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Wintofts Residential 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
Wintofts Residential Home is a residential care home providing personal care for one person aged 65 and over at the time of the inspection. The service can support up to six people. The care home is based in a rural location and is adjacent to a farmhouse. The "care home" is purposely adapted to provide care, with a stair lift to access the upper floor. There is a kitchen area, two dining rooms and bedrooms with a shared bathroom.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
Medicines were not always managed in a safe way. Prescribed nutritional supplements were left in communal areas and decisions to reduce some supplements had been made by the provider without consultation with relevant professionals.

Although the service was clean and tidy throughout, the provider didn't always provide care and support in a safe environment. Government guidance in relation to Covid 19 was not always followed, cleaning schedules were not in place and outbreak management plans were not thorough. They did not demonstrate how the person would be cared for in the event of an outbreak.

The provider supported the person to have the maximum possible choice and independence and they had control over their own lives. The provider focused on the person's strengths and promoted what they could do, so they had a fulfilling and meaningful everyday life.

Right Care:
Staff understood how to protect people from poor care and abuse. However, the provider did not have up to date safeguarding training.

The person was able to communicate with the provider and volunteers because staff supported them consistently and understood their individual communication needs.

The provider encouraged and enabled the person to take positive risks.

Right Culture:
Staff turnover was very low, which supported the person to receive consistent care from staff who knew

them well. The person had been supported by the provider and the same two volunteers for a number of years.

The person led an inclusive and empowered life because of the ethos, values, attitudes and behaviours of the provider. However, they were not involved in any focus or engagement groups and best practice guidance in relation to supporting people with learning disabilities and autistic people. Best practice guidance was not always followed in relation to terminology and dignified terms.

The providers knowledge and skills in relation to regulations, legislation and best practice was lacking which impacted on improvements.

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

Rating at last inspection and update
The last rating for this service was requires improvement (report published 1 June 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 24 March 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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 not changed. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to medicines, infection, prevention and control and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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.

Wintofts Residential 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
One inspector carried out this inspection.

Service and service type
Wintofts Residential 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. Wintofts Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed the information we held about the service and we spoke with organisations and people involved with the service. We used all this information to plan our inspection.

During the inspection
We spoke with one volunteer carer and the provider. We reviewed a range of records. This included one

person's care records and medication record. We looked at records relating to two volunteers and the provider in relation to recruitment and training. We also looked at a variety of records relating to the management of the service, including policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 requires improvement. The rating for this key question has remained 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.

Using medicines safely

At our last inspection the provider had failed to ensure they had robust policies and procedures in place with regards to giving homely remedies. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Medication was not always stored, recorded or administered safely.
- Some prescribed nutritional supplements were left in areas open and accessible to the person living at the service.
- The provider reviewed the person's medicines regularly to monitor the effects on their health and wellbeing. However, the provider had made a decision to stop administering one of the prescribed supplements; this had not been discussed with the person's GP.

Although there was no evidence of harm as a result of this practice, failure to store, record and administer medicines safely was a breach of regulation 12 of the Health and Social Care Act 2008 (regulations) Regulated Activities 2014

- The provider ensured the person's behaviour was not controlled by excessive and inappropriate use of medicines.

Preventing and controlling infection; Visiting in care homes.

At our last inspection the provider had failed to ensure they implemented and followed Covid 19 guidance. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- It was highlighted at the last inspection that there was no plan in place to manage a COVID-19 outbreak and enable self-isolation of the person or staff in the event of a COVID-19 outbreak. Appropriate and

thorough Management plans were still not in place.
● Government guidance in relation to Covid 19 testing and visiting in care homes was still not being followed. The provider insisted that anyone visiting the service completed a Covid 19 test before they could enter.
● The premises were clean, hygienic and free from malodour. However, there was still not an appropriate cleaning schedule in place.

Failure to ensure appropriate and effective infection, prevention and control practices are in place was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The person using the service did not require a DoLS. However, the provider's knowledge with regards to DoLS was lacking. They were not clear when a DoLS authorisation was needed, or the process to follow.

We recommend the provider seeks training and guidance from a reputable source in relation to MCA and takes action to updater their practice accordingly.

Staffing and recruitment

At our last inspection the provider failed to ensure appropriate checks of volunteer carers and robust contingency plans were in place to ensure safe staffing levels. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulations) Regulated Activities 2014.

Enough improvements had been made and the provider was no longer in breach of regulation 19.

● Additional checks had been completed to ensure volunteers working in the service were suitable and of good character.
● A Contingency plan had been developed to ensure safe care could be provided if the provider was in ill health or unable to offer support. The funding local authority had also been asked to support with this planning.
● The service had enough staff, including for one-to-one support for the person to take part in activities and visits how and when they wanted.

Systems and processes to safeguard people from the risk of abuse
● The person was kept safe from avoidable harm because the provider knew them well and understood how to protect them from abuse.
● The provider and volunteers had training on how to recognise and report abuse and they knew how to

apply it.

Assessing risk, safety monitoring and management
● The person lived safely and free from unwarranted restrictions because the provider assessed, monitored and managed safety well.
● The provider managed the safety of the living environment and equipment in it well through checks and action to minimise risk.
● The provider assessed the person's sensory needs and did their best to meet them.

Learning lessons when things go wrong
● There had not been an adverse incident in several years, so the provider had not needed to undertake a lessons learnt report. Restraint was not used.

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 requires improvement. The rating for this key question has remained 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; Continuous learning and improving care

- The provider had excellent understanding of the person's needs. However, the providers knowledge and skills in relation to regulations, legislation and best practice was lacking.
- Policies in place were outdated, referred to organisations that no longer existed and were not written in line with best practice guidance.
- The provider was responsible for all aspects of care and support. However, their knowledge was lacking in relation to training requirements. They had not completed appropriate training in areas such as first aid, medication and food hygiene. Other training had not been refreshed at regular intervals.
- At the last inspection, the provider was in breach of regulatory requirements. Lessons had not been learnt and little improvements had been made to ensure compliance with regulations.

Failure to establish and operate effect systems to ensure compliance with requirements was a breach of regulation 17 of the Health and Social Care Act 2008 (regulations) Regulated Activities 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider put the person's needs and wishes at the heart of everything they did.
- There was a culture of care and the provider valued and promoted the person's individuality, protected their rights and enabled them to develop and flourish.
- The person benefitted from a highly person-centred approach to live independently with choice and control. There was very much a family feel to the service, and it was clear the person was very happy living at Wintofts Residential Home.

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

- Since the last inspection, the provider had improved their knowledge of the duty of candour and their responsibility to notify CQC of any reportable incidents.

Working in partnership with others

- The provider worked well in partnership with other health and social care organisations, which helped to

improve the person's wellbeing.
● The provider was not actively involved in engagement groups or forums organised by the local authority which aim to improve care services in the local area.

We recommend the provider considers accessing local engagement groups and forums to improve their knowledge of regulation, legislation and best practice guidance.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to store, record and administer medicines safely. The provider failed to ensure appropriate and effective infection, prevention and control practices were in place 12(2)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effect systems to ensure compliance with requirements. 17(1)