Upsall House Residential Home Limited

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Inspection report

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Date of inspection visit:
04 October 2016
05 October 2016

Date of publication:
28 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 4 October 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting. A second day of inspection took place on 5 October 2016 and was announced.

The service was previously inspected in April 2016 and was not meeting two of the regulations we inspected. These related to medicine management, risk assessments, quality assurance audits and staff training records. We took enforcement action and issued warning notices requiring the registered provider to be compliant with our regulations by 29 July 2016. We also found that the service was not displaying the rating awarded at an inspection we carried out in October 2015. We also issued a fixed penalty notice in relation to failure to display the October 2015 inspection rating. When we returned for this inspection we found the issues identified had been addressed.

Upsall House Residential Home provides care and accommodation to a maximum of 30 people, some of whom may be living with a dementia. The home is a two storey converted private dwelling situated near Middlesbrough. There are 30 single bedrooms, 24 of which have en-suite facility which consist of a toilet and hand wash basin. There are two communal lounges and a dining room. At the time of our inspection 26 people were using the service.

The service had a manager but they were not a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's medicines were managed safely. Risks to people were assessed and plans put in place to reduce the chances of them occurring. Regular checks of the premises and equipment were undertaken to ensure they were safe for people to use. Plans were in place to help keep people safe in emergency situations.

Policies and procedures were in place to protect people from abuse. The manager monitored staffing levels to ensure sufficient staff were employed to support people safely and recruitment procedures minimised the risk of unsuitable staff being employed.

Staff received the training they needed to support people effectively, and felt confident to request more. Training was clearly recorded, which helped the manager to monitor it. Staff were supported through supervisions and appraisals.

The service worked within the principles of the Mental Capacity Act 2005 to protect people's rights to make decisions for themselves. People were supported to maintain a healthy diet and spoke positively about the food they received at the service. People were supported to access external professionals to maintain and promote their health.

People spoke positively about staff at the service, describing them as kind and caring. Throughout the inspection we saw staff treating people with dignity and respect and numerous examples of kind and caring support being provided.

One person was using an advocate at the time of our inspection, and the service worked with them to ensure the person's voice was heard in planning their care.

Care and support was based on people's assessed needs and preferences and was person-centred. Care plans were regularly reviewed to ensure they reflected people's current support needs, and people said they were involved in these reviews.

People were supported to access activities they enjoyed. Procedures were in place to investigate and respond to complaints.

The manager carried out regular quality assurance audits to monitor and improve standards at the service. The registered provider also carried out monthly quality review visits. The manager and registered provider had worked closely with the local authority following our April 2016 inspection to improve quality assurance processes.

Feedback was sought from people at quarterly resident meetings and through regular informal discussions between people and staff.

Staff spoke positively about the culture and values of the service and said they were supported by the manager and were proud of the improvements made at the service.

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.

People's medicines were managed safely and risk to people using the service were effectively assessed.

Recruitment systems were in place to minimise the risks of unsuitable staff being employed.

Staff had an understanding of safeguarding issues and the action they would take to ensure people were safe.

Is the service effective?

Good

The service was effective.

Staff received the training they needed to support people effectively and this was clearly recorded.

Staff worked within the principles of the Mental Capacity Act 2005.

People were supported to maintain a healthy diet and access external professionals.

Is the service caring?

Good

The service was caring.

People spoke positively about the care they received at the service.

Staff protected people's dignity and treated them with respect when delivering care and support.

The service supported people to access advocacy services. Procedures were in place to provide people with end of life care.

Is the service responsive?

Good

The service was responsive.

Care plans contained details of people's preferences, which helped staff to deliver person-centred care and support to people.

People were supported to access activities, and spoke positively about these.

There was a complaints policy in place, which was publically advertised in the reception area of the service. Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement

The service was well-led but did not have a registered manager in place.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service.

The manager and registered provider had worked with the local authority to improve standards at the service.

Feedback from people was sought and acted on.

Upsall House Residential Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 October 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting. A second day of inspection took place on 5 October 2016 and was announced.

The inspection team consisted of an adult social care inspector 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

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the commissioners of the relevant local authorities and the local authority safeguarding team to gain their views of the service provided at this home. We received feedback that improvements had been made since our last inspection.

