Upton House

Upton House

Inspection report

Deal Road, Worth
Deal
Kent
CT14 0BA

Tel: 01304612365

Date of inspection visit:
04 August 2022

Date of publication:
10 October 2022

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
Upton House is a residential care home providing personal care to up to 20 older people. The service provides support to people living with dementia in one large adapted building. At the time of our inspection there were 17 people using the service.

People's experience of using this service and what we found
Relatives told us they felt their loved ones were safe living at the service. However, the culture within the service was controlling and restrictive. The provider restricted where and how often people were able to have visitors and their ability to go out into the community. People were required to ask permission to go out for social occasions. People and relatives had to agree to these restrictions to live at the service.

There was a closed culture within the service. The provider was insular and did not engage with outside agencies, such as, the local authority to keep up to date with changes and quality improvements.

Potential risks to people had not been assessed and managed to keep people safe. For example, there were no management plans in place to support people when they expressed distressed behaviours. Incidents of aggressive behaviour between people had not been managed and placed people at risk of injury. The registered manager had not recognised the need to report these incidents to the local safeguarding authority or the Care Quality Commission.

There was no effective system in place to monitor the quality of the service. Some audits had been completed but these had not identified the shortfalls found at this inspection. Checks had been completed on equipment, including weekly fire checks. However, there was not always documentation to show outside contractors had completed servicing.

There were enough staff to meet people's needs. However, staff had not been recruited safely. Checks on staffs' character, gaps in employment and conduct in previous social care roles had not been investigated, placing people at risk from receiving care from unsuitable staff.

Medicines were not managed safely. When people were prescribed medicines 'when required' for anxiety there was no guidance for staff about when and how often to give it. This placed people at risk of not receiving the medicine when they needed it.

The provider had not asked people, relatives, staff and other professionals their opinion on the quality of the service and any suggestions they may have.

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

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 22 November 2018).

Why we inspected

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to restrictions within the service including visiting. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 has changed from Good to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Upton House 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, recruitment of staff and the leadership of the service at this inspection.

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
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.

Upton House

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
The inspection was completed by two inspectors.

Service and service type
Upton 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. Upton 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people and two people's relatives about their experience of the service. We observed staff interactions with people in the communal areas. We spoke with six members of staff including the provider, registered manager, deputy manager and carers.

We reviewed a range of records. This included four people's care plans and multiple medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits.

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 Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- There was no effective system to protect people from abuse. The registered manager had not recognised when incidents should have been reported to the local safeguarding authority for investigation. When incidents had occurred, appropriate action had not been taken to minimise the risk of it happening again. People told us they did not always feel listened to when reporting incidents involving staff that had upset them due to the way staff had spoken to them. We discussed this with the registered manager, they did not understand their duty to investigate these concerns.
- We reviewed behaviour monitoring records. There had been numerous incidents of verbal and physical aggression from one person. They had been physically aggressive towards other people and staff which had increased in severity, including punching people. The registered manager had not acted to provide positive behaviour support for the person to reduce the risk of the behaviour. They had not recognised these incidents needed to be reported to the local authority safeguarding team, this had placed people at increased risk of harm. Following the inspection, the provider told us they had informed the local safeguarding of the incidents found at inspection.
- When some people living on the lower floors left their rooms, staff locked their bedroom doors behind them. The registered manager told us this was to prevent other people going into their rooms. By locking their doors staff were restricting people's ability to return to their rooms when they wanted.
- Staff had received safeguarding training and recorded incidents but had not recognised the incidents as potential safeguarding concerns. Staff had not implemented their learning to keep people safe leaving them at risk of potential abuse.
- People were living with significant restrictions leading to their human rights to a private family life not being upheld. The provider was not following government guidance on visiting and people going out with friends and relatives. The provider placed restrictions on where visits could take place, when and for how long. Visitors had to book one of the two appointments each day which were for an hour. These visits took place outdoors or in the visiting room, not in people's rooms. The provider controlled when people left the service and expected people to ask permission to leave. When discussing this with the registered manager they stated, "We let [the person] go to the wedding." The provider told us they believed these restrictions were required to stop people catching COVID-19. They had not recognised these actions were restricting and controlling people's ability to lead their life in the least restrictive way. One relative told us, they had not seen their loved one's room and had to wait to get an appointment to visit them.

