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Waxham House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection was carried out on 17 and 24 November 2015 and was unannounced. At our last comprehensive inspection in March 2015 we found several breaches of regulation. In August 2015 we found the provider had made significant improvements to the care provided in the home.

Waxham House is registered to provide accommodation for persons requiring nursing or personal care. The home can accommodate 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.

After the comprehensive inspection in March 2015, CQC took enforcement action because improvements were needed to ensure the safety and well-being of people living at the home. We issued a warning notice in relation to the safe care and treatment of people living at Waxham House. We inspected again in August 2015 and found improvements had been made to comply with the requirements of the warning notice. In relation to the other breaches of regulation identified in March 2015 we received action plans from the provider stating what they would do to meet the legal requirements to improve their service.

Summary of findings

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was in the process of making an application to CQC to be registered as the manager.

At Waxham House care is provided on three floors. A lift and a stair lift are available for people to access the 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 safe. Risks to people's health and wellbeing were assessed and managed well. There were sufficient staff to care for people safely and staff ensured people had the equipment and support they required. People's care plans were up to date and staff were familiar with people's individual needs and preferences.

Staff had been trained to safeguard people in their care. They were aware of what constituted abuse and were confident to report their concerns. They said the management team would take prompt action. People received their medicines safely and staff took care to make sure people were as comfortable as possible and received pain relief appropriately. The home was clean. Procedures were in place to protect people from the risk and spread of infection.

People spoke positively about the choice and quality of the meals served to them. Staff supported people to eat where this was needed. They did this in a manner that helped people to maintain their independence as much as possible. Staff ensured people gave their consent before providing care. People made choices on a daily basis and staff respected people's right to make decisions for themselves. People contributed to the improvement of the service provided by making suggestions which the provider put into action.

Staff respected people's privacy and took care to help them maintain their dignity. Appropriate action was taken when staff were concerned about a person's health and medical help was sought quickly when needed. People were supported to access specialist health care if this was required.

Staff felt supported to carry out their role. They had completed a range of relevant training. Staff had access to advice and guidance from the provider and the management team and received supervision regularly. Staff meetings were arranged regularly and staff were able to discuss any concerns. The meetings also provided an opportunity for the provider to update staff on changes in the home. Staff took personal responsibility for the care they provided and had developed positive relationships with the people they cared for.

The provider had a range of quality assurance measures in place. When areas for improvement were identified these were acted on promptly to improve the service people received. The values of privacy, dignity and respect were promoted in the home and observed in the way staff provided care to people.

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 safe.

Staff were aware of the signs of abuse and how to report any concerns. There were sufficient numbers of suitable staff to care for people's needs.

Medicines were administered safely and staff adhered to infection control procedures to protect people from the risk and spread of infection.

Risks to people's health and wellbeing were managed and people had the equipment and support they required to remain safe.

Good

Is the service effective?
The service was effective.

Staff received training and support from the management. People's consent was sought and staff respected people's choices and decisions.

People had a choice of nutritious and well-presented food, and staff provided support where this was required.

Staff supported people to access healthcare appointments and ensured people saw a GP when necessary.

Good

Is the service caring?
The service was caring.

Staff had built positive relationships with people and a homely and jovial atmosphere was promoted by them.

Staff took care to protect people's privacy and dignity. People had formal opportunities to express their views and make changes to their care and treatment.

Good

Is the service responsive?
The service was responsive.

People were cared for according to their preferences, and staff supported people to maintain their independence.

Complaints were thoroughly investigated and the provider used these make improvements to the home.

Good

Is the service well-led?
The service was well-led.

The provider had in place a range of quality assurance measures and took action to make improvements to the service.

Good

Summary of findings

People had free access to the provider and the management team. The provider engaged with people regularly and took account of their feedback to make changes and improvements to their care.

The provider worked alongside staff and arranged meetings with them to ensure their concerns were addressed and the care provided was of high quality.

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 17 and 24 November 2015 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor in the care of older people, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service including notifications about important events which the home is required to send us by law and our previous inspection report.

We spoke with sixteen people living in the home and four relatives / visitors. We received feedback from two health care professionals who visited the home. We also spoke with six care staff; the cook; a housekeeper; the deputy manager and one of the providers. We observed how care was delivered in communal areas and reviewed seven care plans and associated records of care. We also reviewed the provider's policies and procedures, accidents and incidents record, medicines administration records, staff duty rosters and three staff recruitment files.

