Mr & Mrs S Munnien

South Wold Nursing Home

Inspection report

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16 January 2018

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

South Wold Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to16 older people and people living with dementia.

We carried out our first comprehensive inspection of the home in November 2014. At this inspection we identified shortfalls relating to fire safety, medicines management and the monitoring of service quality. We rated the service as Requires Improvement.

In August 2016 we undertook a second comprehensive inspection. We found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of concerns about the safety of the premises. We also identified continuing shortfalls in organisational governance relating to the auditing and monitoring of service provision. The rating of the service remained as Requires Improvement.

In March 2017 we conducted a focused follow up inspection to check whether the provider had taken action to address the breach of regulations identified at our August 2016 inspection. We found that the provider had made improvements to the premises and was no longer in breach of regulations. However, some issues remained outstanding and further action was required to ensure the premises were fully safe for people's use.

We conducted this third comprehensive inspection of the home on 10 and 16 January 2018. The inspection was unannounced. There were 16 people living in the home on the first day of our inspection.

At this inspection we found the registered provider had failed to address issues for improvement identified at previous inspections. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of continuing shortfalls in organisational governance; a failure to properly assess and mitigate risks to people's safety and a failure to ensure sufficient staffing to meet people's need for emotional support and to keep them safe. We also found the registered provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 due to a failure to notify us of serious injuries sustained by people living in the home.

In other areas, the registered provider was also failing to provide people with the effective, caring and responsive service they were entitled to expect. People were not supported consistently in a person-centred way and did not receive sufficient physical and mental stimulation to meet their needs. Care staff were not always aware of changes to people's care plans and people's right to privacy was not consistently protected. Senior staff were not always prompt in seeking advice from external healthcare professionals.

Staff did not receive supervision in line with the registered provider's policy requirements and there was no

effective system in place to ensure staff received the training essential to their role. There was little evidence of organisational learning from significant incidents.

The registered manager was well-liked. However, the registered provider employed insufficient management and administrative resources which had a negative impact on the running of the home.

The overall rating for the home is 'Inadequate' and the home is therefore in 'Special Measures'.

We have taken action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements. You can see what action we told the provider to take at the back of the full version of this report.

In some areas the registered provider was meeting people's needs.

Staff worked well together in a mutually supportive way. Staff were kind and caring in their approach and encouraged people to maintain their independence and to exercise some choice and control over their lives. Staff provided end of life care in a sensitive way. People were provided with food and drink which met their individual needs and preferences. People's concerns or complaints were handled effectively.

The home had a registered manager. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider') 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.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection, the provider had been granted a DoLS authorisation for two people living in the home and was waiting for a further application to be assessed by the local authority.

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.

Some aspects of the premises remained unsafe.

Systems to prevent and control infection were ineffective and unsafe.

Some people's medicines were not managed safely.

There were insufficient staffing resources to meet people's need for emotional support and to keep them safe.

Staff recruitment was not consistently safe.

Staff did not consistently follow the guidance set out in people's individual risk assessments.

There was little evidence of organisational learning from significant incidents.

Staff were aware of adult safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive supervision in line with the provider's policy requirements.

There was no effective system in place to ensure staff received the training essential to their role.

Senior staff were not always prompt in seeking advice from external healthcare professionals.

Staff reflected the requirements of the Mental Capacity Act 2005 in their practice.

Staff in the various departments in the home worked closely together.

People were provided with food and drink that met their needs and preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to privacy was not consistently protected.

Staff were kind and caring in their approach.

Staff encouraged people to maintain their independence and to exercise some choice and control over their lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not receive sufficient physical and mental stimulation.

Care staff were not always aware of changes to people's care plans.

People were not supported consistently in a person-centred way.

Staff provided compassionate care for people at the end of their life.

People's concerns or complaints were handled effectively.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to monitor and audit service provision remained ineffective.

The provider had failed to take effective action to address areas for improvement highlighted at previous inspections.

The provider had failed to notify CQC of serious injuries sustained by people living in the home.

The registered manager was well-liked by everyone connected to the home. However, there were insufficient management and administrative resources which had a negative impact on the

running of the home.

Staff enjoyed their job and worked together in a mutually supportive way.

South Wold Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was 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.

We visited South Wold Nursing Home on 10 and 16 January 2018. On the first day our team consisted of an inspector, a specialist advisor whose specialism was nursing 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. On the second day our inspector returned alone to complete the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR) and we took this into account when we made the judgements in this report. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. In preparation for our visit we also reviewed other information we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams.

