Winterfell Care Home Limited

Winterfell Care Home

Inspection report

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Date of inspection visit:
11 February 2021

Date of publication:
09 March 2021

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Winterfell is a residential care home providing accommodation and personal care to older people and younger adults living with dementia, mental health needs and/or physical disabilities. The service can support up to 41 people. At the time of our inspection, there were 22 people living at the service. The home can accommodate people over three floors of the building accessible by lifts and stairs. There are various large communal areas for eating, relaxation and activities. The home has a garden and enclosed smoking area. The majority of rooms have ensuite facilities.

People's experience of using this service and what we found
People received safe care, their health needs were monitored, and risk assessments were in place which reflected people's changing needs. Care plans were detailed and covered people's physical and mental health.

Accidents and incidents were monitored and reported. Staff had a good understanding of how to protect people against abuse and were knowledgeable about their needs and how to support them.

Staff received effective training and there were enough staff to meet people's needs. Recruitment processes were in place to ensure appropriate staff were employed.

The service was clean and followed current infection control guidance. The environment was well maintained.

Medicines were managed safely, and people received the medicines they were prescribed.

Quality assurance systems assisted the registered manager to effectively monitor the service. The registered manager was well supported by assistant managers and directors.

Incidents were analysed, and lessons learnt. The service engaged the views of staff and people to continue improvements to the service.

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 Inadequate (published 5 October 2020) and there were multiple breaches of regulation. 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 improvements had been made and the provider was no longer in breach of regulations.

This service has been in Special Measures since October 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service sustained a serious injury. This incident is subject to a potential criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Good. 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 Winterfell Care Home on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our Safe findings below.

Is the service well-led?

Good

The service was 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.

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
The inspection was carried out by three inspectors on site on 11 February 2021.

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 and professionals who work with the service. 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 three people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including a director, registered manager, assistant manager, senior care workers, care workers, housekeeping staff and the chef. 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 five 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 policies and quality assurance records.

Good

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 Inadequate. At this inspection this key question has now improved to Good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection, the provider had failed to ensure that systems and processes were operated effectively to prevent the risk of abuse. This was a breach of Regulation 13 (Safeguarding service uses from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had been made at this inspection and the provider was no longer in breach of Regulation 13.

- Systems and processes were in place to protect people. Staff we spoke with had a good understanding of how to identify abuse and what to report.
- There was a safeguarding and whistleblowing policy in place and staff had received training on how to protect people from abuse.
- Safeguarding incidents were investigated, and analysis of trends were in place to identify any themes which could prevent reoccurrence.
- Staff we spoke to knew people well and were able to describe in detail how they supported people's physical and emotional needs.
- One person we spoke to told us, "I like living at Winterfell, staff are nice and there is a good choice of what to eat". A relative we spoke to told us they felt their relative was safe and well cared for at the home.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to do all that was reasonable possible to assess, manage and mitigate risks to people's health and safety. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had been made and the provider was no longer in breach of Regulation 12.

- People's needs and risks to their safety were assessed before they came to the service to ensure they could be supported safely. During the assessment the management team considered the impact on other people at the service before accepting new admissions.
- Care records were person centred and contained extensive and detailed assessment of people's physical and mental health risks with detailed measures in place on how to support people.
- For example, one person who had complex mental health needs had signs to look out for of a

deterioration in their condition. Clear strategies were given for staff to support them to avoid their condition worsening and which external agencies to involve when necessary.
● People had personal evacuation plans in place to assist in the event of a fire. Recent recommendations from a fire inspection had been actioned to ensure safety.
● There was an open staircase which had been risk assessed, and people's individual mobility risks regarding stairs were risk assessed on a monthly basis to identify any changes. This helped to keep people safe.
● We found the door to the cellar had been left open accidentally. The director took immediate action to place additional locks to all doors, including the cellar and cleaning cupboards, to ensure this did not reoccur.

Staffing and recruitment

At our last inspection the provider had failed to recruit staff safely. This was a breach of Regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the service was no longer in breach of Regulation 19.

● Staffing levels were safe. Staffing numbers were calculated using a detailed dependency tool which identified people's specific needs and support required to care for people safely.
● Staff told us they had lots of time to support people, and we observed staff supporting people in a calm, caring and unhurried way. We observed staff were present and attentive in communal areas to ensure people's safety.
● Recruitment processes were safe. Pre-employment checks were performed on staff to ensure they were suitable to work at the home. This reduced the risk of people being cared for by inappropriate staff.
● Staff training records were up to date. Training included specific health conditions. For example, how to care for people with diabetes. Records showed that following training sessions staff completed a reflective document to show what they had learnt and identify areas for improvement.