Good

Is the service safe?

Our findings

At our last comprehensive inspection in March 2015 we found the service was in breach of regulations relating to the safety of the service. The provider had failed to ensure that staff followed infection control procedures to prevent the risk and spread of infections. The provider sent us an action plan which stated they were addressing the concerns.

People said they felt safe and at home in Waxham House. They commented, “The best thing is that you don't have to worry about anything” and, “I feel safe all the time”. People knew who to talk to if they had any concerns about their safety. A relative said, “At no time have I ever seen or heard anything I’ve been concerned about”. Responses from a recent residents’ survey showed that people were, ‘very satisfied’ with the safety and security arrangements in the home.

Care provided at Waxham House was safe. Staff were aware of how to safeguard people from harm and abuse and knew how to report any concerns, viewing this as their duty of care. They were familiar with the home’s safeguarding policy and were confident that the management team would address any issues they raised. Staff expressed that they would take their concerns further if they felt the management were not dealing with their concern appropriately and knew how to contact the local authority safeguarding adults team. Safeguarding concerns were reported to CQC and to the local authority promptly and investigated thoroughly. If people had unexplained bruising this was documented along with action staff had taken. This enabled staff to monitor people’s condition and seek medical help if necessary.

Risks to people’s health and wellbeing had been assessed and action recorded to enable staff to care for people safely. Where people were at risk of pressure injury, or falls, this had been assessed and equipment was in place to reduce the risk. Staff were aware of risks to individuals and how to mitigate these. They knew where to find information about people’s risk assessments and said these were up to date and were aware of the home’s policies in relation to caring for people, for example, after a head injury had been sustained. Records showed that staff followed these procedures in practice. Staff reminded people, where appropriate, to use walking aids, or to use their call bell to summon staff assistance. One person’s care plan indicated the person should be encouraged to elevate their feet when sitting. Staff supported this person to sit down and ensured a footstool was in place for the person to use. When people were being assisted to move around the home, staff showed awareness of the risks involved and provided support in a safe and unhurried manner. One member of staff who was assisting a person said to them, “Take your time; let me know if you want to sit down, I have a chair right here”. When the person chose to take a rest on the chair, the staff member said, “That’s it, feel for the chair first; now sit down”. A person spoke about the way they were assisted to have a bath each week, saying, “I had a bath last night; it was lovely. I felt safe; it was wonderful”.

A call bell system was in place and people reported that staff attended to them quickly when they activated the bell. One person said, “[staff] help me to the toilet. I press the buzzer and they come quickly, even in the night-time”. Each person had a personal evacuation plan to aid staff and the emergency services to support people to safely exit the building should this be required. These were individualised to each person and their particular requirements. Staff had been trained in first aid and fire awareness and were aware of what to do if an emergency occurred in the building, and how to respond if the fire alarm activated.

There were sufficient staff on duty to care for people’s needs. The deputy manager, who prepared the staff rotas said they took into account staff skill mix, experience and dynamics when choosing which staff should work together. The number of staff required was based on people’s needs, including whether the person occupied a room upstairs or downstairs, and how much staff assistance they required. They said they had staff that, “Will come in at the drop of a hat”, to cover absences at short notice. Both the provider and the deputy manager were qualified to provide care and they shared the on-call responsibility, which meant staff always had a member of the management team to consult if necessary. Staff were clear about their responsibilities on each shift and had tasks delegated to them by the senior staff in charge of the shift. A visiting health professional said that there were always staff available to escort them to their patient’s room, and to get them the information they required.

Staff recruitment practices were safe. Staff applying to work in the home were subject to an interview which covered their skills, knowledge and suitability to work with people living in the home. Checks were made as to their medical

Good

Is the service safe?

fitness to work, conduct in previous employment and criminal record checks with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

People said they received their medicines appropriately. Staff gained people's consent before giving them their medicines, explaining to the person what they were for. They did this in an unhurried manner, allowing the person to take their time. A relative said, "[Care staff] have done all they can [for their relative's arthritis]. They rub in cream every night". People's care plans stated whether they were able to tell staff if they were in pain or if they had difficulties communicating this. When people were prescribed medicines that varied in dose, such as warfarin, a care plan was in place to ensure this was given appropriately. When a person expressed to staff that they were in pain, staff responded kindly. On one occasion when a person asked for pain relief, the member of staff checked the person's medicines administration record (MAR) and found that it was not safe to administer further pain relief at that time. They explained to the person that they would need to wait for half an hour, and in the meantime they assisted them to be as comfortable as possible, providing a hot water bottle and supporting them to sit comfortably in their room.

