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 27 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
The procedures in place to assure fire safety were very unsafe. The oversight of risk needed to be further improved. Repeated incidents had taken place; lessons had not been learned. Recruitment practices were inadequate. There were enough staff on duty who knew people's needs well. People received their medicines when they needed them. People were very happy with their care.

A lack of robust oversight had led to deterioration in the service. Quality assurance systems were ineffective. Notifications had not been submitted to the Commission when needed. Leadership needed to be strengthened. The staff team worked well together. The service had good relationships with relatives and professionals.

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 requires improvement (published 11 May 2021). At this inspection, we found improvements needed to be made. The service has deteriorated to inadequate.

Why we inspected
We received concerns in relation to recruitment, staff practices, leadership and management. 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. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
We have found evidence that the provider needs to make improvement.

You can see what action we have asked the provider to take at the end of this full report. The overall rating for the service is 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 Residential Care Home Limited on our website at www.cqc.org.uk.

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 people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, recruitment and the governance of the service.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 the 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
One 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 Residential Care 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 registered manager left in September 2021. A new manager was in post. They had not yet submitted their application to become registered manager. This means that they (when registered) and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from Redcar and Cleveland local authority safeguarding and commissioning team, South Tees infection prevention and control team and Cleveland fire service. We asked Cleveland fire service to carry out a visit to the service to review fire safety. 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 used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and 14 relatives about their experience of the care provided. We spoke with eight members of staff including the nominated individual (The nominated individual is responsible for supervising the management of the service on behalf of the provider), the operations manager, new manager, a senior care worker, a care worker, two domestic staff and a laundry member of staff.

We reviewed a range of records. This included four people's care records and five medication records. We looked at nine staff files in relation to recruitment and induction. 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 training data and 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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Immediate action was needed to address fire safety concerns. The fire service had issued a notification of deficiencies during the inspection. Checks of fire systems were insufficient, evacuation procedures and planned fire drills were not appropriate, a fire risk assessment was out of date and some aspects of the building were not fire resistant.
- Safety issues identified during inspection were addressed following feedback. This included unlocked doors, accessible electrical wiring and an unsafe electrical socket.

Failure to have robust procedures in place to manage the safety of the service has led to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Records to oversee risks to people were in place and had been regularly reviewed. Staff knew people well and anticipated risks to them providing timely support.

Systems and processes to safeguard people from the risk of abuse

- Care plans were in place for some people to support with restraint. These were not necessary, and staff were not trained to carry out restraint. Where people lacked capacity, best interest decision making had not been carried out.
- Procedures to work in-line with the Mental Capacity Act (MCA) 2008 had not been followed. Records demonstrated MCA assessments and best interest decisions had been completed for people to receive personal care, assistance with food and to maintain contact with relatives. This is not in-line with MCA guidance. Best interest decisions did not demonstrate those involved in the decision making or the outcomes of decisions made.
- No action was taken by leaders to assure themselves they were working in-line with MCA guidance. A flu vaccination for a person without capacity had been administered without a best interest decision.

Failure to have accurate record keeping in-line with the Mental Capacity Act 2008 in place has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff demonstrated their understanding of safeguarding practices. They had openly reported concerns to leaders and investigations had taken place. The quality of investigations and information shared around safeguarding matters need to be further improved.

● People and relatives said their care was safe. One person said, "They [staff] do look after us. The staff steady us when we are walking. I feel safe." One relative said, "I think [person] is safe there. [Person] gets on well with all of the staff and thinks that it is their home."

Staffing and recruitment
● Recruitment procedures were unsafe. They had not been carried out in-line with the providers policy or within regulatory requirements. There was a lack of oversight of recruitment by the provider.
● Seven staff were started without DBS checks in place. Risk assessments were not timely. Two references were not always in place and at times references were inappropriate. Gaps in employment had not been sufficiently explored.
● New staff and newly promoted staff had not received an induction to carry out their role. There was minimal oversight of these staff and the provider could not demonstrate they had the rights support in place for their roles or were competent to work at the service.

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

● There were enough staff on duty who knew people well. People said they received good care. One relative said, "There's always plenty of staff around." Another relative said, "A lot of local girls work there, and I am very happy with the way they treat [person] They interact with [person] very well and understand what [person] needs.''

