Upsall House Residential Home Limited

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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
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 there were 22 people living at the service. The service accommodated people in one adapted building over two floors.

People's experience of using this service and what we found
People's care remained unsafe. Although people said they received good care from staff who knew them well, we found risks were not always anticipated or responded to. Staff were not supported with supervision, appraisal and training. Recruitment procedures remained unsafe. There were always enough staff on duty. Infection prevention and control measures had significantly improved.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Little improvement had been made since the last inspection. Leaders did not have the necessary skills and knowledge to deliver a safe service. Quality assurance measures continued to be ineffective and did not support the service to make continued improvements. The quality of the environment had started to impact upon people's dignity.

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 7 January 2022). At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 15, 18 and 23 November 2021. Breaches of legal requirements were found. We served a warning notice. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, fit and proper persons employed and good governance.

We undertook this focused inspection to check they had met the requirements of the warning notice and they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains inadequate. 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 Upsall House on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to recruitment and quality assurance procedures at this inspection. Whilst enforcement action was proposed and being processed, the provider submitted a Voluntary Cancellation of their registration and therefore our enforcement action did not proceed.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures.' The provider has submitted a Voluntary Cancellation of their registration.

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 Health and Social Care Act 2008.

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
An inspector, a medicines inspector and an expert by experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Upsall House is a 'care home.' People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Upsall House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was no registered manager in post.

Notice of inspection:
This inspection was unannounced. Inspection activity started on 23 June 2022 and ended on 18 July 2022. We visited the location's service on 23 June, 1 July and 5 July 2022.

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 professionals who work with the service, such as Cleveland Fire Service and South Tees infection prevention and control team. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke to nine people who used the service and nine relatives. We also spoke with nine staff. These included the nominated individual, the manager, the deputy manager, a domestic member of staff and five care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed four care records and nine medicine administration records. We reviewed seven staff recruitment records, induction supervision and appraisal records. We also reviewed the training matrix for all staff. We reviewed records relating to the day to day running of the service, including policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection robust procedures in place to manage the safety of the service had led to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Oversight of risk remained unsafe. Quality assurance checks needed to be widened in scope to oversee the safety of the service. Leaders lacked knowledge about the processes and checks needed to deliver a safe service. Professionals raised concerns about the ability of leaders to recognise and respond to risk. Lessons had not been learned when incidents relating to risk occurred.
- Rooms required to be locked for safety reasons in staff areas still did not have locks. No action had been taken to resolve consistently low water temperatures in the laundry and kitchen areas despite repeated feedback and signposting to relevant guidance.
- Fire safety actions had been followed up. Staff had still not received fire warden training; this was addressed following further feedback during inspection. Despite feedback, the provider had not identified this training was needed to oversee fire safety.
- The quality of information in care records varied. Some records had improved and contained the detail required. Areas such as medicines and mental capacity lacked information to provide the most appropriate support to people. Some records contained inaccuracies, such as whether a DoLS was in place. There were care plans and risk assessments in place for aspects of care not required. These omissions had not been identified during quality assurance checks.

Quality assurance checks had not supported the service to consistently oversee and manage the safety of the service. This has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

At the last inspection the provider did not have procedures in place to learn lessons. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

- A lessons learned process was not embedded and needed further development. The provider had not

carried out their own investigations when serious incidents had occurred; no lessons learned had been completed for these to determine where improvements could be made. The current approach did not support improvement at the service or embed principles to ensure people received safe care.
● Accidents and incidents were recorded. No analysis was carried out to determine any patterns and trends. Relatives gave mixed reviews about communication when incidents occurred.
● Insufficient improvements had taken place since the last inspection. The provider did not have the knowledge and resources needed to make improvements.

Failure to have an effective lessons learned procedure in place to support improvement has led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection recruitment procedures were not safe. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 19.

● Recruitment procedures remained unsafe. Gaps in recruitment records remained. Some action had been taken to address missing records and information; despite auditing of these records, some remained incomplete. No recruitment records or DBS certificate were in place for one staff-member despite a review of all staff recruitment taking place. Gaps in the records for newly appointed staff were also identified. This was not in-line with the provider's policy or within regulatory requirements.
● Staff did not receive appropriate induction into the service to equip them with the knowledge they needed to safely support people. The manager and deputy manager had not received an induction into their new roles. There were no development plans or competency checks in place to support them in their roles. New staff did not receive reviews during their induction.
● There were no members of staff who had completed the care certificates despite prompts to do so at previous inspections. This is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Failure to have safe recruitment and induction procedures in place has led to a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had not received appropriate support to carry out their roles safely. Leaders had not identified staff had not received supervision and appraisal in-line with the provider's policy. Some staff had not received this support for over one year.
● Staff training was not up to date. Insufficient action had been taken to arrange training dates for staff. Checks of staff practices to ensure they remained competent in areas such as medicines management and moving and handling were not up to date. Quality assurance systems had not identified gaps in the support provided for staff to allow timely action to be taken.

Failure to have robust systems in place to provide staff with support to carry out their roles has led a to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff on duty at all times to support people. People told us they had good relationships with staff and were very complimentary about the care they received. Comments included, "They [staff] are friendly, kind and have a lovely sense of humour" and, "They [staff] are caring."

