Keiro Limited

The Gateway

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We inspected The Gateway on 21, 28 October, 5 November and these were unannounced inspections which meant that the staff and provider did not know that we would be visiting. During this period a number of concerns were raised by the local commissioners following their visits and on 23 November 2015 the registered manager provided additional information to support an assertion that they had not been notifying us of incidents. On 8 December 2015 we were notified that the home had gone into administration so we completed an additional visit on the 11 December 2015 to check if this change was having any detrimental effects.

The Gateway is a newly built care home, which has health and spa facilties on the ground floor. There are four separate floors, which can accommodate upto 40 people and can provide nursing and residential care. They provide respite services for children with long-term physical health conditions; adults with complex physical health conditions; people with spinal injuries and people with acquired brain injuries and neurological conditions.

The home has a registered manager and they have been in post since April 2015. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

On the 8 December 2015 the local media reported that Kiero Limited had gone into administration and we were contacted by the local authority and registered manager who also informed us of this development. The registered provider asserted they had informed us on 4 December 2015 however we found that the only contact with CQC was when the clinical services director rang to discuss an on-going registration application. On the 9 December 2015 the administrator formally notified us that they were now overseeing the operation of the home but prior to this the registered provider had not informed us of the difficulties they were experiencing or that the home was going into administration.

We gave feedback on 5 November 2015 highlighting that we had not received statutory notifications about events that had occurred from March to November 2015. The registered manager stated that they had sent us notifications and on 23 November 2015 provided us with nine copies of notifications, which they told us had been sent but were not on our system. These dated back to February 2015 and were on our system. However they did not send us any in relations to the events and incidents that we found had occurred post March 2015. Also the registered manager has not notified us of the six safeguarding alerts that were raised in December 2015 and a staffing shortage that occurred on 10 December 2015.

We found that the registered provider at registration stated they would not provide a service to children under the age of 16 years old, however, post registration they had altered the service and commenced providing services to all ages of children. In February 2015 Ofsted informed us this was being provided and our registration team visited to home with the Ofsted inspector to confirm that this was not impacting on the service or that the home now needed a dual registration. Also at some point this year the registered provider commenced accepting people who were detained under the Mental Health Act 1983 (amended 2007) and on section 17 leave to the home. We had not received updated statement of purposes at the time when these changes occurred.

The registered provider suggested it was an error within CQC systems that we had not received them but this is not the case. We have received notifications about Deprivation of Liberty Safeguard (DoLS) authorisations and amended statement of purposes in August, September and October 2015, which related to the removal of diagnosis and screening procedures from the registration and about registration applications. But we have not received any of the other required notifications.

When our inspection commenced in November 2015 the registered provider informed us they were reviewing the service to determine if they could provide services to allievate winter pressures for local NHS Trusts and also to operate a learning disability service. The home is not registered to provide services for people with a learning disability and we had not been requested to add this to their service user bands.

We found that none of the staff were registered mental health nurses and none of the staff had received indepth training for working with people who have mental health and neurological conditions; yet the registered provider advertised as a specialist service working with people who had these conditions and needs.

During the inspection the number of people who used the service varied, as they operated respite care, transitional services and rehabilitation services. On the 11 December 2015 there were 18 adults using the service and one child who was on overnight respite. All of the people had very complex needs and most people required two to one support for all of their care needs.

We found that two nurses and, ten care staff for two units and one paediatric nurse with one child care assistant for another unit were on duty during the day. Overnight there were two nurses with five care staff over two units and one paediatric nurse with two child care assistants for another unit.

From these numbers three support workers were needed per day and two support workers needed at night to provide one-to-one care to people.In addition other staff were needed for seven people who required one-to-one support per week.

This meant that for 15 adults with very complex needs there were two nurses and seven care staff available

Summary of findings

during the day which at times was reduced further when the six people received their one-to-one support at varying times across the week. Two nurses and three staff were available during the night.

The registered provider and registered manager told us that there were enough staff on duty to meet people's needs. Some of the people we spoke with told us that they had to wait long periods of time to get assistance. Also some of the staff described how they had to prioristise their work to ensure people with more pressing needs could get ready and leave others in bed until late in the morning. We also saw that one of the nurses took several hours to give 10 people their medicines as they were repeatedly needed to see the doctor or other visiting professionals. They did ask for assistance but this was not forthcoming and meeting minutes showed the nurses had asked for an additional nurse to be employed during the day.