During the inspection we spoke with five people who lived at the service and one relative. We looked at three care plans, and medicine administration records (MARs) and handover sheers. We spoke with eight members of staff, including the registered provider, the manager, the deputy manager, care staff and kitchen staff. We looked at three staff files, which included recruitment records. We also completed observations around the service, in communal areas and in people's rooms with their permission.

Good

Is the service safe?

Our findings

During our last inspection in April 2016 we identified a breach of our regulations in relation to medicines management and risk assessments. People's medicine records did not always contain the information needed to safely support them with their medicines and the use of prescribed controlled drugs was not always properly recorded. We also found that risks to people were not always effectively assessed. We took enforcement action and issued warning notices requiring the registered provider to be compliant with our regulations by 29 July 2016. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in April 2016.

People told us the service kept them safe. One person we spoke with said, "I feel settled and safe." Another person told us, "I feel safe here, much more than when I lived at home." A relative we spoke with said, "The family have no worries about [named person] living here. We know they are safe."

People's medicines were managed safely. Since our last inspection the registered provider had employed a Head of Care, who – along with senior care staff – had reviewed medicine management practices. The Head of Care also assisted staff who administered medicine in reviewing medicine administration records (MARs) and medicine stocks to ensure people always had access to the medicines they needed. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

Each person had a MAR. This contained their photograph and information on any known allergies or special administration instructions. This helped staff ensure the right people were receiving the correct medicines. People using time sensitive medicines such as warfarin had an additional chart to record their use and help staff ensure they were administered correctly. Topical MARs were used to record the use of topical medicines such as creams. We checked five people's MARs and saw medicine administration had been correctly recorded. PRN protocols were in place for 'as and when required' medicines to provide guidance to staff on when people might need these.

Nine people were using prescribed controlled drugs. Controlled drugs are medicines that are liable to misuse. We checked five people's controlled drugs stocks and saw that they matched the levels recorded by staff. Controlled drug administration was recorded in a controlled drug book, containing two staff signatures when they were used and a running total of medicine stocks. Controlled drugs were safely and securely stored in a locked cupboard.

Medicine stocks were regularly checked and returns and disposals recorded. During the inspection we saw staff contacting pharmacists to chase people's prescriptions. This helped staff to ensure people had access to their medicines when they needed them. Medicines were stored in a treatment room that was secure, clean and well-organised. Temperatures of the room were monitored daily to ensure medicines were being stored appropriately.

We observed a medicine round, and saw administering staff explained what their medicine was and gave

them a choice over whether they wanted it. After each medicine was administered staff completed the relevant section of the MAR. This helped to reduce the risk of mistakes in administration occurring.

People told us they received their medicines when they needed them. One person said, "The carers bring my tablets to my room morning, dinnertime, evening and night and I have no worries about remembering to take them." Another person told us, "Everything has been prepared for me. It's given at regular intervals during the day and I never have to worry about running out of tablets."

Risks to people were assessed and plans put in place to reduce the chances of them occurring. Before people started using the service they were assessed in a number of areas, including mobility, skin integrity, personal hygiene, nutrition and continence. Where a risk was identified a plan was put in place to reduce the chances of it occurring. For example, one person was identified as being at risk of neglecting their personal hygiene. A care plan was developed with guidance to staff on how they should encourage the person with this at regular intervals. Where people had specific support needs these were also risk assessed. For example, one person was using oxygen therapy and this had been risk assessed. Another person managed their own medicines and the risks to the person of doing this had been assessed. Risk assessments were regularly reviewed to ensure they reflected people's current levels of risk.

Regular checks of the premises and equipment were undertaken to ensure they were safe for people to use. Required safety and maintenance certificates were in place in areas including fire alarms and firefighting equipment and gas and electrical safety.

The manager monitored accidents and incidents to see if improvements could be made to improve people's safety. In one example, we saw how this led to a referral of one person to the local falls team for additional support with their mobility. The manager told us, "I always monitor them [accidents and incidents] to see if any actions are needed."