During our inspection we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with five people who lived in the home, two visiting family members, the registered manager, the deputy manager and five other members of staff.

We looked at a range of documents and written records including people's care files and staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Inadequate

Is the service safe?

Our findings

At our first full inspection of the home in November 2014 we identified concerns with the management of some people's medicines and told the provider that improvement was required. At our next inspection of the home in August 2016 we were pleased to find the provider had taken the action necessary to improve the management of people's medicines.

However, on this inspection we were disappointed to find this improvement had not been sustained and that, once again, the provider was failing to manage people's medicines safely in line with good practice and national guidance. People's prescription medicines were kept in a locked trolley which was stored in the registered manager's office. This office was situated on the main corridor in the home and was often left unattended with a chair propping the door open. On the morning of the first day of our inspection we found some people's medicines had been left on an open shelf in the office creating an increased risk that they could have been accessed by people living in the home, many of whom were living with dementia. We were particularly concerned to find that one of these medicines was a tub of thickening powder prescribed for the use of a person identified as being at risk of choking. Acknowledging the risk this unsafe storage practice presented to the people living in the home, the registered manager told us he was unaware of an NHS patient safety alert issued in February 2015 in response to the death of a care home resident following the accidental ingestion of a thickening powder that had been left within their reach. This alert instructed 'all providers of NHS funded care where thickening agents are prescribed, dispensed or administered' to ensure arrangements were in place to ensure appropriate storage of thickening powder by 19 March 2015. The registered manager's office also contained a sink which staff used to wash the reusable plastic containers used to administer some people's liquid medications. On the first day of our inspection we saw that some of the containers had been left to dry upside down on paper towels. The towels appeared to have been there for some time and were dirty and impregnated with medicine residue, creating an increased risk of cross-contamination and infection.

On the first day of our inspection we were also concerned to find empty prescription medicine bottles in an open skip on the driveway of the home. Although most labels had been removed before the bottles had been placed in the skip, some still had a label attached, breaching the confidentiality of the person for whom the medicine had been prescribed. Additionally, the bottles had not been washed out prior to disposal and most still had a small amount of medicine inside them. Given that some of the medicines had powerful mood-alerting properties this created a risk to anyone who might have come into contact with the contents of the skip.

At our August 2016 inspection we identified a number of concerns about the safety of the premises and found the provider to be in breach of regulations. In March 2017 we conducted a focused follow up inspection to check progress in this area. We found that the provider had made some improvements and was no longer in breach of regulations. However, we noted that some issues remained outstanding and further action was required to ensure the premises were fully safe for people's use.

At this inspection, we found that some of the remedial work identified as outstanding at our previous

inspection had still not been completed. In particular, the ramp leading up to the front door was still without a handrail and the surface of the patio area at the front of the home remained extremely uneven. Some 15 months after we had first identified these risks to people's safety, it was concerning to find that the provider had still not taken action to address them. When we returned for the second day of our inspection, we found a handrail had finally been fitted to the ramp. Acknowledging that he would have not taken this action if it had not been for our inspection, the registered manager told us, "I rang [the contractor after the first day of the inspection] and said, 'I am in deep trouble. I can't keep failing all the time. I need to be seen to be more proactive'." However, the patio had still not been repaired. Reviewing the surface of the patio with our inspector, the registered manager acknowledged, "It's dreadful." Worryingly, when describing his approach to assessing potential risks and hazards in the in grounds of the care home, the registered manager said, "It's not something we pay a lot of attention to."

At our August 2016 inspection we also identified concerns about the hot water supply in the home. This meant that some people were not receiving hot water in their bedroom and staff were carrying containers of hot water from the kitchen to people's rooms. By the time of our March 2017 inspection the hot water system had been repaired and people told us they were now happy with the supply of hot water throughout the home. However, on this inspection, we found the problems had returned. Discussing the current situation, one staff member told us, "It's very frustrating. We have to make sure the washing machine isn't running [before] someone has a shower. We take bowls from the laundry room to each room. We haven't got time to wait [for the water] to heat up." Reflecting this feedback, on the first day of our inspection we tested the water supply to several ensuite and communal hand basins and found that there was a delay of several minutes in obtaining any hot water. In most hand basins the temperature of the water never became more than tepid and, in one, there was no hot water at all. The ongoing problems with the hot water supply made it harder for staff to maintain good hand washing practice, increasing the risk of the spread of infection. The fact that staff were, once again, carrying bowls of hot water through the home also presented a safety risk to themselves and others. When we raised these issues with the registered manager he said, "Of course it gives me concerns. I will have to get the plumber."