Systems and processes to safeguard people from the risk of abuse

At the last inspection, record keeping in-line with the Mental Capacity Act 2008 was not in place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We found the service was not always working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

● The principles of the Mental Capacity Act (MCA) 2008 were not consistently embedded. Records to support decision making still did not included feedback from those involved and were not always time or decision specific. Relatives gave mixed reviews about being involved in decision making.
● Some best interest decisions were not completed before vaccinations were administered. Training in the MCA was not up to date. The provider had not recognised through their own quality assurance measures that staff lacked understanding of the principles of the MCA.

Failure to consistently work in-line with the principles of the MCA has led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safeguarding alerts were raised when needed. Information was shared with professionals. Many staff had completed training in this area.
● People told us they felt safe living at the service and felt they received good care. Comments included, "I knew from the first day that I wanted to stay here. They [staff] are all good, can't fault them" and, "[Person] is extremely safe."

Using medicines safely
● Medicine records were not always accurate. Two people had medicines administered at an incorrect dose. For one medicine that required additional records, the stock balance record had been altered but had not escalated to management for investigation.
● Some people were prescribed medicines to be taken on a 'when required' basis or with a variable dose. Guidance on how these medicines should be administered for some people was missing. Staff did not always record why they gave a when required medicine. This meant there was a risk people did not receive their medicines consistently or when they needed them.
● Records were not always in place to support the safe administration of topical medicines. We found that

some records were not accurate and did not match the creams that staff had applied.
● We were told one person received their medicines covertly. The guidance for the safe administration of covert medicines was available but the medicines on the day of our visit were administered contrary to the documented guidance.

Failure to have robust systems in place to support the safe administration of medicines has led a to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At the last inspection the service did not have effective procedures in place to manage the risks of cross infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Significant improvements had been made to manage the risks of cross infection. Ongoing improvements were needed to ensure government guidance was continually embedded.
● Aspects of the service needed to be updated to manage the risks of cross inspection. Radiator cabinets needed to be replaced because the veneer had broken or had worn in places; mould in bathrooms needed to be treated and missing toilet roll holders needed to be replaced.
● The service was clean throughout. Staff had undertaken training and their competency checked. Staff responded quickly when outbreaks occurred, and contingency plans were implemented. Staff were involved in regular testing and new admissions into the home were carried out safely.
●People were supported to receive visits when they wanted to. Visits followed government guidance.

We recommend the provider takes action to carry out improvements to the service to manage the risks of cross infection.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained 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.

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

At the last inspection, systems were not in place to deliver good quality and safe care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

● Quality assurance systems were inadequate and did not support continual development of the service. Information technology systems were not sufficient to oversee the safety of the service.
The knowledge of leaders needed to be significantly strengthened to meet regulatory requirements. Insufficient resources were in place to drive innovation and improvement. Leadership arrangements in the absence of the provider were not put in place.
● Quality monitoring such as audits remained ineffective. They were limited in scope and did not consistently identify actions needed to ensure a safe service. For example, they had not identified improvements needed to maintain the safety of the service, managing people's consent, medicines and overseeing incidents. Quality monitoring did not demonstrate how the delivery of care, treatment and support was in-line with current guidance.
● The quality of the environment needed to be significantly improved to support the needs of people. Some aspects of the environment did not maintain the risks of cross infection. The quality of the environment and decision making did not meet people's privacy and dignity needs. Outdated information remained on display at the service. Information in policies had not been fully completed and were not consistently followed.
● A registered manager was not in post. The current manager had been in post since September 2021. Notifications about events taking place at the service had been submitted when needed.

Failure to have acted on previous breaches of regulations and have in place robust and effective governance arrangements has led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

outcomes for people

● The culture of the service did not drive improvement. The staff team worked well together and were very supportive of the manager. People and their relatives were very complimentary about the staff team and the quality of care they received. However, there was a lack of understanding about risk and how failure to have effective systems in place to deliver a safe service increased the risk of harm to people and staff.

● The current system for overseeing incidents did not highlight potential risks and support staff to understand where actions needed to be taken. As a result, lessons were not learned. Relatives told us communication with them still needed to be improved when incidents occurred.

Failure to have acted on previous breaches of regulations to support people to receive consistently safe care has led to a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Regular meetings took place to keep people and staff up to date with changes taking place. People said they wanted to be involved in baking activities and staff put this in place for them.

● Staff worked well with stakeholders and other professionals working with the service. Feedback was listened to, however was not always embedded to support improvements. Visiting health professionals were complimentary about the service. The service was well known in the local community.

● There continued to be a lack of evidence to demonstrate how people, their relatives and staff were involved in shaping the service. Relatives said they hadn't been asked for feedback. A very small number of relatives had been asked to complete a questionnaire; however, no analysis had been carried out and the findings had not been included into quality improvement systems to shape improvements. During inspection people and relatives gave feedback about different areas of the service where improvements could be made such as activities, the environment, the laundry and oversight of the provider.

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 17 HSCA RA Regulations 2014 Good governance (1) The provider did not have robust governance arrangements in place.

The enforcement action we took:

We issued a notice of proposal to remove the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed (1) The provider did not have safe systems in place to safely recruit and induct staff.

The enforcement action we took:

We issued a notice of proposal to remove the provider's registration for this service.