All Saints Care Limited

The Gateway Care Home

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
The Gateway Care Home is a residential care home providing personal and nursing care to older people, people living with dementia and people with physical disabilities. The service accommodates up to 92 people across three separate floors, each of which have separate adapted facilities. At the time of the inspection, one floor was being decorated and not in use, 43 people were using the service.

People's experience of using this service and what we found
People were not safe. Risks to people were not assessed and managed. Medicines were not managed safely. Lessons were not always learned when things went wrong. There were enough staff to keep people safe although there had been a high turnover of staff.

The service was not well-led. There were continued breaches at this inspection with similarities to issues found at the last inspection in relation to risk management and governance. Systems to monitor quality and safety were not effective.

The provider had strengthened how they managed accidents, incidents and safeguarding cases. People were generally positive about the staff who cared for them and their experience at the service. Staff said they felt supported and were complimentary about the management team who worked at the service on a day to day basis. Feedback varied about the overarching management arrangements and role of the provider. The service worked with other professionals to benefit people using the service.

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 18 November 2020) and there were multiple breaches of regulation. The service remains rated inadequate.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made in some areas, but not enough improvement had been made in other areas and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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 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.
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 The Gateway Care Home 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 assessing and managing risks to individuals, managing medicines safely and governance 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
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.

The overall rating for this service is 'Inadequate' and the service remains 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.

The Gateway Care Home

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, a medicines inspector and an Expert by Experience carried out the 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
The Gateway Care Home 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 did not have a registered manager. The previous registered manager left the service and cancelled their registration in April 2021. A manager was in post and had commenced their registered manager's application. This means, once registered, 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
This inspection was announced. We gave a short period of notice of the inspection because we needed to check the arrangements in place for preventing and containing transmission of Covid-19 prior to entering the building. Inspection activity started on 11 May 2021 and ended on 25 May 2021. We visited the service on 11 May 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from Healthwatch, the local safeguarding team and commissioners. 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. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and three relatives about their experience of the care provided. We spoke with twelve members of staff including the provider, manager, assistant manager, senior care workers, care workers and housekeeping.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed.

After the inspection
We received information of concern about a specific incident and the overarching management arrangements. We continued to seek clarification from the manager and nominated individual to validate evidence found about the specific incident and the inspection findings.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess or manage risks associated with people's care. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had produced an action plan and there was evidence actions had been taken to improve how they assess or manage risks associated with people's care. However, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people were not always managed safely. Assessments and care records were sometimes confusing. For example, one person had three records about the use of bedrails, and they all stated something different about how the risk should be managed.
- The service had identified they needed to monitor some people's nutritional intake because they were at risk of becoming malnourished, but records were not always fully completed. This meant staff did not know if those individuals had enough to eat and drink.
- Care records were not always updated after significant events and when people's needs changed. For example, one person had displayed behaviours that challenged towards others, but no information was added to their care plan. There was no information about what action staff should take to support the person and keep others safe.
- Records showed only one fire drill had been carried out in the last 12 months involving 16 staff. Two staff told us they had not taken part in a fire drill even though they had been employed at the service for over a year. The management team agreed to address this.
- The local authority shared with us they had received information of concern about the care planning and risk assessment process.

We found no evidence that people had been harmed. However, risks associated with people's care were not always assessed and managed which 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.

Using medicines safely

At the last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had produced an action plan and there was evidence that actions had been taken to improve management of medicines. However, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not always managed safely. There were gaps in recording when thickener powder was added to drinks, which is used to reduce the risk of choking. This meant it was not possible to establish if thickener powder was administered properly.
● Staff did not record the position a patch was applied, which may cause skin irritation if reapplied regularly to the same place.
● Staff did not have access to information about how to administer 'as required' medicines in a person-centred way. Some guidance was not accurate, and others lacked detail. Information about people's needs was stored separate to the medicine administration records so not readily accessible.
● Records for covert administration (disguising medicine in food or drink) did not follow national guidance. Staff did not have access to sufficient information about how to covertly administer medicines safely.
● Medicines were not stored safely. All staff had the access code to a treatment room and medicines were left on the worktop and in an unlocked fridge.
● A controlled drug had been recorded as returned but this was still kept at the service. This demonstrates that controlled drug audits were not effective.

We found no evidence that people had been harmed. However, medicines management was not safe which 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 to ensure people received time specific medicine at the right time were effective.

Learning lessons when things go wrong

At our last inspection the provider did not have effective arrangements in place for learning when things went wrong. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had produced an action plan and there was evidence that actions had been taken to improve how they learned lessons. However, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Staff identified actions when things went wrong to reduce the risk of events happening again, but these were not always followed up. For example, one person had a skin tear on their hand and staff had recorded, as an action, that the care plan was updated. However, the skin assessment care plan made no reference to the injury.

Failure to implement improvement actions meant people were at risk of receiving unsafe care. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had introduced a more robust system for monitoring accidents and incidents, and events were well recorded. Staff followed guidance to ensure forms and body maps were correctly completed.
● A monthly analysis of accidents and incidents was completed which helped identify themes and trends.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider did not ensure systems, processes and practices safeguard people from abuse. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Systems protected people from potential abuse and neglect. The provider reported safeguarding concerns to the local authority and investigations were carried out when people were harmed. For example, an incident occurred between two people who used the service. The service referred the case to the local safeguarding team and contacted the mental health team for support.
● Staff understood when and how to report safeguarding concerns. They received training to help them understand how to prevent abuse and respond when issues arose. All staff knew they could access whistleblowing procedures.
● People felt safe. One person said, "I feel safe here, there are no problems at all with that." Another person told us they felt safe but were unhappy that another person frequently entered their room. Relatives also told us people were safe but two gave examples where they thought people had been at risk.