Where people had been prescribed medicines 'as and when necessary' (PRN) a care plan was in place to guide staff when to administer these medicines. Staff were aware of the guidance for individual people and used a pain assessment tool to determine how much pain relief to administer. Staff then returned to the person after half an hour to check if the dose had been effective.

Staff administering medicines had received training to do so. Their competency had been assessed before they were given the responsibility to administer medicines. People had indicated in their care plans whether they wanted care staff to administer their medicines. People's allergies to particular medicines were recorded on their MAR and the side effects of medicines were also recorded. This enabled staff to identify if a person was experiencing side effects from their medicines. The deputy manager was able to intervene when a visiting GP prescribed a particular antibiotic to a person who was unwell, informing them that the person was allergic to that particular medicine. This enabled the GP to prescribe a medicine that was safe for the person without delay.

Medicines were stored safely and stock records matched the stock of medicines held in the trolley. One person used self-administered oxygen. This was stored appropriately and on correct settings according to their care plan. Medicines no longer needed were recorded and disposed of safely.

The home was clean and infection prevention and control measures were in place. Domestic staff were clear about their role and cleaning schedules were in place to ensure all parts of the home were cleaned regularly. An infection control policy was in place and staff were observed following the policy in their practice including ensuring they wore personal protective equipment (PPE) such as disposable gloves and plastic aprons. Hand washing facilities were equipped with liquid soap and single use hand towels, and hand cleansing gel was distributed about the home to ensure staff, visitors and people living in the home had access to this.

Good

Is the service effective?

Our findings

At our last inspection in March 2015 we found the service was in breach of regulations relating to the effectiveness of the service. The provider had failed to ensure that staff were supported with appropriate training to carry out their role and people did not always have access to a choice of nutritious food and drink. The provider sent us an action plan which stated they were addressing the concerns.

People felt they were supported effectively by well-trained staff who were attentive to their needs. One person said, "They are very good carers, they do everything you want them to do for you". Relatives said their family members were cared for well and they had no concerns about the care delivered in the home. They commented, "[The staff] appear to be qualified and know what they're doing", and, "[My relative] has everything she needs".

Staff had the skills and experience they required to provide effective care to people. A programme of training was in place and each member of staff had a learning and development plan. Staff said they completed a wide range of training, including food hygiene, fire awareness, moving and handling and safeguarding adults. Some training was face to face, rather than workbook or online training and was delivered by an external provider. Staff said the training they received really helped them, saying it was, "brilliant", and helped them feel more confident. Some staff had completed a booklet on the loss of hearing, blindness and deafness. They said this helped them to support people better, for example, for people with limited sight, helping them identify what was on their plate and where their cutlery and cup was on the table. Others said that training in pressure care had been really helpful, in particular training to support people to reposition regularly. They knew which people needed this assistance and felt confident that, 'in-house systems' were, "much tighter" as a result of staff completing the training. Awareness posters were displayed in staff areas as a reminder, for example, of when redness of skin would be a cause for concern and what action to take in response.

New staff completed an induction to the home which was signed off when it was completed. This covered areas like personal care, safeguarding vulnerable adults and dignity, independence and privacy. This was followed by 'shadow' shifts, accompanying a more experienced member of staff to observe their practice. New staff also completed the Care Certificate. This sets the standards people working in adult social care need to meet before they can safely work unsupervised. New staff received supervision throughout their probation period, to check on their progress and address support any needs they may have. Staff confirmed they received training in safe moving and handling before being required to assist any person to move. New staff said, "[The management team and staff] have been really good here," and, "training is encouraged". Staff said they were supportive of each other and "really helpful".