We saw on the rota that each day different numbers of staff were on duty and on some days the people who received one-to-one support had an allocated staff member highlighted on the rota but but not on other days. We could find no reason for these differences. We did see people being provided one-to-one support.

We found that since the provider went into administration some staff had tendered their resignation and in the last few months there had been a high turnover of staff, which we found from a review of staffing information the registered manager was covering.

The registered provider also employed physio therapists, occupational therapists, an activity coordinator and ancillary staff such as cooks and domestic staff who were on duty throughout the week. The registered manager, an assistant manager and clinical lead worked weekdays. We tended to find that staff on each unit managed the service with little direct involvement of the registered manager.

Albeit the provider had systems for monitoring and assessing the service we found that these had not assisted the registered manager to identify gaps in the care practice or make improvements. In June 2015 the registered manager had asked for changes to procedures and documents but the registered providers governance systems was so cumbersome that these had the main changes had not been made at the time of the inspection.

Alongside this, the audits failed to identify when care records were not accurately reflecting people's needs; that Deprivation of Liberty Safeguard (DoLS) authorisations had expired and that the care records were not always accurately completed.

We found that risk assessments for people with physical health conditions were very detailed. But because staff had not received training around how to work with people whose behaviours may be challenge these issues were not clearly addressed in the care records.

We found that staff had not always followed the registered provider's guidance so for instance had not weighed people more frequently if they were losing weight or made referrals to dieticians. This we found from discussions with visiting professionals had been an ongoing issue and despite it being raised with the registered manager had persisted.

When designing the building insufficient space had been provided for medication and the small rooms were prone to becoming too hot and there was no sinks in them for staff to wash the medicine pots. The registered provider asserted that the staff could wash the pots in each person's sink but this is not a satisfactory means for cleaning these items. Although staff recorded the treatment room temperatures we found no evidence to show action had been taken to either temporarily reduce the temperature or to make a permanent change to the temperature in these rooms to ensure it was at correct levels. Also no action was taken to provide sinks and staff were washing and drying medicine pots in the communal areas.

We found that the registered manager's system for monitoring the operation of the service needed to be improved as they were not effective.

We saw there were systems and processes in place to protect people from the risk of harm. However we found staff were not clear that when incidents such as lack of staff or misplaced essential nutritional supplement items affected people's care this needed to be raised as a safeguarding alert.

Summary of findings

People's needs were assessed and for the children and people with complex physical health care conditions their care was delivered in line with their individual care needs. The staff working with these people, particularly in the children's service were very skilled and competent. But because the registered provider failed to employ mental health nurses or equip the staff with the skills needed to work with people with acquired brain injuries; neurological conditions and mental health needs staff were not sufficiently skilled or confident when working with these people. The registered manager had asked the registered provider to obtain this training but the registered provider had not ensured training was delivered to staff.

People told us they were offered plenty to eat and assisted to select healthy food and drinks which helped to ensure that their nutritional needs were met. We saw that each individual's preference was catered for but at times people were not adequately supported to manage their nutritional needs. Also the registered manager needed to ensure staff were told where nutritional supplements were stored if this changed or the staff were new to ensure people were able to deliver care and support with nutrition.

We saw that the provider had a system in place for dealing with people's concerns and complaints. People we spoke with told us that they knew how to complain and but did feel that their concerns were not taken on board. Staff told us they raised concerns with the registered manager but it did take time for matters to be resolved.

People were supported to maintain good health and had access to healthcare professionals and services. Both a GP and consultant visited the home on a weekly basis.

Staff had received a wide range of training, which covered mandatory courses such as fire safety as well as condition specific training such as those related to clinical issues like delivering care for people who had tracheostomy.

People told us that they made their own choices and decisions. Staff were kind and respectful; we saw that they were aware of how to respect people's privacy and dignity.

We saw that people were engaged in a wide range of meaningful occupation and this was tailored to meet each person's preferences. People accessed the spa facilities and if funded could routinely see the physiotherapists. The registered manager did enable those people who were not funded but would benefit from physiotherapy to gain access to these services. Also people regularly went out to events or into town.

Effective recruitment and selection procedures were in place and we saw that appropriate checks had been undertaken before staff began work.

We found that the building was very clean and well-maintained. Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety.