The provider failed to have systems and processes to effectively recognise and investigate any allegation or evidence of abuse. The provider had introduced restrictions to control people that are not a proportionate response to the risk of infection. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Potential risks to people's health and welfare had been identified, however, there was no detailed guidance for staff to follow and mitigate risks. Some people had a urinary catheter which drains urine from their bladder into a leg bag, which was attached to a night drainage bag. There was guidance stating the bag should be changed every seven days, there was no information of the day the bag should be changed and there was no record of when the bag had been changed. There was no guidance for staff about how to store the night bag during the day to reduce the risk of infection. During the inspection, we observed the night bag left on the floor in the person's room, this increased the risk of infection. Following, the inspection, the provider sent us documentation they had put in place to record when the catheter bag has been changed. We will check this at our next inspection.

● Prior to being admitted to the service, one person had been reviewed by the speech and language therapist (SaLT). They had been advised to have their fluids thickened to help prevent them choking, there was a letter in their care plan to confirming this. The person's care plan did not reference the guidance, and the person was not receiving thickened fluids. We discussed this with the registered manager, they told us the person's family had said they did not need thickened fluids. The registered manager had not verified this information with SaLT to check this was correct. This placed the person at risk of choking. Following the inspection, the provider confirmed contact with SaLT and the person's GP, the person was now receiving thickener in their fluids.

● When some people were distressed, they communicated this by expressing feelings or an emotional reaction to others and staff. There was no guidance for staff about how to manage these behaviours, risk assessments had not been updated when people's behaviour had escalated. People received inconsistent support. Staff described how they supported one person during episodes of distress, other staff supported them in different ways and with varying results. This placed people at continued risk of harm from others.

● Some people were living with diabetes. There was information about how people may present when they had low blood sugar but no information about when people have high blood sugar. The risk assessment did not contain specific information about how the person experienced diabetes and limited guidance on how to support the person if they were unwell.

● Accidents had been recorded but there had been no analysis to identify any patterns or trends. One person had fallen numerous times, there was no evidence of any analysis or action taken to reduce the risk of falls. The person had continued to fall placing them at risk of serious injury. Following the inspection, the provider sent us an analysis they had completed of where falls had taken place within the service in the last 12 months, this did not include analysis of the causes of people's falls.

● The provider understood the requirement to complete checks on equipment and the environment. However, these had not been completed robustly to make sure people were as safe as possible. The last comprehensive fire risk assessment was completed in 2017. There had been some updates to complete the shortfalls found at the 2016 assessment, but the updates had only been recorded till 2019. There were no documented checks to the fabric of the building to assess 'wear and tear' such as fire doors. Checks on the hoists and legionella were due in July 2022 but had not been booked and the provider could not tell us when these checks would be completed. People had personal emergency evacuation plans (PEEP) in place. However, these were not always accurate. One person's care plan stated they required a wheelchair to move around the service, their PEEP stated they would need support of one staff to walk down the stairs. Other people's PEEPs stated they were to be supported by staff to walk down the stairs when their mobility was limited. The registered manager had not considered if there were other ways to move people safely in the event of a fire. Following the inspection, we contacted the local fire and rescue service to highlight our concerns. Following the inspection, the provider arranged for a new fire risk assessment and purchased two fire evacuation sledges. The provider sent us proof, checks which were due had been completed after the inspection.

The registered persons failed to do all that is practicable to mitigate risk and ensuring the premises and equipment was safe to use. The registered persons failed to assess and mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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)

● Staff gave people choices when making day to day decisions such as what they would like to eat. Staff offered choices and respected people's decisions within the restrictions put in place by the provider.
● The registered manager understood their responsibility to assess people's capacity and recorded this. When assessed that the person did not have capacity, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment
● Staff were not recruited safely. Newly appointed staff did not have all the pre-employment checks required to make sure they had the skills and character to work with people requiring care. Staff did not always have references. For example, one staff member had worked in care for over 20 years there was only one reference from their most recent previous employer. However, they had only worked for the employer for two months and the employer was unable to give an accurate assessment of their conduct. There were no evidence other references had been obtained from other previous employers. The provider had no information about their character or conduct in their previous employment, this placed people at risk of being supported by unsuitable staff.
● Staff had completed application forms, however, staff had not always provided full employment histories. Gaps in their employment had not been investigated to establish how staff had spent this time, or to check their conduct. Some staff had not provided consistent information about their previous employment, this had not been checked to obtain accurate information. Recruitment records did not always contain completed interview questions to establish people's knowledge, skills and training needs. We discussed these shortfalls with the registered manager, who told us they were not involved in the process to employ new staff. The recruitment process was undertaken by the provider and general manager.