Staff were supported through regular supervision meetings. Staff reported that they got feedback about their work from other staff and from people living in the home. They were able to discuss their development and training needs. Issues with staff practice were addressed and followed up with further discussion to make sure improvements had been made. The supervision record was signed by the staff member to indicate their agreement with the actions recorded.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. People's care plans showed where necessary, people's capacity to make specific decisions had been assessed and recorded. Most staff knew how the principles of the MCA applied in the home and what to do if they were concerned about a person's ability to make decisions. Where people were not able to verbally indicate their consent, staff supported them to be able to still make a decision. For example, they checked what the person wanted to eat by offering food choices and waiting for response. The person would indicate their choice by giving the 'thumbs up' sign when they wanted what was on offer. This enabled the person to still make this decision for themselves. Some people's care plans stated that a friend or relative had power of attorney to make decisions on their behalf, however the provider did not have evidence of their legal right to do so. The provider said they would ensure this was sought out and made telephone calls to that end during the inspection.

Good

Is the service effective?

Care records contained people's documented consent to personal care, checking of personal belongings, and sharing of information. Each person had been made aware that they could change their mind at any time. We observed staff offering people choices throughout the day and waiting for people to consent before acting. Staff said they, "go by what people say" when providing care and, "get consent to support on a day to day basis".

People were only deprived of their liberty in line with the requirements of the law. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Several people had a DoLS in place and these had been appropriately applied for. Staff knew who the DoLS applied to, and the provider was in the process of following up applications made in the summer of 2015.

People were provided with a choice of nutritious and well-presented meals. People said, "I miss my home cooking, but it is quite good here really; always a choice of two meals; if you don't want either they find something else for you; the quality is very good", and, "I am not a pudding person, so I have a yoghurt, but they always look nice", adding that they were, "always offered sandwiches, soup, beans on toast, whatever you like" and that "there is always cake". A relative said, "[My family member] is a really picky eater, but they give her what she likes here; if she doesn't like the choices they ask her what she wants and they give her that". In a recent survey of people living in the home, people said they were satisfied with all aspects of the food and catering, including the menu and the support people were given to eat sufficient amounts. The mealtime was a sociable occasion with people and staff chatting freely.

People's food preferences were recorded and were made available to the cook and kitchen staff. When a person had not eaten much of their main meal and refused dessert, the cook came and spoke with them, They asked the person if they would like something different to eat. The person refused but did accept the offer of their favourite dessert. Staff said a variety of meals had been frozen so that an alternative could always be offered if people refused both planned meal options.

One person received their food pureed due to a health condition. Staff were aware of the person's health condition and the person's preferences to eat their food this way. People said they could choose where to eat their meal and this changed depending on whether they had visitors or how they felt on the day.

Staff were on hand at mealtimes to provide support to people as needed. One person required their food to be cut up and staff did this for them after first asking if this was what the person required. Adapted crockery and cutlery was available to enable people to maintain their independence when eating and drinking. Where people required their food and fluid intake to be monitored this was done and records were up to date. Staff knew the target intake for the person and encouraged them to eat and drink appropriately.

People had access to healthcare support when they needed it. People with diabetes said they were seen by the diabetic nurse regularly. Other people required support from the district nurse and they confirmed they received the care they needed. Visits from healthcare professionals were recorded in people's care plans and any action required was recorded in the shift handover book to ensure staff were made aware. People said they were seen by their GP when they were unwell.

Staff supported people to attend appointments at the local hospital, to visit the opticians or the chiropodist. Where people had a condition that required the input of a specialist they were supported to access this and their care plan stated clearly how to contact the specialist service if needed. In a survey of healthcare professionals who visited the home, they commented that the, 'healthcare is very good' in the home, and that staff were always, 'prepared for our arrival and well-informed' about the health of their patient. A visiting health professional said they had no concerns about the care provided in the home, and another said that staff contacted them promptly when they were concerned about a person's health.

Good

Is the service caring?

Our findings

People said staff were kind and caring. They commented, "[The staff] are all extremely patient and kind and go out of their way to help you if they can", and, "They're very sweet and nice and they've got a great sense of humour". People said they got on with all of the staff and that there was a friendly and homely atmosphere in the home. Relatives said, "Everything I've seen here has been caring", adding, "it is very, very good here", and, "the attitude of the care staff is good". A display of 'thank you' cards from relatives and people living in the home expressed their thanks to staff and the provider for, "wonderful care", "a loving, caring environment", and, "kindness and care". When people, their relatives, and visiting health professionals were surveyed about the care provided in the home, all of them said that staff were caring and praised staff for the happy atmosphere they promoted in the home.

