Upsall House Residential Home Limited

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Inspection report

Swans Corner, Guisborough Road
Middlesbrough
Cleveland
TS7 0LD

Tel: 01642300429

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21 October 2020
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27 October 2020

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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
Upsall House Residential Home Limited is a care home providing personal care for up to 30 people aged 65 and over. At the time of the inspection 20 people were living at the home. The care home is an adapted building and houses people over two floors.

People's experience of using this service and what we found
Since March 2020 the service has had two outbreaks of Covid-19. We found people were not protected from the risk of harm. Staff failed to wear PPE appropriately. Infection control procedures needed to be significantly improved. Some medicines were not given as prescribed. People said they felt safe living at the home and received good care.

Leaders did not have the right skills to minimise the risk of harm to people. Managerial oversight of the home was limited. Quality monitoring systems failed to identify staff were not adhering to relevant guidance and best practice when working in the home. They did not identify areas where improvements needed to be made.

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 16 May 2019).

Why we inspected
As part of CQC's response to the coronavirus pandemic we are conducting a review of infection control and prevention measures in care homes.

We undertook this inspection to look at the infection control and prevention measures the provider has in place. We widened the scope of the inspection to include the key questions of safe and well-led because we identified concerns in those key areas.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, staffing and good governance at this inspection.

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

Follow up
We will request an action plan for 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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 of their 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 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.

Upsall House Residential Home Limited

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 this inspection.

Service and service type
Upsall House Residential Home Limited 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
We attempted to give short notice of this inspection, however no one answered our telephone calls to the home on the morning of inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from Redcar and Cleveland local authority and South Tees infection control team. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and 10 relatives about their experience of the care provided. We spoke with 13 members of staff including the registered manager, deputy manager, seven care staff, two housekeepers, one member of laundry staff and an administrator. 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 four people's care records and medication records. We looked at two staff files in relation to recruitment. 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 quality assurance records.

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.

Preventing and controlling infection

- Personal protective equipment (PPE) to control infection was not consistently worn or worn correctly. Not all staff had completed PPE training. Used PPE was not always disposed of safely.
- Staff did not follow best practice guidance to manage the risks of cross infection. Social distancing guidelines were not followed, for example, staff were seen hugging.
- Staff did not understand or implement zoning. People who had tested positive for Covid-19 were located throughout the home. Visitors were not screened for infection.
- Aspects of the environment did not support safe infection control measures. For example, skirting boards, radiator cabinets and worktops were worn/broken. Rust was present on bathroom equipment. This meant they could not be cleaned safely.

The risks associated with infection control were not safely managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not safely managed. Staff did not always recognise potential risks to people. Relatives raised concerns about this. Care records and risk assessments were insufficiently detailed to support staff to manage risks to people. There were significant gaps in care records to demonstrate how people's needs were being met.
- Staff failed to provide the right support to people who displayed distress behaviours. This had led to harm. Staff had not received training in this area. Incidents involving people who were distressed were not appropriately recorded or reviewed to determine how risks could be managed.
- The premises were not safe . Rooms required to be locked for safety reasons were found open. Radiator cabinets were not all secured to walls. No action had been taken to resolve consistently low water temperatures.

There was a failure to assess, manage and respond to risks of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not safely managed. People were given 'when required' medicines and topical creams routinely. No review by a GP had taken place. Records to administer 'when required' medicines had not been regularly reviewed.
- There was no guidance in place for staff to safely administer variable dose medicines. Staff decided how much of these medicines to give people.

Medicines were not safely managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not safeguarded from the risk of abuse. One person was able to leave the home on repeated occasions. The measures staff implemented to safeguard this person from harm, such as monitoring their whereabouts in the service were insufficient.
● Safeguarding alerts were not always submitted in a timely manner or not submitted at all. Staff did not follow their training or follow the policies and procedures in place to safeguard people.

Systems and processes were not effective enough to protect people. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People said they felt safe and received good care. One person said, "As far as I'm concerned, I couldn't be any more well looked after." One relative said, "[Person] is getting well looked after and we don't have to worry."

Staffing and recruitment
● Staff were not appropriately trained and competent to meet people's needs. For example, staff supported a person with learning disabilities but had no training to do so. Staff had not received training to deal with distressed behaviours. They did not follow the policies and procedures in place to keep people safe.

This failure to have the right staff on duty to meet people's needs safely increased the risk of potential harm to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appropriate checks were in place to ensure staff were recruited safely. People and relatives were complimentary about staff who worked at the home. Comments included, "The carers are very good, and they treat you nicely. If I use the call buzzer they don't take long to answer" and, "I think [the carers] are angels. Nothing is too much trouble for them."

Learning lessons when things go wrong
● Incidents were not consistently recorded. Care plans and risk assessments were not updated. Incidents were not reviewed to determine if any measures could be put in place to reduce the risk of reoccurrence. Falls were not adequately reviewed to identify patterns and trends.
● There was no evidence of lessons learned following incidents. Improvements had not been made since the last inspection.

These concerns demonstrated a lack of effective systems to ensure the safety 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.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Leaders did not have the right skills, knowledge and experience to deliver safe care to people. Staff at all levels lacked understanding of risk. The practices in place increased the risk of harm to people.
- Staff did not raise concerns with the registered manager when needed. This included low water temperatures and staff not wearing PPE appropriately. The provider failed to have enough oversight of the service, which meant they had not actively reviewed the risks to people.

Failure to effectively lead staff and support people to receive high-quality care had to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Quality assurance measures were not effective. They did not identify where improvements needed to be made. Action plans were not in place to support the development of the service. The quality of care provided to people had deteriorated since the last inspection.
- Accountability at all levels was not understood. Staff practices were not challenged when they were unsafe. Additional resources were not put in place to improve practices.
- Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification.' Ten safeguarding incidents occurred between 18 May 2020 and 20 October 2020 which were not reported to CQC.

This failure to effectively monitor and improve the quality of the service was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to notify CQC of these incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider had applied to become a designated setting for Covid-19. No detailed plans were in place

about how staff would provide this service safely. The provider said they sent relatives letters about this change. Relatives said they had not received one. No consultation had taken place with people.

● Action plans were not developed by the registered manager when the home received feedback from health professionals about areas for improvement. This did not support the staff to make the necessary changes.

● Meetings for people and staff had taken place. People were positive about their care. Relatives gave mixed feedback about communication from the home.

Failure to have effective systems in place to support the improvement and development of the service is 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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13(3) Insufficient action was taken to safeguard people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (2) (a) Staff did not have sufficient training to care for 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 12(1) and (2) (a)(b)(d)(g)(h). People did not receive safe care. Risks were not safely managed. Medicines were not safely managed. Aspects of the premises were not safe. Measures to prevent infection were not safe.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) and (2)(e) Systems to support good governance were not robust.

The enforcement action we took:

Warning notice