Plans were in place to help keep people safe in emergency situations. There was a business contingency plan providing guidance to staff on how to deliver a continuity of care if the premises could not be used. This included details on how people could be safely transported to alternative premises with their medicines and any other support equipment they needed. People also had personal emergency evacuation plans (PEEPs). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

Policies and procedures were in place to protect people from abuse. A safeguarding policy provided guidance to staff on the types of abuse that can occur in care settings and steps they should take to report it. Staff we spoke with said they would be confident to raise any concerns they had. One member of staff said, "We have done safeguarding training" and "I would report anything if I wasn't happy." Another member of staff told us, "I'd go straight to the manager about it. And if they were involved I would go to the local authority." Staff also said they would be confident to whistle blow if they had any concerns. Whistleblowing is when a member of staff tells someone they have concerns about the service they work for.

The manager monitored staffing levels to ensure sufficient staff were employed to support people safely. Day staffing levels (during the week) were one senior carer and five carers working from 8am to 8pm. At weekends staffing levels during the day were one senior carer and four carers. Night staffing levels were (during the week and at weekends) one senior carer and two carers working from 8pm to 8am. A Head of Care was also employed, and they worked a variety of day shifts to support care staff. Rotas we reviewed confirmed this. Staffing levels were based on people's assessed levels of dependency. The manager told us, "If the dependency of people changed I would bring more staff in, definitely." Staff told us there were

enough staff employed to support people safely. One member of staff said us, "I definitely think there are enough staff for the people here."

Four members of staff had been recruited since our last inspection in April 2016. The applicants had been required to complete an application form setting out details of their employment history. Notes from their interviews showed they were asked questions about their care experience. Applicants were required to provide proof of their identity and address. Two references were obtained and checks made with the Disclosure and Barring service before new staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. This meant procedures were in place to reduce the chances of unsuitable staff being employed.

Good

Is the service effective?

Our findings

During our last inspection in April 2016 we identified a breach of our regulations in relation to keeping effective training records. We took enforcement action and issued warning notices requiring the registered provider to be compliant with our regulations by 29 July 2016. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in April 2016.

The manager had simplified the charts used to monitor and plan staff training. One was used to record and plan mandatory training and the other any additional specialist training staff completed. Mandatory training is training the registered provider thinks is necessary to support people safely. Staff completed mandatory training in a number of areas, including fire safety, health and safety, safeguarding, dementia care, moving and handling and food hygiene. Records confirmed that staff had either completed training or it was planned for them. Mandatory training was refreshed annually to ensure it reflected current best practice. Additional training had also been arranged where it would help staff to support people more effectively, such as in oxygen therapy care or behaviours that can challenge.

Newly recruited staff completed an induction programme based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. Staff spoke positively about the training they received and said they would be confident to request any additional training they wanted. One member of staff told us about a specific course they were interested in attending and said the manager had arranged this. Another member of staff said, "Training is brilliant. We have people come in and do it. We've been getting a lot recently. I last did the oxygen [therapy] training. We all have to sign to say we attend. Extra training is always available."

Staff received regular supervisions and appraisals, which they said were useful in supporting them with any issues they had. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. One member of staff told they used recent supervisions to discuss changes to the registered provider's medicine administration policy, saying, "They [the supervisions] were useful in learning the new system."

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 Act 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection seven people were subject to DoLS authorisations. Clear records were kept of when the authorisation had been

granted and when it would need to be reviewed. One person was subject to a Court of Protection order, and the manager was able to describe how their rights were protected under this order.

Assessments were made of people's capacity to make decisions in a number of different areas. This meant staff did not assume that a lack of capacity in one area meant people could not make decisions in other areas, which was in keeping with the principles of the MCA. Staff had a good working knowledge of the principles of the MCA. One member of staff told us, "We have done MCA training. People [living with a dementia] can still make little choices on their own and we will always still ask them. We treat them as everyone else, as a person and an individual." Where people lacked capacity to make decisions for themselves best interest decisions were recorded in their care plan, containing evidence of the involvement of people's relatives.

People were supported to maintain a healthy diet. People's nutritional needs and preferences were assessed before they started using the service, and were regularly reviewed for any changes. At the time of our inspection no one at the service was receiving any specialist diets such as soft or pureed foods, but kitchen staff we spoke with knew how to support people with these should they be needed. People were regularly weighed to monitor their nutritional health, and monthly MUST assessments were completed where appropriate. Malnutrition Universal Screening Tool (MUST) is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

A large daily menu was on display in the dining room, which is where most people chose to eat. The dining room was large with wells placed tables. The tables were set with placemats, cutlery, condiments and napkins. The cook walked around the service every morning and asked people what they would like for lunch, telling us people were free to choose something not listed. At mealtimes we saw staff offering people help and support where this might be needed. For example, we saw one person falling asleep during lunch. Staff asked the person if they would like their food setting aside and keeping for later so they could rest, which the person said they would. Another person said they were not enjoying the food they had chosen. A member of staff responded to this quickly, asking if they would like to swap if for something else. The person decided to do this, and enjoyed the rest of their lunch.