It was clear that staff and people had built positive relationships. Staff greeted people by their preferred name and showed they knew people well, asking about their relatives and events in their personal lives. People were relaxed and shared a joke with staff and with each other. When a person had to wait a couple of minutes for staff assistance the staff member apologised to them saying, "Sorry about the delay [person's name], now, how can I help you?"

Records of care provided to one person who was new in the home indicated that staff took care to make sure they felt comfortable and their needs were met. The person had not been able to settle and was awake in the early hours of the morning. The record stated that care staff took it in turns to sit with the person, 'having a chat' and provided them with a cup of tea. Another person had experienced a bereavement and expressed some distress about this. Care staff took turns to sit with the person and provide some comfort and company for them during the day. Another person said that they spent a lot of their time in their room and that staff, "often pop in for a chat with me". Where people were only partially sighted, staff called the person by name and told the person their name so they knew who was talking to them. If a person was hard of hearing, staff knelt to their level and spoke close to their ear to enable them to hear better.

People were supported to be involved in decisions about their care. All the people we spoke with said they played an active part in discussions about their care, making decisions on a daily basis which staff respected. They said staff did not assume they knew what people wanted. We observed staff asking questions, allowing people time to respond and acting in response to people's replies. All the support staff provided was accompanied by clear and kindly communication. When a person expressed to a member of staff some concern about a visit from a social worker, the care staff said, "let's make a cup of tea and we can have a chat about it".

The home operated a 'You Said' scheme in which people were asked for their ideas to improve the service provided and the environment. People had contributed ideas for a curry night, a meal at a local restaurant, and the décor for the dining room. These ideas had been implemented and the action taken with the date it was completed was displayed for people to see. People said the provider consulted them regularly about their care, and asked them about improvements they would like to see in the home. One person said, "[The provider] comes round and talks to us. When the dining room was due to be decorated he asked us [about the colour scheme]; it looks lovely in there now".

Staff respected people's right to privacy and dignity. Staff spoke discreetly to people about their care needs, for example, when asking them if they would like some assistance to go to the bathroom. Staff described how they took care to cover people and not allow them to be exposed for any longer than necessary when providing personal care. They said they kept people covered as long as possible before their bath and provided them with a towel as soon as they left the water. Where safe to do so, staff provided people with a call bell and left them alone in the bathroom so they could attend to their own personal care in private. People were satisfied with the way care was provided. One person said, "[The staff] always pull the curtains when they are helping me get washed and dressed". We observed that, even though a person's door was open, staff knocked and said, "Do you mind if we come in [person's name]?" Two people shared a room. A privacy curtain was in use as well as a walled partition which enabled both people to have privacy. One person said they had expressed their desire for their own room and this was being arranged with staff in the next few days.

Staff took care to protect people's dignity during mealtimes. If a person spilled part of their meal or drink

Good

Is the service caring?

staff quickly and discreetly provided assistance. People had chosen the level of privacy they wanted in their rooms.

They could choose to have staff knock and enter, knock and call out the person's name or knock and wait for an answer from the person. Their particular choice was posted on the door to their room to inform staff.

Good

Is the service responsive?

Our findings

At our last inspection in March 2015 we found the service was in breach of regulations relating to the provision of a responsive service. People had not always received the correct healthcare and health monitoring they required, and care was not individualised. The provider sent us an action plan which stated they were addressing the concerns.

People were involved in the way their care was planned, and they had signed their care plans. They said they were involved in any decisions affecting them and their care on a daily basis. Reviews of people's care were carried out regularly involving people and their relatives if the person wanted this.

Detailed care plans had been prepared covering all aspects of people's care. These indicated people's level of independence. Individual tasks were described in detail showing what people could manage for themselves and what they needed assistance with. For example, some people were able to carry out some personal care themselves and needed help with other parts. One person said, "I try and do as much as I can - they let me do what I can". Specific manoeuvres people had to make, such as from bed to chair or from chair to standing were documented with the support the person required. This enabled staff to support people to the right degree and helped people maintain their independence as much as possible.