The registered persons had failed to have effective recruitment processes in place. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us there were enough staff to meet people's needs and our observation supported this. Staff spent time with people, talking with them and playing cards with them.

Using medicines safely
● Medicines were not managed safely. Some people were prescribed medicine on a 'when required' basis such as, medicines for anxiety and pain relief. There was no guidance for staff about when to give the medicine, how often or the action to take if it is not effective. The side effects of some medicines given for

anxiety can cause drowsiness, placing people at risk of falls. Without specific guidance, administration of this medicine could be inconsistent increasing this risk. Following the inspection, the provider sent us documentation they were introducing to provide guidance to staff for the administration of as required medicines.

● Some medicines have specific requirements about storage, administration and record keeping, these were not always adhered to. Records of the amount of medicines available were not accurate. Medicines delivered from the pharmacy had not been checked and recorded in the required register. Medicines had been incorrectly recorded in the register; each strength of medicine should be recorded separately. Staff had recorded two different strengths of analgesic patch together.

The registered persons had failed to manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Inadequate

Is the service well-led?

Our findings

Our findings - Is the service well-led? = Inadequate

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 Good. At this inspection the rating has changed 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

- The culture within the service was poor and did not promote positive outcomes for people. The management team had placed restrictions on people that were not proportionate to risk. These restrictions prevented people from spending time in their rooms and limited time with their family and friends. The management team actively discouraged people and their relatives from going out into the community, such as going to a café.
- The management team had a paternalistic view of their role in keeping people safe and the management of risk. They expected people and relatives to ask their permission to go out and used language such as 'letting' people do things. The provider told us they had not received any complaints about the restrictions, and people had to agree to the rules before they moved into the service. However, they did not consider the control they had over people and relatives, and how this was being used to restrict and disempower people. Before the inspection, we had received a complaint from a relative about the visiting restrictions. They had been required to agree to these before their loved one had moved into the service. One relative told us, "We had spent so long looking for a home that we felt we had to agree."

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

- There was not an effective system in place to monitor the quality of the service, the service had deteriorated since the last inspection. The management team were unaware of the shortfalls within the service. The registered manager had completed medicines audits and the care plans had been reviewed monthly, these audits had failed to identify shortfalls found at this inspection. There had been no other checks or audits completed.
- During the inspection, the management team showed a lack of understanding about their responsibility to meet and adhere to regulatory requirements. The management team had not completed the required checks when new staff were employed and were not in line with regulatory requirements. The management of risks such as when people are expressing feelings, or an emotional reaction was not viewed by the management team as their responsibility. They had referred people to the mental health team. However, they did not understand their responsibility to develop a management plan alongside measures put in place

by the mental health team to support staff to provide consistent safe care.

● Staff competency and the effectiveness of training had not been assessed to make sure people were receiving safe care. Staff had not always implemented their training, for example, staff had not recognised incidents as possible safeguarding incidents, putting people at risk. Staff had not received regular supervision from the management team. They had not used supervision to develop the skills of staff to improve the service.

● The registered manager did not understand their responsibility under the duty of candour and had not kept relatives informed when incidents between people had occurred. A duty of candour incident is where an unintended or unexpected incident occurs that result in things going wrong. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

● Staff contacted health professionals for people when required, but the service did not engage with other agencies for continuous learning and development. The management team did not have any contact with the local authority or local clinical nurse specialists to keep up to date with changes and developments.

● Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This is so we can check appropriate action had been taken. The registered manager had not submitted notifications concerning incidents between people as required. They had not notified CQC when a person sustained a serious injury.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was no effective system in place to engage with people and relatives. There had been no resident or relative meetings held. The registered manager told us it was not possible to hold meetings with people, though they had spoken to each person individually. Records of these conversations and any suggestions made had not been documented. We discussed this with the registered manager, they were unable to provide examples of changes made from suggestions.

● There had been no recent quality assurance surveys carried out. People, relatives, staff and visiting professionals had not been asked for their opinion of the quality of the service since 2018. The registered manager told us they planned to send out surveys this year. Following the inspection, the provider told us they had started to send out client surveys.

● There had been no staff meetings. The registered manager told us it was difficult to get staff to attend meetings. They told us they discussed any issues at the morning hand over. However, the subjects discussed and any input from staff had not been recorded.

The registered persons had failed to assess, monitor and improve the quality and safety of the service provided. The registered persons had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. The registered persons had failed to maintain accurate and complete records. The registered persons had failed to seek and act on feedback from relevant persons. This is a breach of Regulation 17 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 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons had failed to have effective recruitment processes in place.