People spoke positively about the food they received at the service. One person told us, "All the meals are always nice." Another person said, "There is always plenty of choice." A third person told us, "The food is very good and varied."

People were supported to access external professionals to maintain and promote their health. Care records contained references to visits from GPs, district nurses and dieticians. During our inspection an optician attended to carry out some eye tests. People told us they had access to health professionals whenever they needed them. One person told us that when they recently felt unwell staff had acted quickly to arrange treatment. Another person told us how staff had arranged a physiotherapist visit to help them with some pain they were experiencing. This meant people were supported to access external health professionals whenever they were needed.

Good

Is the service caring?

Our findings

People spoke positively about staff at the service, describing them as kind and caring. One person told us, "They [staff] look after me and are worth their weight in gold." Another person said, "The staff are very good and there is sufficient to be well looked after. They help me to walk around with my frame and wheelchair. It's very good here." Another person said, "The staff here are lovely and very friendly."

Throughout the inspection we saw staff treating people with dignity and respect. Staff called people by their preferred names, and spoke with them in a friendly but professional way. Where people indicated that they needed support staff approached them and asked discreetly how they could help. If staff needed to discuss a person or make additions to their care records we saw that they did privately and away from communal areas. This helped to protect people's dignity. Staff knocked on people's doors and waited for an answer before entering, and asked for permission before supporting people.

We saw numerous examples of kind and caring support being given. Staff were happy, polite, attentive and interested in people and their welfare. In one example, we saw a person asking for help to move to another part of the building. A member of staff took time support the person to do this, encouraging them to do what they could for themselves by giving short, simple instructions on the best route for the person to take. The member of staff walked with the person at the person's own pace and we saw them having a relaxed and pleasant conversation as they did so.

In another example, we saw a person asking if they could sit next to a particular person in the lounge. Staff reassured the person that they could, and joked that they would reserve the seat for them and come and raise the alarm if someone else tried to sit there. During lunchtime we saw a member of staff humming a tune to themselves as they were helping to return dishes to the kitchen. Some people overheard this and started to sing the tune, which led to an impromptu sing-along with staff and people all joining in. A hairdresser visited the service during the inspection, and was saw staff talking with people about what they were planning on having done and then complimenting them afterwards.

Staff knew the people they supported well. We saw staff and people enjoying conversations about their life histories, families and things they enjoyed doing. Staff took time to speak with people as they were moving around the service, and clearly enjoyed spending time with the people they cared for. For example, we saw some people working on a puzzle and a member of staff stopped to help and chat with them whenever they were passing by. We also saw staff visiting people who preferred to stay in their rooms to have chats about what they had been up to that day and any recent family news.

One person was using an advocate at the time of the inspection. Advocates help to ensure that people's views and preferences are heard. The manager was able to describe how the service would support people to access advocacy services should one be needed.

At the time of our inspection no one was receiving end of life care. The manager described how the service would work with other professionals such as GPs and district nurses to deliver this if needed. Care plans

contained evidence of discussions with people about their final wishes.

Good

Is the service responsive?

Our findings

Care and support was based on people's assessed needs and preferences and was person-centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

People's care plans began with a, 'This is my life' section. This contained details about the person's life, events, people that were important to them and their likes and dislikes. This helped staff to deliver person-centred care and support to the person. Where a care need was identified a plan was put in place to guide staff on how the person would like to be supported. This included support in areas including mobility, medicines, sleeping, nutrition and personal hygiene. Care plans contained details of people's preferences. For example, one plan contained clear instructions on how a person liked to have their hair washed and styled in a certain way. Another person's care plan contained information on how staff could recognise non-verbal indicators that the person may require support. People with specialist support needs such as oxygen therapy and self-medication had care plans in place for those, based on their personal preferences.