Where people had specific conditions, such as diabetes, a care plan was in place to ensure the person received the support they required to remain healthy. When people had a short term condition, such as a urinary tract infection (UTI), or a chest infection, a short-term care plan was created and put in place to enable staff to support the person appropriately during this time. Staff took action in response to concerns about people's health. A relative said they had expressed concern about their family members unexplained weight loss. They related when they spoke with the management of the home the concerns had already been acted on and an appointment made with the person's GP. Another person's records showed they were not eating well. A food monitoring chart had been in place, and this was discontinued once the person regained their appetite. When people fell and sustained any kind of head injury regular checks were put in place and recorded to ensure action could be taken promptly if the person suffered complications following the fall. Staff were aware of this process to keep people safe. Staff knew of the changes to people's skin that may indicate they were at risk of pressure injury. They recorded their concerns and completed a body map along with the action they had taken in response to their concerns.

People's preferences for the way they liked their care to be delivered had been recorded and staff were aware of these. For example, one person liked sitting in a well-ventilated area and we noted they were sitting near a slightly open window. Another person liked their television to be left on all night and records showed this was arranged. People had expressed a preference for the time they would like to get up and go to bed and records showed they were supported at their preferred time. Other preferences had been recorded, for example, how often a person wanted staff to check on them at night. Staff said they were aware that one person did not like rough clothing and they were at risk of taking their clothes off if their skin was irritated by the cloth. To avoid this staff ensured that the person had cotton next to their skin when they supported them to get dressed. One person said, "They [the staff] do whatever I want". A relative said, "[their family member] goes to bed when she wants, and if she wakes in the middle of the night, she gets a cup of tea brought in".

If a person changed their mind about a certain aspect of their care, this was accommodated without fuss. Records of care delivered to one person showed they had decided to go to bed at 10:30pm but subsequently changed their mind. The record showed that staff assisted the person to get up and move to the lounge. Staff provided them with a cup of tea and the person spent some considerable time listening to the radio and singing. Another person expressed to staff that they may not want to have their bath at the usual time. The staff member said, "[person's name], you can have your bath tonight, or tomorrow, whenever you like, it's up to you". A person newly admitted to the home, expressed a preference for listening to the radio rather than watching television. Staff found the person a radio and ensured they were comfortable and settled in.

A system was in place to ensure that staff on duty were aware of people's changing needs. A communication book was in use and staff recorded their information about people's care. For example, if a person was on a new medication; required an earlier wake-up call than usual; or

Good

Is the service responsive?

if they required more than usual support to mobilise. When staff started their shift they received a handover from the senior staff finishing their shift. The discussion was held confidentially and staff used the communication book to ensure everything that needed to be handed over was, and staff were able to ask questions to clarify people's needs.

Formal meetings were held every two months to which all people living in the home, and their relatives, were invited. People were aware of the next meeting and some had items for discussion prepared. The minutes from the previous meeting, in September 2015, were displayed in the reception area of the home.

A range of activities were planned, either as a group or on a one to one basis. One staff member worked on four days to provide activities such as painting, keep fit / exercise and manicure / pampering. Only one activity was planned for each day and some people said they would welcome more to do and more intellectually challenging activities such as quizzes. One person said, "I can't do the painting, but I do like the ball games". The provider said they were looking into producing a personalised plan for activities for each person. An outing had been arranged to a local restaurant and photographs were displayed showing people enjoying the occasion. Another outing was planned nearer to Christmas.

The complaints procedure was displayed in the home and people were aware of who to complain to if they needed to. No one had anything they wanted to complain about, however, they said that because the provider was in the home daily and came to speak to them regularly, if they had any concerns they just told the provider and it was sorted out. A relative said of the deputy manager and the provider, "If I have a query the answer has always been there; they both know what they are doing". When a complaint was received this was recorded and investigated thoroughly. One complaint, regarding some lost clothing, had been addressed in a meeting with the complainant. The notes of the meeting were documented and the provider had arranged recompense to the complainant which resolved the matter to their satisfaction. If a concern was raised, even if it was found to be unsubstantiated, the provider used the opportunity to remind staff of the home's policy about the matter.

Good

Is the service well-led?

Our findings

At our last inspection in March 2015 we found the service was in breach of regulations and was not well-led. Quality monitoring systems had not ensured people received a safe, effective, caring and responsive service. The provider sent us an action plan which stated they were addressing the concerns.