In addition to the lack of a reliable supply of hot water, other aspects of the provider's approach to infection prevention and control were ineffective and unsafe, creating an enhanced risk to people's health and welfare. For example, on the first day of our inspection we found some hand towel and hand sanitizer dispensers were empty, increasing the risk of poor hand hygiene by staff when providing people with personal care. On one occasion we observed an experienced and long-serving member of staff assisting a person to go to the toilet. Quite correctly, the staff member put on single-use protective gloves whilst supporting the person in the toilet. However, at one point they left the person to enable them to use the toilet in private and went off to talk to another person in their bedroom. We watched as they placed their hand near this person's face on the headrest of their armchair, still wearing the gloves they had been wearing whilst assisting the other person in the toilet. When we raised this poor practice with the registered manager he told us that the staff member had "forgotten the golden rule". On the first day of our inspection we found the clinical waste bin on the driveway of the home was so full the lid could not be closed and bags containing hazardous items such as used incontinence pads, wipes and dressings were over-flowing from the bin. Some of the bags had split, exposing the contents and increasing the risk of cross-contamination and infection. Coincidentally, shortly after our inspection, a member of the public contacted us and told us they had had concerns for many years about the provider's approach towards the storage of clinical waste on the care home site.

We looked at people's care records and saw that a range of possible risks to each person's safety and wellbeing had been considered and assessed. However, in some cases the preventive measures set out in these risk assessments were not followed by staff, increasing the risk of harm. For example, in January 2017

the provider had assessed one person as being at high risk of weight loss and staff were instructed to weigh the person weekly to ensure close monitoring of the situation. Despite this guidance, staff continued to weigh the person on a monthly basis. Over the next six months the person lost over 13% of their body weight and it was only in August 2017 that staff sought specialist advice from a dietician. Following this intervention, the person was prescribed a dietary supplement and started to regain weight. However, had staff observed the requirement to weigh the person weekly, their significant weight loss might have been picked up earlier and action taken to reduce the risk to their health. In other cases, poor record keeping meant it was unclear whether staff had followed the guidance in people's individual risk assessments or not, creating a further potential risk to people's health and welfare. For example, in May 2017, the provider had assessed one person as being at very high risk of developing pressure sores and staff were instructed to assist the person to change position every two hours. However, when we reviewed the charts used by staff to record when they had supported this person to reposition we found multiple gaps. For instance, the record for December 2017 alone had over 130 missing entries.

We also found that the provider's staff recruitment procedures were not consistently safe. For example, we reviewed the file of one member of staff who had commenced their induction on 5 April 2017 and started work as a full member of the care staff team on 10 April 2017. However, the provider did not receive DBS clearance for this person until 18 April 2017 and references were not received until 20 and 21 April 2017, almost two weeks after the person had started to provide intimate personal care to the people living in the home.

Taken together, the provider's failure to properly assess and mitigate risks to people's safety was a breach of Regulation 12(2)(a),(b),(c),(d),(g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the provider employed sufficient staff to meet their physical care and support needs without rushing. For example, one person said, "Oh yes … there's always lots of [staff] about. We are never short." A member of the care staff told us, "We have time to meet the basic care needs [and] sometimes the nurse helps us out [if needed]. [People] are not waiting for buzzers." However, whilst staffing levels were sufficient to meet people's physical care requirements, people told us that staff did not have enough time to meet their emotional needs. For example, one relative said, "I think the staff have the skills to do their job. It's just they could do with more time to sit and talk …. and do things … with the residents." Describing the many pressures on their time, one staff member told us, "When we are not doing personal care we are doing laundry … the housekeepers don't do laundry. Making beds is [also] part of our role. Once we have done all the basic stuff we don't have time for emotional care. As soon as we sit down with someone the [call] bell goes and we get interrupted. One-to-one stimulation is what people need [but] we [do not have time] to address emotional needs." Reflecting this feedback, on both days of our inspection we saw people sitting for long periods of time with no stimulation or occupation and only occasional, fleeting interactions from passing staff.

