Winterfell Care Home Limited

Winterfell Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Winterfell Care Home is a residential care home providing accommodation and personal care for up to 41 people. The service supports older and younger adults living with dementia, mental health support needs, learning disabilities and people with physical disabilities. At the time of our inspection there were 32 people using the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The provider did not always mitigate environmental risks such as windows, trip hazards, radiators, fire safety, and items that could injure people. People did not always have safe equipment to help them mobilise. Recruitment checks needed to be improved to ensure safer practices in relation to obtaining references and right to work documentation. People were safeguarded from the risk of abuse, and lessons were learnt following incidents and accidents. People were supported by staff to receive their medicines safely. There were sufficient infection prevention and control arrangements in place.

Audits completed by managers to ensure the environment was safe were not always accurately completed. Care plans were not always accurate and up to date. We received mixed feedback from relatives concerning how well the service communicated and engaged with them. However, staff received supervision, team meetings were held, and there was evidence the service worked in partnership with external professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were two people using the service who have a learning disability and who are autistic.

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

Rating at last inspection
The last rating for this service was good (published 09 March 2022).

Why we inspected
We received concerns in relation to safeguarding and management oversight. As a result, we undertook a

focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. The provider took action to mitigate risks to some of our concerns during the inspection, however concerns remained in other areas.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Winterfell Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed. We have identified breaches in relation to people's safety and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Winterfell Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors 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.

Service and service type
Winterfell Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Winterfell Care Home is a home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service. We observed people and their interactions with staff and each other. We spoke with 13 relatives about their experience of the care provided.

We spoke with eight staff during our inspection including domestic staff, kitchen staff, carers, senior carers, admin staff, the assistant manager and the manager responsible for overseeing the service in the absence of a registered manager.

We reviewed four people's care records. We looked at four staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including health and safety checks and incidents and accidents.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Window restrictors were not fitted to all windows. We found window restrictors were not fitted to windows on one stairwell and another had become broken. This increased risks to people who could fall out of windows. In response to our concerns, the provider arranged for these to be fitted during our inspection.

● Hoist slings were not always safe for use. We found a person had been receiving support to mobilise in a sling no longer safe for use and should have been discarded. The manager arranged for this sling to be removed during our inspection and told us they would introduce new safety checks in this area.

● Radiator covers were not fitted to radiators in the home. The manager told us they had not identified anyone using the service who would be at risk from uncovered radiators. However, we found incidents and accidents had recently occurred where people had fallen, some people were using the service with reduced mobility, at greater risk of falls and could not understand the risks of injury from uncovered radiators.

● Fire door safety was not always maintained, which increased risks to people. For example, during the inspection, we found a fire door had been held open with a chair, another fire door would not automatically close due to it sticking on the carpet, and a mechanical door closure in a person's room was broken. In addition, there was evidence of this person smoking in their room, which increased the risk of fire spreading throughout the building. The provider arranged for these concerns to be addressed during our inspection.

● Trip hazards were not always mitigated which increased risks of people falling. We found the carpet in a hallway and a lift had come up, creating trip hazards. The provider showed us the hallway flooring was due to be replaced and arranged for the hallway carpet to be secured during our inspection. However, this meant these risks had not been effectively mitigated prior to us highlighting the concerns.

● People were at risk of injury from sharp items. We found a metal cabinet with a door which did not shut properly, could have cut people if they got caught on it. In addition, a roughly cut tin can being used as an ashtray by a person on a first-floor terrace could have also caused injury to people.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate environmental risks and ensure safe use of equipment used to deliver care. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's health related risks were monitored consistently. Records showed, the provider regularly updated and reviewed health related risks to people such as their weight, skin health and oral hygiene. The provider had sought advice from health professionals when monitoring indicated a concern.

Staffing and recruitment

● Staff were not always recruited safely. Staff had been recruited without references from verified sources and limited information about staff's previous employment history. A staff file we reviewed did not contain any copies of identification to confirm the staff member had the right to work in the UK. Disclosure and barring check (DBS) information was not always kept up to date on staff files. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This is covered further in the well led section of this report.
● People told us at times they had to wait for long periods for call bells to be answered. However, during the inspection we found there were enough staff to meet people's needs and call bells were responded to promptly. Staff told us they felt staffing levels were appropriate and staff schedules showed the home was consistently staffed in line with the provider's assessment of required staffing levels.
● Staff had access to an on-call manager when they required additional support. There were systems for a designated on-call manager to support with out of hours concerns and emergencies.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse.
● The home had a 'safeguarding protection officer' to help facilitate people, staff and visitors to report any safeguarding concerns.
● Staff received safeguarding training and knew how to report concerns externally to the local authority safeguarding team and CQC.
● Safeguarding concerns were reported to the local authority safeguarding team. We found the provider was using their systems in line with their policies to investigate safeguarding concerns and actions were taken to mitigate future risks.