We found the provider was breaching five of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care, safeguarding people from improper treatment and abuse, staffing, governance and duty of candour. We also highlighted that the registered provider needed to ensure statement of purpose were submitted in line with the requirements of The Care Quality Commission Registration Regulations 2009 when the design of the service changed. Plus statutory notifications needed to be submitted in line with The Care Quality Commission (Registration) regulations 2009.

In considering the enforcement action that would be taken consideration has been given to the fact that the home is in administration and therefore the provider no longer operates the service. Also the actions that the administrator has taken to date to ensure the service is improved and that it operates in a safe manner.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

Staff lacked the skills needed to meet the needs of people with mental health needs associated with neurological conditions. There were insufficient skilled and experienced staff on duty to meet the needs of people who had physical health care needs and children.

Staff were knowledgeable in recognising signs of potential abuse and reported any concerns regarding the safety of people to senior staff.

Robust recruitment procedures were in place. Appropriate checks were undertaken before staff started work.

Appropriate systems were in place for the management and administration of medicines. But the design of the building failed to provide adequate storage facitlities and mechanisms to maintain the correct temperatures in the treatment rooms,

Appropriate checks of the building and maintenance systems were undertaken, which ensured people's health and safety was protected.

Is the service effective?

Requires improvement

The service was not effective.

The registered provider was regularly changing the aim of the home and diversifying into new areas of care. However prior to any change they failed to ensure the staff were equipped with the knowledge and skills to support the new client group.

Staff understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The registered manager had raised with that the care records did not provide templates for recording capacity assessment and best interest decisions. But the complex governance arrangements the registered provider had in place had delayed action being taken to address this gap.

People were provided with a choice of nutritious food, which they chose at weekly meetings. However, nutritional screening was not always completed or accurately recorded.

People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Requires improvement

This service was not always caring.

Summary of findings

Most people told us that they liked living at the home. We saw that the staff were very caring and discreetly supported people to deal with all aspects of their daily lives.

We saw that staff constantly engaged people in conversations and these were tailored to ensure each individual's communication needs were taken into consideration.

Action needed to be taken to equip staff with the skills needed to enable staff to effectively assist people with mental health needs associated with their neurological conditions.

On the whole people were treated with respect and their independence, privacy and dignity were promoted.

We saw people were encouraged and supported to take part in activities and routinely went on outings to the local community.

Is the service responsive?

Requires improvement

The service was not responsive.

People's needs were assessed and care plans were produced, which identified how to meet each person's needs. These plans were tailored to meet each person's individual requirements and reviewed on a regular basis. However the staff lacked the skills needed to draw up care plans for people who displayed behaviours that challenge.

The people we spoke with were aware of how to make a complaint or raise a concern. The registered manager had a clear understanding of the process for investigating and dealing with compliants.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider's governance systems were ineffective and led to lengthy waits for simple changes to be made to policies. Also they failed to recognise that prior to diversifying the kind of service they delivered staff had to have the skills and knowledge to provide a different specialism.

The registered provider failed to notify us of changes to the statement of purpose.

We found that the registered manager oversaw the home and identified gaps and concerns, which they referred to the registered provider. However, the registered manager delegated tasks to the nurses but did not have a system in place to check that these tasks were completed to an appropriate standard or levels of quality were sustained.

The Gateway

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Two adult social care inspectors, a specialist professional advisor who was a senior lecturer in occupational therapy and an expert by experience visited the home.

An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who formed a part of the team specialised in the support for people with mental health needs.

The provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed all the information we held about the home. The information included reports from local authority contract monitoring visits. We also reviewed information from Ofsted who had visited to check if the children's service would need to be registered with them. Ofsted had found that there was no need for the provider to register as a children's home.

During the inspection we spoke with 13 people who used the service, two relatives and a care cordinator. We also spoke with the registered manager, deputy manager, clinical lead, two registered general nurses, the senior paedatric nurse, a learning disability nurse, 10 support workers, the maintenance person and reception staff.

We spent time with people in the communal areas and observed how staff interacted and supported individuals. We observed the meal time experience and how staff engaged with people during activities. We looked at nine people's care records, staff recruitment and training records, as well as records relating to the management of the service. We looked around the service and went into people's bedrooms (with their permission), the bathrooms and the communal areas.

Requires improvement

Is the service safe?

Our findings

We found that since the provider went into administration some staff had tendered their resignation and before then there had been a high turnover of staff in the last few months, which the registered manager told us they were covering. We confirmed this to be the case from a review of the staffing rotas, allocation sheets and recruitment records.