Some people also expressed concerns that staffing resources were insufficient to ensure people were properly supervised and kept safe from harm. For example, one relative commented, "The staff are a very good, caring bunch. But … there are just not enough of them …. to keep an eye on .. the residents. It would be good to have a staff member in the sitting room sitting with the residents [and] supervising them. They can easily forget to use their walking frames when they get up from the chair. This is a risk. It would be safer if a member of staff was around." In confirmation of these comments, throughout our inspection, we saw several people, most of whom were living with dementia, were left for extended periods in the main lounge without any staff support or supervision. On both days of our inspection we also saw a person who was living with dementia walking repetitively around the home without supervision, creating an increased risk to

themselves and others. At one occasion we saw this person enter the lounge and remove a blanket from another person who was sleeping in a chair, clearly causing them alarm. Another person who was living with dementia had been assessed as being at risk of harm if they left the home without staff support. However, in the two months preceding our inspection, this person had gone missing from the care home on two separate occasions. Confirming that there were insufficient staffing resources to provide people with the supervision they needed to keep them safe, one staff member told us, "We have other things to do. You can't watch them all the time." When we discussed staffing levels with the registered manager [who was also one of the owners of the home] he told us, "I think staffing will never be sufficient. [If it was at the required level] ... [I] ... couldn't make a living."

The provider's failure to ensure sufficient staffing to meet people's need for emotional support and to keep them safe was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the registered manager told us that he was "always learning, always reflecting", we found little evidence that the provider had a systematic approach to the review of significant incidents to identify any lessons which might reduce the risk of something similar happening in the future. For example, as described above, a person had recently gone missing from the care home for the second time in two months, indicating the provider had failed to properly understand the risks highlighted in the first incident and embed preventive measures in staff practice for the future. Talking about the second incident, one staff member told us, "[Staff] hadn't followed protocol … to keep an eye on [name]."

More positively, staff had received training in adult safeguarding procedures and were aware of how to report any concerns relating to people's welfare, including how to contact the local authority or CQC, should this ever be necessary.

There were two twin rooms in the home. The registered manager was aware of the potential risks of people sharing a room, particularly if either person was living with dementia. However, looking ahead, he agreed to formalise the risk assessment of any room sharing arrangements and ensure these were fully documented in people's care files.

Requires Improvement

Is the service effective?

Our findings

People told us they thought staff had the right skills and knowledge to meet their needs effectively. For example, one person's relative told us, "I am happy with the care [name] receives."

New members of staff participated in a structured induction programme which included a period of shadowing experienced colleagues before they started to work as a full member of the team. Talking positively about their own induction, one recently recruited member of staff told us, "I had three days. A day shift, an early shift and a late shift. Shadowing all the time. It prepared me for taking over [as a full member of the care staff team]." The provider was aware of the national Care Certificate which sets out common induction standards for social care staff and told us he incorporated it into the induction of any new recruit who lacked prior experience in the care sector.

The provider's training policy stated, 'South Wold Nursing Home believes that continuous improvement of its services is dependent upon the continuous development of the skills of its workforce. The organisation will therefore review and plan for that continuous development'. However, despite this commitment to plan for the continuous development of staff, there was no effective system in place to identify each staff member's mandatory training requirements and ensure these were refreshed on a regular basis. Acknowledging that this increased the risk that staff would not receive the essential training necessary for their role, a member of staff who was just about to return to work following a period of absence told us, "There isn't an ongoing record of what is outstanding. [No one] has been doing it for long period of time. It's [part] of my plan of action when I come back …. to do it more thoroughly."

Although there was no system in place to ensure mandatory training requirements were met, the provider did organise a variety of courses which staff told us they found beneficial to them in their work. For example one member of staff said, "I do enjoy [the] training. It's become more frequent in the last year. I did first aid the other day. It's always good to brush up our skills and learn something new." The registered manager was studying for a NVQ Level 5 in management and told us that he supported nursing staff to maintain their continuing professional development requirements and encouraged care staff to study for nationally recognised qualifications in care. Talking about the support she had received in this area, one member of the care team said, "[Name], my supervisor is going to find about more about NVQ2. She is quite encouraging."

The provider's supervision policy stated, "The purpose of supervision is to promote safe, consistent and best practice. Every employee will be invited to a … private… supervision session with their manager or supervisor at least 4 times each year'. However, staff told us that the provider was failing to meet this commitment to provide them with a three-monthly opportunity to reflect on their practice and discuss any issues that might have arisen during that time, increasing the risk that people would not receive effective care. For example, one staff member said, "It's been more frequently [recently] but it's not as regular as it should be. I've just had one [but] the last one was May time." When we reviewed the provider's 'supervision and appraisal' record we found, for the majority of staff, there was no record of them having received any supervisions at all during 2017.

