Winterfell Care Home Limited

Winterfell Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service

Winterfell Care Home is a 41-bedded residential care home situated in a residential area of Nottingham. The home provides accommodation and personal care to older people and younger adults living with dementia, mental health needs, and/or physical disabilities. At the time of our inspection there were 19 people using the service.
The care home accommodates people over two floors in an older style adapted building.

People's experience of using this service and what we found

People living in the service were not safe and were placed at risk of harm. The environment, poor infection control processes and lack of consideration of fire safety measures at the service put people at risk.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and effective care for people. Lessons were not learned, and improvements were not made when things went wrong.

Records relating to people's care did not always contain information and guidance to enable staff to provide the safe care and support people required. Risk management was not in place for some people who were at a high risk of falls and who may present a risk to others from their behaviour.

We received mixed feedback from both people and their relatives regarding their opinions of the quality of the care and support they received and the response to any concerns they had raised. Although we observed positive interactions between staff and people using the service during the inspection.

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 15 January 2020).

Why we inspected
We received concerns in relation to a lack of governance and oversight of the service, a failure to safeguard people, infection control, falls, diabetes management, palliative care, risk assessments and care planning. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only.

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.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have identified breaches in relation to fire safety, safeguarding of people, infection control, records, improving the quality of the service, and other risks at this inspection. After the inspection we wrote to the provider and requested that they provided us with urgent information regarding poor standards of care and record keeping, staffing, issues relating to infection control, the management of falls and fire safety concerns to ensure people were safe. The provider responded and took action to address some of the areas of concern that we had identified, however concerns remained in several areas.

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.
We will continue to monitor information we receive about the service and we will continue to work with partner agencies. We will work alongside the provider and the local authority to closely monitor the service. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and once it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors on site on July 28 and August 4, with an assistant inspector making calls to relatives of people using the service and staff on July 28 and July 29.

Service and service type
Winterfell is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

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, community health teams, fire & rescue service, environmental health and other professionals who work with the service. We contacted Healthwatch for their views on the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with nine people who used the service and three relatives about their experience of the care provided. We spoke with eleven members of staff including a director, the registered manager, two assistant managers, senior care workers, care workers, domestic staff and the cook. 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.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies and quality assurance records. We spoke with one professional who regularly visits the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The service had not investigated incidents to ensure that no abuse had occurred, or identified themes and trends for people in relation to falls, manual handling, staff training and competency, tissue viability, diabetes management, palliative care requirements or equipment needs.
- During inspection some people disclosed concerns about the way staff supported them and specific incidents. These had not been investigated or reported to the local authority safeguarding team. We brought these incidents to the attention of the registered manager immediately and made subsequent referrals to the local authority safeguarding team for these people.

The provider had failed to ensure that systems and processes were operated effectively to safeguard people from the risk of abuse. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- We found a lack of risk assessments in place for people using the service, this placed people at risk of harm. One person was at risk of pressure sores and falls. We found a lack of clear guidance for staff on how to support them safely. This person's mobility risk assessment stated that staff were to give 'minimal assistance' with movement during transfers from being seated to standing but gave no clear guidance for staff. Control measures in place for this person relating to their pressure area risk assessment were unclear. They were scored as low, for pressure area risk in the dependency tool used by the service, which did not reflect their current level of mobility. This placed this person at high risk of damage to their skin.
- One person was required to be supervised at all times when in communal areas due to their risk of falls. We did not observe this being carried out on both days of our inspection. We discussed the staffing of communal areas with a member staff who told us, "We check as we go past, sometimes we sit with them [people]."
- Other people's risk assessments were not always robust. For example, there were no risk assessments for one person's mental health diagnoses. This person lived with a range of complex conditions which had not been reviewed or robustly assessed. Their plan stated this person had capacity, yet there was no Mental Capacity Assessment (MCA) assessment in situ. There was a comment this person had previously shown 'aggression' and that there were 'no issues with aggression at present, we believe the risk to be low'. There was no clear risk assessment or positive behavioural support plan for staff to follow to support this person if this should escalate in future. This person was rated as '0' or low in the dependency assessment tool in the section marked as 'behaviour'.
- Risk assessments relating to the environment were not robust enough to mitigate risks for people. This included Personal Emergency Evacuation Plans (PEEP's) for use in case of an emergency.