Since opening we found that the numbers of people supported has fluctuated but we saw that all of the people who used the service had very complex needs but at any one time, no more that 25 people have been using the service. The numbers of people who used the service changed over inspection period as children and adults came for respite at the service and people moved on

On the 11 December 2015 there were 18 adults using the service and one child who was on overnight respite. All of the people have very complex needs and most people required two to one support for all of their care needs.

We found that two people were funded for 24 hour one-to-one support; one person was funded for 15 hours one-to one support per day. One person had 10 hours one-to-one supported funded per week and another five people were funded for six hours one-to-one support per week but it was extremely difficult to determine from the rotas who provided this support.

We found that two nurses and, ten care staff for two units and one paediatric nurse with one child care assistant for another unit were on duty during the day. Overnight there were two nurses with five care staff over two units and one paediatric nurse with two child care assistents for another unit.

From these numbers four support workers were needed per day and two support workers needed at night to provide one-to-one care to people.In addition other staff were needed for seven people who required one-to-one support per week.

This meant that for 15 adults with very complex needs there were two nurses and seven care staff available during the day which at times was reduced further when the six people received their one-to-one support at varying times across the week.

The registered provider told us that they used a bespoke dependency tool. The registered manager was unaware of this tool and told us they were reliant upon contractual arrangements with the local commissioners to determine how many staff were needed. This was not an effective arrangement as the registered manager determined staffing levels without the use of the tool. We found that all of the people had very complex needs and would require two staff at times to assist them to meet their needs. We observed that at times throughout the day there were no staff to assist the majority of people as they were all occupied undertaking personal care tasks for people.

Although the home was described as a specialised service for people with acquired brain injury and neurological conditions and accepted people from mental health hospitals who were detained under the Mental Health Act 1983 (amended 2007) and on section 17 leave none of the staff were registered mental health nurses. We could find no clear rationale as to why mental health nurses would not be required to provide nursing care at the home. The registered provider told us that they had previously employed registered mental health nurses but did not explain why this practice had stopped or why they felt these specialised nurses were not needed.

We saw on the rota that each day different numbers of staff were on duty and on some days the people who received one-to-one support had an allocated staff members but not on other days. We could not establish from the rota if the four staff needed during the day and two staff needed overnight for funded one-to-one care were provided and we also could not see from the rota when the other people received their one-to-one care during the week. We could find no reason for these differences in recordings on the staff rota. Staff could tell us who they were allocated to provide one-to-one care for, one person told us they received the support and we observed other people receiving one-to-one support.

The registered provider also employed physio therapists, occupational therapists, an activity coordinator and ancillary staff such as cooks and domestic staff who were on duty throughout the week. The registered manager, deputy manager and clinical lead worked weekdays. We observed that the registered manager spent little time

Is the service safe?

away from the office and staff on each unit managed the service. The registered manager outlined that they had delegated tasks such as the completion of audits and oversight of the care to the nurses.

The staff we spoke with told us that there were enough staff on duty to meet people's needs. However some of the people we spoke with told us that they had to wait long periods of time to get assistance. One person told us that they had a physical health condition which meant it took a lengthy period of time to digest a meal. In order to have their breakfast then be ready to have their painkillers so they could go to their physiotherapy sessions they had to be up by 7am. They told us on several occassions because of staffing pressures they had not been assisted to get up in time to complete all of their preparations for physiotherapy. Other people told us that they had to wait for staff to attend to their personal hygiene and could wait for up to an hour for staff. Other people told us that staff always promptly attended to their care needs.

People said "I feel very safe the staff are very kind to me the staff are all nice nothing is too much trouble for them I think sometimes they are short." And, "The staff are very caring and I am looked after very well all the time I would like to go out more but I know they are sometimes short staffed."

Also some of the staff described how they had to prioristise their work to ensure people with more pressing needs could get ready and leave others in bed until late in the morning. We also saw that one of the nurses took several hours to give 10 people their medicines as they were repeatedly needed to see the doctor or other visiting professionals. They did ask the assistant manager for assistance but this was not forthcoming. We found that the complexity of people's needs meant individuals needed two-to one support for all their care needs and the current staffing levels were not always sufficient to meet these needs. We noted that the staff meeting minutes showed that staff had also expressed this view and requested that additional nurses were on duty during the day.