From looking at people's care plans we saw that staff worked with a range of local health and social care professionals to monitor and support people's healthcare needs. However, we were concerned that senior staff were not always prompt in seeking appropriate external advice, creating enhanced risks to people's health and welfare. For example, as described in the Safe section of this report, staff waited six months before seeking specialist advice about the care of someone who had been assessed as being at high risk of weight loss. During this period, the person lost over 13% of their body weight. In 2016 another person developed a sore on their toe. From November 2016 to August 2017, this wound was cared for by nursing staff in the home with support from the person's GP and practice nurse. In early September 2017, at least nine months after the sore had first been detected, the registered manager (who was himself a registered nurse) asked the GP to refer the person to the Tissue Viability Nurse (TVN) due to the "slow progress with the toe". The GP made a referral and the TVN visited the person in the home and advised that they be referred to the vascular team at a local hospital. On 7 November 2017 the person attended an outpatient appointment with the vascular team and was admitted immediately as an inpatient on an emergency basis. The vascular team's clinical notes stated that the emergency admission was because the person had a wound which had been 'gangrenous' for several months. Acknowledging that the person had developed an extremely serious 'grade four' wound, the registered manager told us that he was unaware that the TVN service operated a single point of referral and that, as a registered nurse, he could have referred the person directly to the TVN service at any time without the need to go through the GP. Although, by the time of our inspection, the person had been discharged from hospital and their toe was finally beginning to heal, we were concerned at the registered manager's delay in seeking specialist advice from the TVN directly and the additional suffering and risk to the person's health this caused.

Staff were aware of the Mental Capacity Act 2005 (MCA) and understood the importance of obtaining consent before providing care or support. 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 made on their behalf must be in their best interests and as least restrictive as possible. Describing their approach in this area, one staff member said, "You have to give [people] choices. I wouldn't force anyone to do anything."

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection the provider had been granted DoLS authorisations for two people living in the care home and was waiting for a further application to be assessed by the local authority.

Senior staff made use of best interests decision-making processes to support people who had lost capacity to make some significant decisions for themselves. For example, one person was receiving some of their prescription medicines 'covertly' in their food without their knowledge. This decision had been taken by the registered manager as being in the person's best interests and was recorded in the person's care file. Although we were satisfied that people's rights under the MCA were protected, the registered manager agreed to document more fully everyone consulted as part of any future best interests decisions-making processes.

Staff had access to a range of publications and other information sources to help them keep up to date with changes to good practice and legislative requirements. For example, senior staff responsible for administering people's medicines had access to the most recent guidance on the use of medicines in care homes. Staff noticeboards had information on topics including influenza and mental health awareness and the registered manager told us the topics on the noticeboards were refreshed on a regular basis throughout

the year.

Staff from the various departments within the home told us they worked closely together to meet people's needs as effectively as possible. For example, describing her relationship with the care staff, the cook told us, "I try and help them [to] help me. Silly little things [like] turning on the light in the staff room to let them know that I am ready to [serve] lunch." Talking positively about their relationship with the nursing team a member of the care staff said, "[They] are always out on the floor. There is not a them and us culture."

People said they were satisfied with the food and drink provided in the home. For example, one person's relative told us, "[Name] likes the food and I know he eats well." Another person's relative said, "[Name] eats well and I think they keep a good eye on her nutrition." People were offered a continental breakfast with the additional option of a cooked breakfast every Saturday. The cook said that she was considering offering a cooked breakfast more frequently but, in the meantime, she told us, "I [do] poached eggs on toast a few mornings. [They] are popular." At lunchtime, people had a choice of two main course options, although alternatives were available if requested. Discussing one person in particular, the cook told us, "Sometimes [name] eats more for tea and [prefers a light lunch. So I ask her] if she wants a cheese toastie [or] a sandwich or fish fingers." Confirming this flexible approach, another person's relative told us, "They offer alternatives if he doesn't like something."

Kitchen staff understood people's likes and dislikes and used this to guide them in their menu planning and meal preparation. For example, the cook told us, "I noticed some people didn't like the gravy [in the cottage pie] and now we do it separately. Mince and potato rather than a full cottage pie. It went down [well]." The cook was also aware of people's individual nutritional requirements, for instance people who needed their food pureed to reduce the risk of choking. Taking positively of the support they received to manage a long-term health condition, one person told us, "I am a diabetic and they manage my diet well for me."