Care plans were regularly reviewed to ensure they reflected people's current support needs. People told us they were involved in reviewing their care plans and that staff asked them how they would like to be supported. One person told us, "It's very important to talk about these things as you get older." Staff said care plan reviews had improved since the new manager started in August 2016. One member of staff said. "A lot has changed for the better since [the manager] took over. Seniors (care assistants) spend a lot more time on the paperwork." Another member of staff said, "Care plans are much better now. They are easier to follow and much more individual."

People were supported to access activities they enjoyed. One person told us, "There is a wide range of activities which are advertised but I particularly enjoy the knitting group on a Friday and the church service on a Monday when there is a communion and a sing-a-long to some hymns." Another person said, "I really enjoy the singing and the exercise in the chairs."

During our inspection we saw people enjoying chair exercises and board games. We saw people were given a choice over whether they wanted to take part in activities and could decline if they did not wish to do so. Where people did not want to take part in group activities we saw staff making an effort to spend them individually. Staff told us they thought people enjoyed activities at the service but that more trips into the wider community would be welcomed. Records confirmed that activities were discussed at resident meetings and that people made suggestions about what they would like to do that were then acted on by the manager and staff.

It was clear that people using the service enjoyed socialising with one another. One person told us, "I like to come down to the communal areas and mix with the other residents." Another person said, "Some of the other residents come to my room for a nice chat and company."

Procedures were in place to investigate and respond to complaints. A complaints procedure was publically

displayed in the reception area. This set out how complaints would be investigated and information on what people could do if they were unhappy with the response. The manager told us no complaints had been received since our inspection in April 2016.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in April 2016 we identified a breach of our regulations in relation to the management and completion of quality assurance audits. We also found that the service was not displaying the rating awarded at an inspection we carried out in October 2015. We took enforcement action and issued warning notices requiring the registered provider to be compliant with our regulations by 29 July 2016. We also issued a fixed penalty notice in relation to failure to display the October 2015 inspection rating.

During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in April 2016. The service was also prominently displaying the rating awarded following our April 2016 inspection.

The service had a manager but they were not a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. It was a condition of the registered provider's registration with the Care Quality Commission that the service was managed by a registered manager. The previous registered manager left the service at the end of July and the current manager took over at the beginning of August. At the time of our inspection the manager had not applied to be registered manager but said they would do so on the first day of our visit.

The manager carried out regular quality assurance audits. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. Audits were carried out in areas including infection control, care plans, medicines and falls. Records confirmed that audits were carried out every month, and where issues were identified action plans were put in place to take remedial action. For example, a care plan audit in August 2016 identified that one person's care plan had not been signed by relatives who were responsible for consenting to their care. As a result an appointment was made for the person's relatives to attend and sign the care plans.

The registered provider was now carrying out monthly quality review visits. These visits reviewed standards in a number of areas, including the quality of the premises and kitchen and laundry services. Records confirmed that where issues were identified remedial action was taken. For example, the August 2016 visit identified a broken bin in a communal bathroom and this was quickly replaced. A director from the registered provider told us, "I'm a lot more hands on now and do monthly reviews."

The manager and registered provider had worked closely with the local authority following our April 2016 inspection to improve quality assurance processes. We received positive feedback from the local authority on the manager and registered provider's engagement with the support on offer, and on the improvement in standards since our last visit.

Feedback was sought from people at quarterly resident meetings and through regular informal discussions

between people and staff. Minutes from the last meeting in July 2016 showed 12 people and one relative attended and were free to raise any issues they had. The manager was in the process of designing an annual feedback questionnaire, and hoped to have this completed by the end of 2016. We saw numerous examples of staff asking people for feedback during the inspection.

Staff spoke positively about the culture and values of the service. One member of staff told us, "We have very homely values. We observe good care practices." Another member of staff said, "I think the atmosphere is great here. It's made great by the people living here, staff, the manager and relatives." Another told us, "I work in a lovely, friendly and hardworking environment."

Staff said they were supported by the manager and were proud of the improvements made at the service. One member of staff said, "The manager is absolutely fantastic. We want to get back to normal. The home is back running now as it should be. It has turned around since [the manager] took over. The atmosphere is different." Another member of staff said, "You can ask [the manager] anything." Staff confirmed that staff meetings took place, and they were free to raise issues at these.