We heard that the service was a specialist provision for adults and children with complex physical health conditions; spinal injuries as well as for people with acquired brain injury and neurological conditions. Some of the people with acquired brain injury were admitted from Walkergate; a mental health hospital operated by Newcastle Tyne and Wear Mental Health Trust yet none of the staff employed in the Gateway were mental health nurses. Also we found that the registered provider prior to setting up these services has not ensured staff received detailed training around working with people who have neurological conditions.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People who were identified to be at risk in relation to their physical health care conditions had appropriate plans of care in place such as plans for ensuring action was taken to manage pressure area care, tracheotomy care and safely assist people to eat. We saw there were systems and processes in place to protect people from the risk of harm. However we found that the care records were not always accurately completed so we could not establish if people had received the care and treatment in line with their care plan. For instance on the second day of inspection we found that one person's fluid balance chart had not been completed. The assistant manager investigated this on the day and established that the person had received the appropriate amount of fluids but staff had not filled the chart in.

At our next visit we found that staff were making sure fluid balance charts were completed appropriately but had not kept accurate records for monitoring the people's weight. These types of errors are not just record keeping issues because not having sufficient fluids or weight loss not being detected could lead to a detrimental impact on the individuals concerned.

We also found that visiting professionals had also identified poor recording as a problem at the home and this had been a feature of safeguarding alerts raised over the last year. The registered provider could always provide supporting evidence to show that a person's care had not been compromised but lessons were not learnt and errors continued.

We found that there were appropriate arrangements in place for obtaining medicines, checking these on receipt into the home . We looked through the medication administration records (MAR's) and it was clear all medicines had been administered and recorded correctly. Adequate stocks of medicines were securely maintained to allow continuity of treatment.

However we found that the controlled drugs were stored on the top floor, which was in line with the provider's policy

Is the service safe?

but impractical for staff working on four floors. In order to obtain medication they had to go upstairs which caused delays. Also the provider's policy required two nurses to sign for them which meant the nurse off the other floor needed to join them, which took resources from two floors. We discussed this with the registered manager who had raised this with the provider and was confident that the policy would be changed.

We were told that the registered provider had completed medication competency checks but these were stored offsite and the registered manager did not have access to them.

When designing the building insufficient space had been provided for medication and the small rooms were prone to becoming too hot and there was no sinks in them for staff to wash the medicine pots. Although staff recorded the treatment room temperatures were too high, we found no evidence to show action had been taken to either temporarily reduce the temperature or to make a permanent change to the temperature in these rooms to ensure they were correct. Also no action was taken to provide sinks and staff were washing and drying medicine pots in the communal areas.

We found that the system for monitoring and overseeing the operation of the service needed to be improved as they were not effective.

This was a breach of Regulation 12 (Safe care and treatment) and 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with six members of staff about safeguarding and the steps they would take if they felt they witnessed abuse. We asked staff to tell us about their understanding of the safeguarding process. Staff gave us appropriate responses and told us they would report any incident to senior managers and they knew how to take it further if need be. Staff we spoke with were able to describe how they ensured the welfare of vulnerable people was protected through the organisation's whistle blowing and safeguarding procedures.

However staff did not recognise when general poor care practices such as not being able to attend to a persons personal care in a timely manner to such an extent that they were left wet for an hour or not sharing with staff where a person Percutaneous endoscopic gastrostomy PEG feed was stored so this was given late could constitute abuse. These matters were raised by visiting professionals when they became aware of the issues.

This was a breach of Regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Since we started the inspection to our knowledge six safeguarding alerts have been raised but the registered manager has not submitted statutory notifications for these incidents.

This was a breach of Regulation 18 (Notifications of other incidents) of The Care Quality Commission (Registration) Regulations 2009. This matter is being dealt with outside of the inspection process.

We saw that staff had received a range of training designed to equip them with the skills to deal with all types of incidents, including medical emergencies. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. Staff could clearly articulate what they needed to do in the event of a fire or medical emergency. Staff were also able to explain how they would record incidents and accidents. A qualified first aider was on duty throughout the 24 hour period. The nurses on duty were competent to deal with emergencies related to the failures in the specialist equipment such as ventilators and issues associated with people very complex physical health care needs.

We saw evidence of Personal Emergency Evacuation Plans (PEEP) for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

Accidents and incidents were managed appropriately. The registered manager discussed how they analysed incidents to determine trends and how they used this to assist them to look at staff deployment and find ways to mitigate any risks.