As detailed in the Safe section of this report, we were concerned to find that the provider had failed to rectify some of the outstanding environmental hazards identified at previous inspections. However, in other areas the provider had made some improvements to the physical environment and equipment in the home to ensure they remained suitable for people's needs. For example, internal signage and colour schemes had been upgraded to make it easier for people living with dementia to find their way about the home. Discussing this initiative, the registered manager told us, "We painted [one of the toilet doors] a different colour [to help] one gentleman who didn't know where the toilet was." A new wet room had also been installed to make it easier for people in wheelchairs to enjoy the option of a shower.

Requires Improvement

Is the service caring?

Our findings

Staff told us of the importance of supporting people in ways that respected their privacy. However, during our inspection we found this commitment was not reflected consistently in their practice. For example, on several occasions we watched staff go into people's bedrooms without knocking. Additionally, people's care plans were stored in the registered manager's office which opened onto the main corridor of the home. As described in the Safe section of this report, this office was frequently left unlocked and unattended which meant people's private, confidential information could be accessed by people and visitors passing in the corridor.

More positively, people told us that the staff treated them well and had a kind and caring approach. For example, one person said, "I feel … well cared for here." Another person's relative commented, "[Name] is well treated by the staff. They always do their job with a smile. They are lovely." Reflecting this feedback, during our inspection we saw staff engaging with people in kind and considerate ways. For example, we observed one person who spent most of their day in bed ask a member of staff if they could have a marmalade sandwich. Although the person had only recently had breakfast, the staff member was happy to oblige. On another occasion, we watched a member of staff patiently assisting someone to eat their lunch, gently encouraging them and chatting to them in kind and friendly tone of voice throughout. Describing their approach to the people in their care, one staff member told us, "I enjoy my work here. It's nice helping people out. What we do is important."

Staff were committed to promoting choice and independence and reflected this in the way they delivered people's care and support. For example, one person told us, "I go to bed at 10pm and get up at 7am. [And] I like to eat in my room. I prefer it here." Describing their approach to helping people with dementia choose what they wanted to eat, the cook told us, "Some people are quite difficult to [communicate with verbally]. I try not to make decisions [for them]. I use [a photo menu]. It really works! It's easier to see from a photo." Telling us how she encouraged people to retain as much independence as possible, one staff member said, "I get [people] to do as much as they can. [For instance], holding a cup themselves. Brushing their own hair. It's good for their self-esteem. And for pain relief [as people's] hands and arms become stiffer." Another staff member told us, "I don't want people to lose their independence. [I encourage] them to do as much as they can for as long as they can. Washing themselves. Standing up themselves [although] always being there just in case."

The registered manager was aware of local lay advocacy services. Lay advocacy services are independent of the provider and the local authority and can support people to make and communicate their wishes. At the time of our inspection two people living in the home had the support of a lay advocate. The registered manager told us that both people benefitted from the arrangement and that he would not hesitate to help others to obtain similar support, should this be required in the future.

Requires Improvement

Is the service responsive?

Our findings

The brochure for South Wold Nursing Home stated, 'The home provides a variety of … social and recreational activities. The activity organiser … accompanies the residents to the local café and fishing lake. Social events are arranged that include … day trips and visits to local amenities.'
However, despite this clear and vivid description, there was no 'activity organiser' employed in the home and people told us that outings were rare. The registered manager had developed an activities programme which included visits from professional entertainers and a manicure session led by a member of staff. However, these activities were relatively infrequent and, as a result, during both days of our inspection we saw people spending much of their time sitting and staring into space with little or nothing to do. One person occupied themselves walking repetitively around the corridors of the home. When we reviewed the provider's 'activities' record sheets, we found the average number of activities recorded per person for the whole of 2017 was just seven – slightly more than one every two months.

As detailed in the Safe section of this report, staff told us that the need to prioritise physical care tasks left them with little time to respond to people's emotional support requirements. Describing their role, one member of staff told us, "Care staff don't do activities. [There is] not time for that … just the care. [We have games and other resources but] I've not seem them in use. It's not something care staff have time to use. It would be good if we had someone employed [to take the lead in this area]." Expressing their concerns about the lack of stimulation and the negative impact this had on people's health and well-being, one staff member said, "I think people are bored. I would be bored. It's important to have things to do. Someone comes in to do exercises once a month [but] one-to-one stimulation is what people need. People need that extra bit of help [and without it people] start to withdraw. We get more challenging behaviour [because] people [do not] have enough stimulation. People [are] more depressed, more anxious. We definitely need someone for activities." Another member of staff commented, "To tell you the truth … [we have] very little spare time … to do social interaction .. after we have provided basic care and [kept] people safe. We could do with someone who is dedicated to providing stimulation." Talking specifically about the lack of outings, one person said, "No, I don't get out at all. I don't get taken into the garden … or go shopping." A staff member commented, "I just think if there was … more [for people] to do … they would be more settled [and] less restless."