Staffing and recruitment
● There were enough staff to keep people safe although there had been a high turnover of staff. The manager said they had carried out a recruitment drive and were aiming to have a more stable workforce.
● Feedback about staffing levels was mixed; some said staffing arrangements worked well, but others felt staff did not have enough time to support people without rushing. Several concerns were raised about different staff providing support and the arrangements during the night. One person said, "There are a lot of staff changes, it's a bit hit and miss." A member of staff said, "Some staff do not know people. It would be ok if we had more experienced staff."
● The provider had introduced a new format to help make sure the right staffing arrangements were in place. The manager said they would continue to review the staffing levels.
● Recruitment checks were carried out before staff commenced work although two satisfactory references were not always obtained. The manager said they would ensure these were completed in future.

Preventing and controlling infection
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.

The service had systems in place to carry out COVID-19 tests when visitors arrived at the care home. However, during the site visit, one visitor went to the top floor unit, with permission from staff, to see their relative even though they confirmed they had not had a test. The manager acted when this was brought to their attention and told us it was a one off and they would ensure it did not reoccur.

● We were somewhat assured that the provider was meeting shielding and social distancing rules.

The service had systems in place to encourage social distancing. However, during the site visit, staff did not always adhere to this, for example, three staff travelled in the lift together when the instruction was only two should use the lift. The provider and manager agreed to reinforce safe working practices to help prevent transmission of COVID-19 with all staff.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely.

The service had a good supply of PPE which was available throughout the building. Staff were observed wearing PPE, but they did not always wear masks correctly, for example, covering mouth and nose. The provider and manager agreed to reinforce safe working practices to help prevent transmission of COVID-19 with all staff.

● 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 somewhat assured that the provider's infection prevention and control policy was up to date.

The provider had guidance around COVID-19, but their infection prevention and control policy did not reflect full infection control measures to avoid COVID-19 spreading to others. For example, there was no reference to staff wearing masks or eye protection.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

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 inadequate. At this inspection this key question has remained the same. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At the last inspection the provider had failed to assess, monitor and improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had produced an action plan and there was evidence that actions had been taken to improve quality assurance. However, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Significant shortfalls were identified at this inspection. There were continued breaches in relation to governance, medicines and management of risk to individuals. These had not been identified and addressed through the provider's governance arrangements.

● Some issues were similar to the last inspection. Plans to address risks to individuals were not always clear which meant safety concerns were not always addressed. For example, care records did not always provide staff with guidance around how to manage situations in a positive way when people behaved in a way that challenged others. This was highlighted at the last inspection.
● After the site visit the provider told us they had reviewed some care records and sent through revised plans. They said these had been improved but the information shared about some risks was limited.
● The service had systems in place to assess and monitor quality and safety, but these were not effective. Monitoring checks were carried out, but these did not always identify shortfalls or areas to improve. For example, a medicines audit was carried out in April 2021 and did not pick up on the issues raised at the inspection. An external audit in April 2021 rated the service as outstanding.
● Organisational risks were not always recognised and managed. For example, the service had a medicine policy but part of it did not provide correct guidance for staff to follow. The provider had an infection prevention and control policy which was audited during the pandemic, but this did not accurately reflect full infection control measures.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● The provider had strengthened some of their monitoring systems such as accidents and incidents, people's weight and safeguarding cases.
● The management team had introduced a new audit programme and were confident once this was fully implemented and embedded it would be effective and highlight shortfalls.
● The service did not have a registered manager. A manager was in post and had commenced the registration application process. They said they felt supported in their role.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff were supported in their role. All staff we spoke with were complimentary about the management team who worked at the service on a day to day basis. One member of staff said, "[Name of manager] and [name of assistant manager] are very approachable." Another member of staff described a recent situation which had been resolved "straightaway".
● People were complimentary about the staff and during the site visit the atmosphere at the home was relaxed. A relative described the manager and assistant manager as "fantastic".
● Feedback was varied about the overarching management arrangements and role of the provider. CQC received assurance from the provider that the arrangements were appropriate to oversee the quality and safety of the care provided. We will continue to monitor this.
● Feedback about the quality of the service was mainly positive although some felt some aspects such as staffing arrangements and meals could improve. One person said, "I am happy with the place and the staff are good." Another person who thought the food could improve said, "I say about it to the carers but don't know if it goes any further."
● The management team and staff worked with other professionals to benefit people using the service. Health professionals, such as, pharmacists were contacted when staff wanted advice and guidance.

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

At our last inspection the provider failed to submit required notifications which meant CQC were not made aware of some notifiable events. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Registration) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Notifications about significant events such as expected and unexpected deaths, serious injuries and abuse or allegations had been submitted to CQC and showed appropriate action was taken in response.
● An incident had occurred between people who used the service in May 2021; records showed it was discussed with the local safeguarding team although not all relevant details were shared. CQC were not notified about the event. Records of the incident were reviewed and indicated CQC should have been informed. The provider was asked to submit a notification retrospectively. The manager gave assurance that additional measures would be introduced to ensure protocols were followed in future.

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 Risks associated with people's care were not always assessed and managed which placed people at risk of harm. Medicines management was not safe which placed people at risk of harm.

The enforcement action we took:

Served warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people were at risk of receiving poor quality care.

The enforcement action we took:

Served warning notice