Preventing and controlling infection
● Government guidance in relation to infection prevention and control was not embedded. Full checks of visitors were not completed, for example, temperatures were not taken, checks for vaccinations were not completed and some staff did not change their clothes before and after work in-line with guidance.
● Actions in place following a visit from an NHS infection control nurse in September 2021 had not been fully addressed. Some aspects of the environment needed to be updated to meet infection prevention and control guidance.
● Action was taken following feedback to address cleaning records, cleaning of frequently touched areas and storage of items and rubbish in bathrooms.

Failure to have effective procedures in place to manage the risks of cross infection has led to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Systems were not in place to make sure lessons were learned. Accidents and incidents were monitored, however some types of repeated incidents had taken place, such as people leaving the building unnoticed and inappropriate moving and handling procedures. These patterns and trends had not been addressed.
● Improvements identified at the last inspection had not been maintained. The quality of the service had deteriorated. Key safety issues had not been identified during quality monitoring of the service.

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

● Relatives said they had been kept informed when accidents and incidents had taken place. Comments included, "[Person] had a fall. We were told about this immediately by the Home. We also had a call from

Safeguarding the next day and they asked me questions about the incident. I could see how this happened and she shouldn't have been left on her own at the time, but I am happy with how it was dealt with.'' and, "They [staff] always ring me if [person] is unwell or if anything has happened which they feel I need to know about.''

Using medicines safely

● Systems to support medicines were improved. People received their medicines when they needed them. Staff had undertaken training and checks of competency to safely administer medicines.

● Relatives were happy with how medicines were managed. One relative said medicines were safely managed. They said, "I believe so, by looking at [person's] demeanour. I know that they [staff] have been observing [person] and review their medication. I understand that they are happy with what [person] is receiving at the moment.

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 requires improvement. 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.

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

● There was a lack of effective oversight of the service. This had led to significant deterioration in the quality of the service. Responsibilities and accountability at all levels was not understood; this did not support governance arrangements.
● Quality monitoring processes, such as audits were not effective. The lacked the scope needed to identify where improvements needed to be made. They had not identified the concerns found at this inspection. Insufficient resources were in place to drive improvement and manage future performance.
● The knowledge of leaders needed to be strengthened to meet regulatory requirements. Key challenges were not always understood. Learning from incidents needs to take place and shared with people and their relatives. The current approach did not support improvement.
● A registered manager was not in post. CQC had not been notified about this until the inspection took place. A new manager had started but had not yet submitted an application to become registered manager. Two notifications about safeguarding incidents taking place at the service had not been submitted. There was a lack of understanding about regulatory requirements in relation to notifications.

Failure to have systems in place to learn lessons has led to a 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The service worked with health and social care professionals to support people with their care. Recommendations for improvements were listened to but not always embedded.
● People and relatives were asked for feedback about the quality of their care. There was a lack of evidence to demonstrate how people, relatives and staff were involved in shaping the service. Relatives said communication, laundry and the hot water were areas which needed to be improved.
● People and relatives were happy with events taking place at the service. A relative said, "They [staff] put a lot of things on for the residents." Another relative said, "The manager rang me the other day to tell me

about a possible pantomime over Christmas."

● The staff team were supportive of each other and worked well together as a team. They had good links with the local community. People and relatives were very happy with their care. Comments included, "They [staff] treat the residents with the utmost respect and dignity.'' and, "I think the staff do care about my Mum and are very good with her.'' And, "I think it is the personal touch from the staff and the caring approach. The staff all know [person] very well and that gives me reassurance.''

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) (2) The service was not safe. The service was not compliant with fire safety legislation. Safety issues such as unlocked doors, accessible wiring and an electrical socket had not been identified prior to inspection. Infection prevention and control measures were not robust. These concerns increased the risk of harm to service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19 (1) (b) and (2) Recruitment procedures were not safe and not in-line with the providers policy. New staff and staff promoted into new roles had not received an appropriate induction.

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 17 (1) Records did not demonstrate staff were working in-line with MCA guidance. Lessons had not been learned since the last inspection. Patterns in incidents had not been identified. Quality monitoring was ineffective. The service had a history of non-compliance which had not been robustly addressed. Notifications had not been submitted when required.

The enforcement action we took:

We issued a warning notice.