Describing his personal philosophy of care, the registered manager told us, "You have to treat each individual as a person. Listen and provide support. Listening is very important." However, despite the registered manager's strong personal commitment, at times staff lacked insight into how to support people in truly person-centred ways that were responsive to their individual needs and preferences. For example, there was a bird feeder in the garden outside the main lounge. However, the way the chairs had been arranged in the lounge obscured the window overlooking the garden which meant people were deprived of the pleasure of watching the birds and other animals using the feeder. Similarly, on the morning of the first day of our inspection we saw some people sitting in the lounge eating their breakfast and watching the television, something staff told us they enjoyed. However, the lounge was also a thoroughfare between the kitchen and the other parts of the home and at that time in the morning it was busy and noisy making it harder for people to enjoy the television. When we asked the registered manager why the subtitles option

had not been activated on the television he replied, "That would help [but] it hadn't occurred to me." There were ceiling-mounted loudspeakers in various places throughout on the home. These were linked to a computer which could be used to play music. On both days of our inspection, we saw that staff made musical selections and broadcast them throughout the home without any attempt to ask people whether they wanted the music on and, if so, what would be their preference.

We reviewed people's care plans and saw that they were well-organised and provided staff with information on people's individual needs and preferences. For example, one person's plan stated, 'I like to get up at about 8.30am. I like cornflakes and sometimes toast for breakfast." Another person's plan stated that they had enjoyed bicycle touring as a hobby in their younger days. Nursing staff took the lead in preparing the care plans and keeping them up to date. Worryingly however, members of the care staff team told us they did not have time to read the care plans on a regular basis, increasing the chance they would be unaware of changes in people's needs and preferences and creating another barrier to the provision of properly person-centred care. For example, one member of the care team said, "I look at the care plans when I can [but] we haven't got protected time [to do this]. [It is] essential information [and] it's a worry that I don't have time to read them. I [have to] go with my basic knowledge of the residents." Another member of staff commented, "Sometimes I read them [to see] what has happened. [But] I don't read them a lot."

The registered manager told us that he had good links with the local Marie Curie and Macmillan nursing teams and worked closely with them when providing people with end of life care. He also said that the support of local priests was helpful, particularly if the person didn't have any family. Describing his approach in these situations, the registered manager said, "We become their family. I sit with [the person] in their final hours. We don't leave them on their own." Where people did have a family, the registered manager described the importance of providing them with support as well. He told us, "After the funeral we invite the family for sandwiches and drinks [at the home]. It is a very difficult time and [it is] our way of saying thank you [to the family]."

The registered manager was unaware of the new national Accessible Information Standard (AIS) which provides best practice guidance in communicating with people in ways that meet their individual needs and preferences. However, he told us he would research the AIS and incorporate into the provider's approach in the future. In the meantime, during our inspection we observed staff use a variety of strategies in response to people's individual communication needs. For example, as described elsewhere in this report, the cook used a photographic menu to help some people living with dementia choose what they wanted to eat.

Information on how to raise a concern or complaint was displayed on a noticeboard in the home and the registered manager maintained a log of any formal complaints that were received. However, the people we spoke with told us they had no reason to complain. For example, one person said, "No problems whatsoever." The registered manager told us that formal complaints were rare as he was readily accessible to people and their relatives and was often able to resolve issues informally. Describing his approach, the registered manager said, "I say to people, 'I am here. If you need to see me, just speak to me'."

Inadequate

Is the service well-led?

Our findings

The registered manager had been in post for many years and was clearly liked by everyone connected with the home. For example, one person told us, "I like the boss. He's a lovely man." Another person's relative said, "The boss is very kind and caring with [my family member]." One staff member commented, "[The registered manager] is supportive [and] approachable. He's helped me out in the past. We had a takeaway curry just before Christmas [which] he paid for." Another member of staff said, "[The registered manager] is a good boss. I respect him. You can talk to him [and], if you have a problem, just go in and see him." Reflecting this feedback, throughout our inspection we saw the registered manager spent much of his time out of his office circulating through the home, engaging with people, relatives and staff in a warm and friendly way.