Using medicines safely
● Medicines were managed safely. Medicines were stored and disposed of securely. Administration records were up to date. This meant people received their medicines as prescribed.
● People who were on pain patches had body maps to identify how they were rotated to prevent skin irritation.
● Staff had their competency to administer medicines checked regularly to ensure they continued to support people with their medicines in a safe way.
● PRN (as required) protocols did not always contain sufficient information about the maximum dose allowed in 24 hours and one medicine was being given on a regular basis. The registered manager took immediate action to review all PRN protocols.

Preventing and controlling infection
● Items of open food were not always labelled. The registered manager rectified this immediately.
● We found some hand sanitisers were empty and the cleaner had not started work. The registered manager took immediate action to replace sanitisers and changed practice to ensure this would not happen again.
● Checks were performed when visitors arrived at the service. There were signs reminding staff and visitors of the current restrictions and good practice guidelines. People were admitted to the service safely.
● People had their temperature checked once a day but there was no guidance for a normal temperature

range. The registered manager put this in place after our inspection and increased temperature checks to twice a day.

● We were assured that the provider was using personal protective equipment (PPE) effectively, staff maintained social distancing and the management team performed spot checks on staff.

● There were up to date infection control policies and procedures in place and we were assured that the provider was accessing testing for people using the service and staff.

Learning lessons when things go wrong

● Issues identified around a lack of learning at the last inspection had been resolved.

● Analysis of accidents and incidents was in place to identify themes and trends to learn lessons and prevent re-occurrence.

● Analysis of incidents was shared with staff at meetings to share learning from incidents.

Good

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 Inadequate. At this inspection this key question has now improved to Good.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

At our last inspection the provider had not ensured systems in place to monitor and improve the quality of the service were 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.
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 (Notification of incidents) of the Care Quality Commission (Registration) Regulations 2009.

Improvements had been made and at this inspection the service was no longer in breach of Regulation 17 or 18.

- The service had a registered manager in post who was supported by two assistant managers and directors, all who were involved in overseeing improvements the service had implemented and monitoring the quality of care.
- Monitoring systems were in place to check the quality of the service. Directors performed quality audits of the service and set action plans for the registered manager. We saw recent areas for improvement had been identified and actioned.
- The registered manager performed a daily walk round of the service to check safety issues and monitor staff PPE compliance and standards of care. For example, lighting around the home had been altered following a walk-round and discussion with people living at the service.
- The registered manager was aware of and could tell us what they needed to report to CQC and the safeguarding team.
- Staff performance was monitored, and we saw records of training, supervision and appraisals staff received. This meant staff had the right skills to support people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 management team showed commitment to improving and providing person-centred care.
● The registered manager understood duty of candour and how to respond in an open and transparent way when necessary. We saw records to show relatives had been notified of accidents or illness.
● One relative we spoke to told us how well the service supported their loved one. "Communication is very good they keep in touch and we know exactly what is going on".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We saw records of well attended, regular staff meetings. Staff told us the management team were very supportive and suggestions they made were listened to. Meetings had been arranged online to minimise staff contact. This helped to keep staff safe.
● Meetings were held to give people who lived at the service the opportunity to raise issues and complaints. Records showed that issues people had raised, were responded to effectively.
● People were supported to keep in contact with families using social media while visiting was limited to reduce anxiety and loneliness.
● We spoke to one person who lives with complex needs who told us of a concern they had raised which made them feel anxious. When we discussed this with the management team, they had already taken action to address the issue and resolve the problem, to prevent an incident occurring.

Continuous learning and improving care; Working in partnership with others
● The management team were committed to improving the service and had implemented new ways of working to improve care. For example, they had implemented a new electronic care plan system that staff told us was much better.
● The service worked well with a local GP and health care professionals to support people. We spoke to a health care professional who told us the service had worked with them to support people and improve their systems.
● We spoke to one relative who told us how staff had supported their family member, taking them to hospital appointments for treatment on a regular basis, staying with them and then letting them know how it went.
● Following the last inspection, the service had worked with the local authority and CQC to ensure improvements were made and new systems were in place to ensure these were sustainable.