The Mental Capacity Act 2005 (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 MCA 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.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. People's care plans considered people's mental capacity in areas such as consenting to care and treatment.

Using medicines safely
● People received their medicines safely. Each person had a medicines profile in place detailing what medicines they took, how they liked to be supported and important information such as GP contact details and any allergies they had.
● Staff received training to give people their medicines, and the provider had systems in place to regularly review staff competency in this area.
● There were arrangements in place to safely store medicines. Managers regularly audited medicines to ensure people had been given these correctly.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were able to receive visits in line with government guidelines. During our inspection, we saw visits taking place. People were able to receive visitors in communal areas or their bedrooms. Relatives we spoke with told us they had not experienced any visiting restrictions.

Learning lessons when things go wrong
● Lessons were learnt following incidents and accidents.
● Managers reviewed incidents and accidents and detailed what actions were taken to mitigate future risks; this included making environmental changes where applicable and updating people's care plans.
● Trends and themes of incidents and accidents were analysed. The provider looked for patterns of where incidents were taking place, who was involved and what kind of incident occurred. This helped to inform how risks of future occurrences could be reduced.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Safety checks and audits carried out by managers were not always completed accurately. Managers had signed to say window restrictors and radiator covers were in place and moving and handling equipment used to lift people was safe for use. This increased the risk of injury to people.
- Care plans did not always contain accurate and complete information. A person's care plan did not accurately detail the increased staff support needed for care related decisions and using the toilet. In addition, the care plan had not been effectively updated for increased staff awareness following an incident where the person had left the service without support.
- Management oversight of staff files was not effective. Staff records were not always consistently maintained to ensure people had right to work information on file. This was not in line with government guidance to prevent people from illegally working in the UK. In addition, staff records were not always maintained to include the most up to date information. For example, during the inspection, we found up to date DBS information was not always on staff files. However, the provider was able to provide details of up to date DBS checks after our inspection.

The provider failed to ensure systems and processes operated effectively to ensure people's safety and accurate record keeping within the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the time of our inspection, the home did not have a registered manager. However, we saw evidence the provider was actively seeking to recruit, had conducted interviews and made arrangements for another manager to support the service in the interim.
- The provider submitted statutory notifications to the CQC when required to do so. This included making us aware of incidents where police had been involved and allegations of abuse.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics Working in partnership with others

- During the inspection, we found evidence the provider had sought feedback from relatives via a survey and the feedback they had received was mostly positive. However, relatives we spoke with told us they had not received a survey to complete.
- We received mixed feedback about how well the service communicated with relatives; some felt they were kept up to date and others did not feel this was the case. For example, one relative told us they had not been

informed when their relative went to the hospital.
● Team meetings were held, and staff received regular supervisions from managers. Staff we spoke with felt well supported by managers.
● People's complaints and concerns were responded to. The provider had made the complaints policy available in communal areas and people's rooms. We saw evidence where complaints were raised, these had been appropriately resolved.
● There was evidence the service worked in partnership with others. Records showed the provider had met with families where there had been any concerns. Support was also sought from external health professionals when required for people's care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Relatives gave us mixed feedback about the culture in the service. Some relatives told us they felt people were well treated. For example, one relative told us how the service promptly supported a person to have their own fridge in their bedroom, which promoted their choice and independence. Other relatives told us of less positive experiences like their relative not always being appropriately dressed and people's items going missing.
● Staff we spoke with had a good understanding of people's needs. Staff were able to tell us about people's support needs in detail and about people's likes and dislikes, including how people liked spending their time. Staff felt they were able to approach managers with any concerns they had and valued their views about people's care.
● During our inspection, we observed staff interacting with people positively. In addition, we also observed staff responding to a medical emergency promptly.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their Duty of Candour responsibilities. The provider's policies supported an open and transparent practice within the service.

Continuous learning and improving care
● Managers consistently reviewed information from incidents, accidents and safeguarding concerns. Actions they had taken was documented, this promoted quality of service delivery in relation to people's care needs to be maintained and improved.
● The provider had acted on our most urgent concerns during our inspection and was open to feedback on improving the service.

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 Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate environmental risks and ensure safe use of equipment used to deliver care. This placed people at risk of receiving unsafe care.

The enforcement action we took:

We issued a warning notice to this provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes maintained accurate and complete records.

The enforcement action we took:

We issued a warning notice to this provider.