● We raised our concerns in relation to fire safety with Nottinghamshire Fire & Rescue Service, who visited on the 31 July following our first inspection, and issued a 'Notice of Deficiencies', which the registered manager had begun to address by the time of our second visit.
● Whilst staff were aware of some risks to people, there were areas where they were not. For example, two people were Type 1 diabetics. Staff did not always know what the signs and symptoms were if these people became unwell due to their health conditions. The best practice guidance contained in their care plans for staff to follow was incorrect, as it was shown for Type 2 diabetes. There was no information on how staff should support these people to manage their diabetes effectively, such as through monitoring weight, diet and nail care robustly. This meant staff might not identify and act on concerns. One of these people told us, and we saw, that they had long toenails, which needed professional cutting. They told us this had not been addressed by staff.
● On both inspection dates we found several areas of concern in relation to poor infection control practice at the service. It was stated in the reception area that there was hourly cleaning being carried out of areas of 'high contact' in response to the Covid-19 pandemic. We requested records for this, and these did not show regular cleaning of touchpoints in line with Covid-19 guidance. The member of domestic staff we spoke with did not indicate they were carrying out any extra cleaning of touchpoints as part of their daily tasks. A review of the staffing rota's and discussion with the domestic staff showed the domestic staff had not increased their hours to ensure this increased cleaning was taking place.

Using medicines safely
● Medications were administered in a safe way for people using the service, although we found some errors in the way these were recorded. Some medicine administration records, (MARS) were incomplete. For example, one person had a pain patch which needed to be removed and rotated after seven days. There was a record where two staff had signed and dated this had been done, but not which side of the body this had been removed from and a new patch reapplied to, this potentially placed the person at risk of skin damage from the patch being applied in the incorrect place. This meant the provider could not evidence medicines were administered as prescribed.
● Some people took 'as and when' (PRN) medicines and there was no clear information for staff on the protocols for administering these. For example, how many doses could be given within 24 hours. We discussed that these needed to be more robust for each person, as this could lead to people being given too much medication.
● The medication round we observed was given in a timely manner, with people given the correct doses of their medications at the correct time of day. We were concerned however, that some people were taking their medicine from their named pots with unclean nails and then putting the tablets into their mouths to take them with a drink. We brought this to the attention of the registered manager in relation to our overall concerns regarding some people's lack of cleanliness.
● Medicine administration records (MARs) were handwritten. MARs can be handwritten, and we saw they were checked, dated and countersigned by a second person to ensure they were accurate. The MARS sheets had clear details on them including people's name, date of birth and a recent photograph.

People were placed at risk of harm due to poor risk management. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Despite support from the local authority and other professionals, no robust action had been taken by the service to ensure people's safety was being maintained. The registered manager had failed to take appropriate actions to ensure lessons were learnt and improvements were made.
● Systems and processes to review incidents and analyse these to reduce further re-occurrence was

ineffective, this meant the service did not learn from events and take action to improve safety. For example, there was no evidence of analysis of falls to reduce further harm.

This lack of learning meant people were at risk of avoidable harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff to support people safely.

● For example, there were several people who required the support of one or two staff to meet their care needs and ensure safety. The staffing levels were not adequate to meet people's needs and keep them safe.

● We found that staff had been recruited without appropriate references and disclosure and barring service (DBS) checks being in place prior to their appointment. This means that the registered manager could not be assured that people were protected from the risk of potential abuse from unsafe staff.

● Although people told us staff were kind and caring towards them, people and their relatives One relative told us, "My family member has said to me a number of times, if they ask for something, the staff say to come back in 15 to 20 mins but it sometimes doesn't happen."

Failure to ensure there were enough staff was a breach of Regulation 19 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- The provider had failed to meet their responsibility to report all significant events to CQC in a timely manner. At this inspection, CQC had not been informed when one person had been injured and transported to hospital. It is important that CQC has a clear overview of all incidents at the service, so they can check that the provider has taken appropriate action.

Systems were either not in place or robust enough to demonstrate CQC were notified of all incidents with regards to people's health, safety and welfare. This was a breach of Regulation 18 (Good governance) of the Care Quality Commission (Registration) Regulations 2009.