However, in addition to his management responsibilities, the registered manager was one of the owners of the care home and also worked hands-on as nurse for several shifts each week. Acknowledging that he found it very difficult to combine these three roles effectively without any administrative support, the registered manager said, "I … enjoy nursing [and] spend a lot of the time on the floor. [But] paperwork has always been my main concern. [It] has always been an issue where I let myself down. I need to find a dedicated secretary." Commenting on the negative impact the registered manager's multiple roles had on the effective running of the home, the deputy manager told us, "He's very caring [but] has too much on his plate. That is a key difficulty. He has too much on doing all these roles [and] some things may fall through."

At our previous two full inspections of the home, in November 2014 and August 2016, we identified shortfalls in the monitoring of service quality and told the provider that improvement was required. However, on this inspection we found the necessary improvements had not been made and the provider's approach to the auditing and monitoring of service provision remained ineffective. For example, although regular care plan reviews and medicine and infection control audits were conducted by senior staff, they had failed to pick up the shortfalls in individual risk assessment, infection control practice and the management of people's medicines we identified on our inspection. Additionally, some of the audits and quality monitoring checks that had been introduced had been allowed to lapse. For example the provider's 'general risk assessment' of the premises had not been conducted since July 2015; the weekly 'nurse checklist' had not been completed since May 2017 and a weekly 'controlled drugs' check introduced in May 2017 had not been completed since August 2017.

The provider had also failed to address or sustain other areas for improvement identified at our previous inspections of the home. For example, as detailed in the Safe section of this report, on the first day of our inspection we found the provider had not rectified health and safety hazards we had first highlighted at our inspection of August 2016, some 15 months earlier. Additionally, the improvement in the management of people's medicines we had found at our August 2016 inspection had not been sustained and the provider was, once again, failing to manage people's medicines safely. As detailed throughout this report, shortfalls in organisational governance had also contributed to issues of concern in many other areas including individual risk assessments; staffing levels; staff recruitment; infection prevention and control; staff training and supervision; organisational learning from significant incidents; the promotion of people's right to privacy; engagement with external health professionals and the provision of properly person-centred care.

At both of our previous two full inspections we rated the home as Requires Improvement. On this inspection, far from improving, we found the quality of the service had deteriorated and people were not receiving the safe, effective, caring or responsive service they were entitled to expect.

Taken together, the provider's persistent failure to effectively assess, monitor and improve the quality of the service and to take action to address and mitigate a range of risks to people's health, safety and well-being was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In preparing for our inspection, we reviewed the notifications (events which happened in the home that the provider is required to tell us about) we had received from the provider. We noted that, since the home was first registered with CQC in 2010, no notification of a serious injury sustained by someone living in the home had ever been submitted by the provider. When we queried the absence of serious injuries notifications with the registered manager, he initially told us that there had been no notifiable injuries in this time. However, he subsequently confirmed that there had been several serious injuries sustained by people living in the home which had not been notified to CQC, as required by the law. These included the case outlined in the Effective section of this report of the person who had developed a gangrenous toe.

The provider's failure to notify CQC of serious injuries sustained by people living in the home was a breach of Regulation 18(2)(a) of the Care Quality Commission (Registration) Regulations 2009.

More positively, staff told us that they enjoyed their job and worked together in a mutually supportive way. For example, one staff member told us, "I enjoy it. We all get on [and] work as a team. We've got a good atmosphere [and] if you have a problem there is always someone there to hold your hand." Team meetings, daily logs and shift handover sessions were used to facilitate internal communication. Commenting positively on their experience of attending staff meetings, one member of staff said, "They are helpful. We can talk and express how we feel."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person's failure to notify CQC of serious injuries sustained by people living in the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person's failure to properly assess and mitigate risks to people's safety.

The enforcement action we took:

We imposed an additional condition of registration to prevent the registered person admitting any service user to South Wold Nursing Home without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person's persistent failure to effectively assess, monitor and improve the quality of the service and to take action to address and mitigate a range of risks to people's health, safety and well-being.

The enforcement action we took:

We imposed an additional condition of registration to prevent the registered person admitting any service user to South Wold Nursing Home without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider's failure to ensure sufficient staffing to meet people's need for emotional support and to keep them safe.

The enforcement action we took:

We imposed an additional condition of registration to prevent the registered person admitting any service user to South Wold Nursing Home without the prior written agreement of the Care Quality Commission.