registered manager had been "understanding and supportive" and, "she is really easy to talk to; you can go to her with any problem". They said the registered manager was firm but supportive. One staff member said, "there are no questions that are too stupid". The registered manager told us, "I'd do anything for the residents", and, "when things go wrong I take it personally".

The registered manager carried out quality surveys with people using the service, their relatives and health

Requires improvement

Is the service well-led?

professionals. The most recent of these was in September 2014. The service had scored highly for quality of care. The lowest mark was for staffing levels and since then staffing levels had been increased. Where specific concerns were raised in the survey these were posted on the noticeboard and staff were directed to address them. The registered manager followed these up with staff at supervision, and arranged refresher training where this was necessary.

A maintenance member of staff was employed and was shared with the sister home. Accident and incident records were kept and the registered manager analysed these for trends that may indicate improvements could be made to the service to prevent further accidents.

Staff meetings were arranged regularly and minutes from these showed that areas of concern which had been raised were addressed with the staff group. Staff said they felt involved in people's care. We observed staff approached the registered manager throughout the day to pass on information and ask advice. Records of staff supervision showed the registered manager gave positive feedback to staff acknowledging where they had done well.

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	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People did not always have access to suitable and nutritious food and hydration Regulation 14 (1), (2), (4)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Staff did not always act in a manner that respected people's privacy and dignity Regulation 10 (1), (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive care that was appropriate to their individual needs Regulation 9 (1) (a), (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The quality of the service was not effectively monitored and improvements were not made as a result Regulation 17 (1), (2), (a), (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The provider had not ensured staff were supported with appropriate training to carry out their duties Regulation 18 (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not safe because risks were not adequately assessed and arrangements put in place to mitigate risks. Medicines were not managed safely. Procedures were not followed to prevent and control the risk of infection and ensure service users are cared for in a clean and hygienic environment. Regulation 12 (1),(2) (a),(b),(g),(h)