- People were placed at risk of potential abuse. There had been no safeguarding concerns reported by the registered manager prior to us prompting them to submit notifications during our Emergency Framework Support Call with them. This meant the service did not follow its own safeguarding policy.
- People were at risk of infection. Staff had access to facemasks, gloves and aprons but we observed they were not wearing these in line with current guidance in relation to Covid-19. Masks, gloves and aprons are worn by staff to reduce the risk of infection transferring from person to person. All of the hand gel sanitising points in the service were found to be empty on both days of the inspection. The registered manager had placed small bottles of gel out as replacements for these during the first day of inspection. The provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety in relation to the risk of infection.
- Quality management systems were not effective and provider oversight of the service was poor. Provider audits were carried out and identified issues, however there were no action plans following these to show who, how or when these issues would be addressed or followed up to ensure they had been completed.
- The registered manager lacked a clear oversight on what was happening in the service. We spoke to the registered manager and assistant manager about the provider's action plan. This document detailed what actions the registered manager would be taking to make immediate improvements to the service. We discussed which actions had been addressed, and with the exception of one care and support plan which had been updated onto the newly purchased electronic system we found that none of the other areas of required action had been addressed.
- Key policy documents we viewed had not been regularly reviewed, such as the Covid-19 contingency plan

and risk assessment, which had not been updated since 11 March 2020.
● The registered manager was not proactive about ensuring the quality of care being provided. Despite support from the local authority quality monitoring and contracting team, safeguarding team and community health professionals. They did not demonstrate the systems in place were keeping people safe and ensuring they received the care and support they required. We found the guidance given by the contracting team in relation to the care planning system had not been implemented, which meant that care and support plans and risk assessments remained inadequate for people living at the service.
● The registered manager was unable to demonstrate they had learnt lessons or improved care when issues were identified. For example, we saw that they had reviewed recommendations from a safeguarding outcome, but not looked at how these potentially could have been prevented or if any disciplinary action or further training was required for staff.
● At a multi-agency meeting in July 2020, the local authority requested an immediate increase in staffing to improve the running of the service and a review of the dependency tool for people using the service. We found the dependency tool, care and support plans and associated risk assessments for people, in order to determine their needs and the level of support they required, had not been reviewed or updated. This meant the provider did not have a clear understanding of people's needs and the staffing that was required to support them. We were concerned there were not enough staff with the right skills and competencies to ensure people's needs were being met.
● Where concerns had been raised by external professionals about people's care, these issues had not been addressed and subsequent concerns were found on our inspection. For example, a visiting health professional had expressed concerns regarding people not accessing a regular cleansing routine, and we observed this to be the case during our inspection. The service had a bath and shower rota, and although some people living at the service may be resistive to personal care, there was no guidance in people's care and support plans regarding positive encouragement and support for staff in relation to peoples' personal care requirements.
● One person we spoke with told us they had been, "Asking for support with a shower for three days, and when it happened, it was not a pleasant experience." This meant that the service had not taken opportunities to learn from feedback and improve people's experiences.

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 registered manager lacked understanding of their responsibilities under duty of candour. The provider had not informed people and families or advised of incidents as required and had not issued an apology when things had gone wrong. There were incidents recorded at the service which qualified as duty of candour incidents.
● One relative we spoke with told us, "Once my family member had a fall and the home didn't contact me, so they were in hospital with staff. I didn't know until my family member told me the next day. I did ring the service and said I wasn't happy. They said lessons learnt. I asked about a different piece of equipment for my family member and a referral to the falls team, but this hasn't been done as yet."
● The systems used to monitor incidents were not effective and the actions taken to address concerns had not been effectively implemented.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager did not seek regular feedback from people, relatives or staff about the service. They had not fully considered if people or their relatives had any concerns or wanted to review their care and support plans. We saw no evidence of service user or family review in care and support plans. There

were no regular surveys carried out to engage people in understanding their views in shaping the future of the service.

● We received some positive comments from relatives in relation to the support offered for people who did not have English as their first language. Staff had sought innovative ways to communicate with people in order to engage with them and enable them to express their wishes. This could be through the use of flashcards or particular forms of technology; however, this had not been effectively translated into meaningful guidance in people's care and support plans for staff to use. This lack of accurate and up to date guidance placed people at risk of not having their needs met.

Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that there were sufficient fit and proper persons employed to support people safely

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 provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety.

The enforcement action we took:

We imposed conditions upon the providers registration which required them to report upon actions taken to ensure the quality and safety of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that systems and processes were operated effectively to prevent the risk of abuse

The enforcement action we took:

We imposed conditions upon the providers registration which required them to report upon actions taken to ensure the quality and safety of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service.

The enforcement action we took:

We imposed conditions upon the providers registration which required them to report upon actions taken to ensure the quality and safety of the service