Requires improvement

Is the service safe?

All areas we observed were very clean and had a pleasant odour. Staff were observed to wash their hands at appropriate times and with an effective technique that followed national guidelines.

We saw that personal protective equipment (PPE) was available around the home and staff explained to us when they needed to use it. We spoke with the housekeeper who told us they were able to get all the equipment they needed. We saw they had access to all the necessary control of hazardous substances to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely.

We saw records to confirm that regular checks of the fire alarm were carried out to ensure that it was in safe working order. We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, fire extinguishers and portable appliance testing (PAT). This showed that the provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We saw that the water temperature of showers, baths and hand wash basins in communal areas were taken and recorded on a regular basis to make sure that they were within safe limits.

We found recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the home. We saw evidence to show they had attended interview and the service had obtained information from referees. A Disclosure and Barring Service (DBS) check had been completed before they started work in the home and this included the additional checks required when people were in contact with children. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

Requires improvement

Is the service effective?

Our findings

We found that staff had completed an in-depth induction when they were recruited. This had included reviewing the service's policies and procedures and shadowing more experienced staff.

All the staff we spoke with told us that they were supported in accessing a variety of mandatory training and learning opportunities. One member of staff said, "We get lots of training and I find it is all really helpful." Staff were able to list a variety of training that they had received in the last few months such as moving and handling, infection control, meeting people's nutritional needs and safeguarding. We confirmed from our review of staff records and discussions that the staff received a wide range of mandatory training and condition specific training such as working with people who had complex physical health needs and PEG feeding.

However the registered provider had failed to equip staff or employ staff with the skills needed to work with people with mental health needs or to work with people who displayed behaviours that challenge.

At the time there were eight people in the service with these conditions and two people could display behaviours that challenge. One person we observed shouted out and appeared distressed but we saw that most staff would avoid engaging with this person. We observed that one support worker did work well with this person. We also found that a registered nurse for people with learning disabilities who had previously working in forensic settings was very knowledgeable and able to support this person in a caring and considerate manner. None of the other staff had received any training around working with people who had complex mental health needs that were long standing or associated with their acquired brain injuries and neurological conditions.

Tthe registered provider advertised the home as offering a specialist 'Step Forward' rehabilitation service catering for people with brain injury and a range of other complex neurological conditions and disabilities. We found however that they had never provided any form of training for staff around the specialism. The registered manager had asked the registered provider to obtain this training for the whole staff team. However this training had not been provided.

It is a requirement that staff are equipped with the skills and knowledge needed to meet the needs of the client group being provided a service to and that this is completed both prior to opening a service, as part of induction and as ongoing mandatory training. This ensures safe care and treatment is delivered to people.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found that some people who had difficulty making decisions were under constant supervision; and prevented from going anywhere on their own. We found that that staff were unclear as to who was subject to a Deprivation of Liberty Safeguard (DoLS) authorisations. DoLS is part of the Mental Capacity Act (MCA) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

We found that one person who was said to be subject to a DoLS authorisation was not as it had expired. Staff had only noticed this was due to expire some four days prior to the expiry date and so had put the application in then instead of the recommended 28 days beforehand. We found that four of the care records we reviewed indicated people lacked capacity and they were under constant supervision but there were no DoLS authorisations in place or evidence to suggest applications had been sent.

We found that the registered manager was aware of the recent Supreme Court ruling, which required that anyone who lacked capacity and who was under constant supervision and not allowed to leave the building needed to be subject to a DoLS authorisation. However all of the appropriate applications had not been made. We found that staff kept people under constant supervision and did not ensure people were free to come and go despite the DoLS authorisations not being in place. We found that no 'best interest' meetings had been held for these people to determine if the practices they followed were the least restrictive and appropriate whilst applications for DoLS were being made.

We found that the staff were not aware that people subject to DoLS authorisations had the right to object to this restriction and make representations about the DoLS to the Court of Protection.

Requires improvement

Is the service effective?

This was a breach of Regulation 13 (5) (Safeguarding service users from abuse and improper treatment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since March 2015 we have been notified about three people being subject to DoLS authorisation but we found that more people had been subject to DoLS authorisations.

This was a breach of Regulation 18 (Notifications of other incidents) of The Care Quality Commission (Registration) Regulations 2009. This is being dealth with outside of the inspection process.