At this inspection we found that the issues identified at the inspection in March 2015 had been addressed and action had been taken to become compliant with all regulations. The home did not have a registered manager and the provider was in the process of registering with the commission to become the home's registered manager. The provider was in the home on a daily basis and together with the deputy manager had implemented many changes to the way care was delivered in the home and as a result the care that people received had improved. Events in the home, such as injuries or allegations of abuse, were documented, investigated and notifications were made appropriately to the Commission and to the local safeguarding team.

People said the home was well-led and that they had seen improvements since the last inspection. They commented, "I've noticed the difference; things seem better. The boss is here more", "[the provider] is brilliant; a lovely man", and, "nothing is too much trouble for [the provider]". All the people we spoke with said they would recommend Waxham House. A relative said, "We wouldn't want mum anywhere else".

The provider had in place an ongoing programme of formal and informal measures to monitor the quality of the care provided in the home. Audits of all aspects of care had been carried out within the last six months, including infection control, food and nutrition, the environment, consent, end of life wishes and record-keeping. Each audit was thorough, recorded and an action plan produced. The action plans were all completed within three weeks of the audit. An audit of medicines management in the home had been carried out by an external pharmacist. A report had been produced and action was being taken to address several minor points. Improvements were made promptly to the service.

The provider held one to one conversations regularly with every person in the home. This helped them to identify areas that could be improved or any changes to their preferences. These were then communicated to staff. A record of the discussion was made and the changes transferred to the person's care plan where necessary. People's care plans were reviewed regularly and any changes were noted and the person signed to indicate their agreement with the change. Relatives said they had opportunities to talk with the provider whenever they wanted to.

A survey was sent to all people in the home, their relatives and regular visitors to the home including GPs and community nurses. The survey asked people to comment on all aspects of the home including the quality of personal and healthcare, the availability of the management team, the attitude of staff and the atmosphere in the home. All of the responses were positive. Additional comments were welcomed and where these were made the provider had addressed these. For example, several people had made comments about the timing of meals and menu planning. The provider made sure these were discussed at the residents' meeting and had arranged for the cook to visit each person to talk about their meal preferences. The provider said this would help them to prepare individual food and nutrition care plans for people.

The values of privacy, dignity, respect, autonomy, right to choice, and enabling people were promoted in the home. We saw these were embedded in the care practice. Staff commented, "The residents come first; this is their home". The provider reiterated these values through working alongside care staff and encouraging staff to talk about the values in staff meetings which were held regularly. The areas for improvement that arose from audits were communicated to staff at these meetings. An agenda was circulated in advance of the meeting and staff were encouraged to add items they wished to discuss. Staff said they were able to contribute to the meeting freely and discuss anything that may concern them. Minutes were taken at each meeting and staff signed to say they had read them. Reminders were displayed in staff areas including any immediate changes that were necessary to people's care and changes to the home's policies and procedures. The reminders also informed staff which areas of care provision the provider would be looking at next.

The provider fostered an open culture in the home. The previous inspection report was available for people and visitors and the rating was displayed publicly. Staff had free

Good

Is the service well-led?

access to the provider, the deputy manager and the head of care. The provider was able to identify staff strengths and weaknesses and provide support and training appropriately. They added that this had resulted in senior staff taking more personal responsibility for what happens on their shift and leading by example. Each shift leader had quality monitoring tasks to carry out, such as checking that the home was clean, and that essential records of people's food and fluid intake had been completed. If anything required action they ensured staff did this and reported directly to the management team if these actions were not carried out. A member of staff said that since the last inspection expectations of staff have been heightened and the responsibilities of staff, including junior staff had increased.

Staff said the provider and the management team were supportive, approachable and that they could access advice and guidance whenever they needed this. One member of staff said, "I can go to them for anything and get advice" and gave examples of when they had sought further advice on the prevention of pressure sores. Staff felt confident in the management team, commenting, "Now we have three people to go to". Other staff said that action was taken promptly if they raised a concern to the management team. One said, "Things get done". Staff had access to the home's procedures and policies and reminders were posted in staff areas about key policies. Staff said they were now working in, "a healthy environment". The provider said, "I don't ask my staff to do anything that I wouldn't do myself".