Sylvia Robson

Wintofts Residential Home

Inspection report

Lendales Lane
Pickering
North Yorkshire
YO18 8ED

Tel: 01751475233

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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.

The service is not required to have a separate registered manager, because the registered provider is an individual who is registered with us. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's experience of using this service and what we found
The service did not have robust infection, prevention and control systems in place to manage the risk of COVID-19 within the service. Visitors were not screened for COVID-19 and the provider did not have systems to allow essential visitors to attend the service.
Medicines were not always safe where non-prescribed medication was given against medical advice.

Volunteer carers were not vetted to make sure they were of good character to work with vulnerable people. The service ensured that the person's care needs were met and provided a "home from home" approach to give person centred care. The provider knew the person very well and had a close working relationship with the person living at the service and their relatives.

Care planning was person centred and detailed the support the person needed. The provider understood the person's non-verbal communication method and was able to understand when additional support was needed. For example, if the person was distressed and required additional support.

The person living at the service was supported to have maximum choice and control of their life. Volunteer carers 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.

This service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

The person was supported to live in an environment which had a homely approach, with support being tailored around what the person wanted. Care planning was person-centred, and it promoted the person's dignity, privacy and human rights. The provider demonstrated their person-centred values, attitudes and behaviours to ensure the person was confident, felt included and empowered.

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 (30 April 2018).

Why we inspected
We received concerns in relation to an alleged incident which had taken place in the property, involving one of the volunteer carers. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. Therefore, we did not inspect them. Ratings from previous comprehensive inspections 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 requires improvement. This is based on the findings at this inspection.

We found no evidence during this inspection that the person was at risk of harm from this concern. However, we have found evidence that the provider needs to make improvements. Please see the safe and well-led sections 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 the person safe as a result of this inspection. We will continue to monitor the service to keep the person safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to regulation 12: safe care and treatment, regulation 18: good governance and regulation 19: fit and proper persons employed 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 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?

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 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
Two inspectors carried out the inspection at the service.

Service and service type
Wintofts Residential Home 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.

Notice of inspection
This inspection was unannounced.

What we did before the 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.

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

During the inspection
We spoke with two volunteer carers 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 supervision. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service and one relative.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people were not always safe and protected from avoidable harm.

Preventing and controlling infection

- People were not always safe from the risk of infection transmission.
- We were not assured that the provider was using PPE effectively and safely. During the inspection, the provider removed their mask on multiple occasions and asked the inspection team to do the same to facilitate communication. This would have posed a high risk of infection transmission for the person living at the service.
- The premises were clean, hygienic and free from malodour. However, there was no cleaning schedule in place. Furthermore, COVID-19 recommended cleaning products were not being used.
- Visitors were not permitted to visit the service unless they had received their COVID-19 vaccinations and had a negative COVID-19 test result. This impacted on the safe running of the service where essential visitors, such as fire safety engineers, were delayed in completing routine checks and audits.
- The provider and volunteer carer lived in the same dwelling as the person living at the service. There was no plan in place to manage a COVID-19 outbreak and enable self-isolation of the service user or staff in the event of a COVID-19 outbreak.

Although there was no evidence of harm, this was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (regulations) Regulated Activities 2014.

- The provider and volunteer carers participated in routine COVID-19 testing.

Using medicines safely

- Medication was not always administered safely.
- There were handwritten entries on the medication administration record (MAR) for non-prescribed medication. This handwritten medication was given "as and when required" but there was no protocol in place to detail when to give this medication or agreement from the GP.
- The person was given medication, such as supplement drinks or paracetamol, without a prescription or medical justification.

Although there was no evidence of harm as a result of this practice, failure to have a homely remedy procedure to evidence why medication was being given, without a prescription, was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (regulations) Regulated Activities 2014.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management.

● The person was protected from the risk of abuse and neglect and the provider had risk assessments to monitor people's safety.
● Care plans and risk assessments were person centred and up to date to ensure any changes in the person's needs were identified to ensure their safety and wellbeing.
● There had not been any safeguarding incidents for a number of years. The provider had systems in place to record and report incidents to the relevant organisations if required.

Staffing and recruitment
● Staff were not recruited safely.
● Appropriate checks had not been completed with regard to volunteers working at the service, to ensure they were suitable and of good character.
● The provider had not considered what contingency plans may be needed to ensure safe care could be provided to the person. For example, what arrangements would be needed if the provider was in ill health or a volunteer was unable to offer support.
● The service had not recruited staff for several years. The provider provided most of the care with relatives of the provider acting as volunteer carers to provide ad-hoc support, if required.
● There was no contingency plan in place to ensure safe staffing levels in the event of an emergency.

Failure to have appropriate checks of volunteer carers and have a robust contingency plan to ensure safe staffing levels was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulations) Regulated Activities 2014.

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.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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 and volunteer staff were not always clear about their role and regulatory requirements.
- The provider did not have clear, adequate contingency plans in place to ensure appropriate support could be provided to the person at all times. There was no system in place to recognise when additional support may be required.
- The provider did not have a clear understanding of what training was required and when this needed to be refreshed. There was no training policy in place to audit and monitor volunteer carer training records.
- The provider had a lack of knowledge around Government COVID-19 guidance and recruitment check guidelines.

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 did not always understand their legal responsibility to report certain incidents that had occurred at the service.
- CQC had not received two statutory notifications for reportable incidents and the provider was unaware of their responsibility regarding this.

This was a breach of regulation 16 of the Care Quality Commission (Registrations) Regulations 2009.

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 promoted a positive, person-centred culture which was empowering and inclusive.
- The person living at the service benefitted from a highly person-centred approach to live independently with choice and control.
- The person's characteristics and specific needs were considered throughout to minimise potential barriers and promote the person's wellbeing.

Working in partnership with others

- The provider worked in partnership with others.
- The provider had good working relationships with the GP, District Nursing Team and Pharmacy.

● Following the inspection, the Local Authority provided additional support and input to the person living at the service to improve working relationships. There is also the intention for a jointly agreed contingency plan to be put in place should the provider and volunteer carers become unable to care for the person living at the service..

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 16 Registration Regulations 2009 Notification of death of a person who uses services 16 The provider failed to notify CQC of the death of a service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(h) Infection prevention and control practices were not robust to minimise the risk of infection transmission. 12(2)(g) Homely medication was given without a protocol in place and against medical advice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19(5) The provider did not have the systems in place to routinely check the suitability of volunteer carers to provide support to vulnerable people.