People's needs were assessed and for the children and people with complex physical health care conditions and their care was delivered in line with their individual care needs. The staff working with these people, particularly in the children's service were very skilled and competent. But because the registered provider failed to equip staff with the skills needed to work with people with mental health needs staff failed to adequately assess the needs of these people or design appropriate care plans.

The care plans showed evidence of risk assessments, assessed needs, plans of care that were underpinned with evidence based nursing; for example people who used a range of specialist mobility equipment and breathing aides. But this depth of knowledge was not mirrored for the specialist service they were providing to people who had acquired brain injuries and neurological conditions, mental health needs or for the rehabilitation service being provided.

We saw that lots of information was recorded in the daily records but staff did not appear to use this to assist them to evaluate whether the care plans remained appropriate. We found that staff on the whole had a good understanding of people's needs and had altered the way they worked to meet peoples needs. However they did not use this knowledge when writing care records and they did not ensure pertinent information about people's specific, individual needs was recorded. This was particularly evident in relation how they worked with people who displayed behaviours that challenge.

We saw that MUST tools, which are used to monitor whether people's weight is within healthy ranges were being completed. But found at times these were not accurately completed or if some one refused to be weighed an alternative method for calculating if the BMI was within a healthy range was not used. From recent safeguarding alerts we also noted that if people had lost weight additional monitoring had not occurred and records did not clearly show that staff had taken appropriate action to refer to dieticians to ensure prompt action was taken to determine reasons for this and improve individual's dietary intake. We found that this type of issue had been raised previously by visiting professionals but persisted.

We found that the registered manager system for monitoring the service had failed to identify these issues or ensure remedial action led to sustained improvements.

We found that the registered manager was taking action to make sure staff adhered to the requirements of the Mental Capacity Act 2005 and the associated Code of Practice. Staff had received Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards training. However the care records were not compliant with the Mental Capacity Act 2005 requirements.

The care records we reviewed did not contain appropriate assessment forms for staff to complete when determining a person's capacity to make decisions. Care records also did not contain information about whether efforts that had been made to establish the least restrictive option for people, or record the ways in which the staff sought to communicate choices to people, for instance via people going with the staff or pointing to what they wanted. Neither was there an appropriate template for recording 'best interest' decisions.

We saw that care records showed that at times relatives not the people themselves had signed care plans. We were unclear why this was occurring and under what legal framework this action was being taken. Where relatives made decisions the care records did not to show whether relatives had become Court of Protection approved deputies, or if they had enacted power of attorney for care and welfare or finance or if they were appointees for the person's finance. Relatives cannot make decisions about care and welfare unless they have the legal authority to do so and the person lacks the capacity to make these decisions for themselves.

The registered manager provided information to show that in June 2015 they had raised that the appropriate paperwork and information was needed with the registered

Requires improvement

Is the service effective?

provider. We found that the registered provider's system for making changes to the system was so cumbersome that this matter had yet to be addressed at the time of the inspection

We found that the audit tool the provider used did not check if the information in the care records reflected people's current needs and if the care documentation meet the needs of the service. Had the audit tool been more effective these gaps would not have been evident.

This was a breach of Regulation 12 (Safe care and treatment) and 17(1) (Good Governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people and relatives we spoke with told us they thought the staff were excellent and had ability to provide a service, which met their needs. We heard that relatives were confident that each person was effectively supported. They told us that the staff worked very closely with them and always kept them informed of any changes in their relative's condition.

We observed that on the whole people received appropriate assistance to eat however, staffing pressures on the second day of our inspection led to one person waiting some 10 minutes for support them eat their meal. This was only provided because their relative visited and provided the assistance. Also we found that staff failed to correctly record what people ate and drank.

People said, "I have a care plan that I look at sometimes and I am well looked after each day, my family and I are happy with my care." And, "I came here from the hospital after I was beaten up I want to go to college to take my mind off things I don't have enough to do really I have been here nearly three weeks I went for some fresh air yesterday when he went for a fag." And, "The staff write things in my file all the time but I don't read it."

Staff we spoke with during the inspection told us they regularly received supervision sessions and had an annual appraisal. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. We were told that an annual appraisal was carried out with all staff. We saw records to confirm that supervisions and appraisals had taken place. We saw that competency checks had been completed with nurses and those staff who assisted people to eat.

We saw records to confirm that people had regular health checks and were accompanied by staff to hospital appointments. We spoke with the visiting GP and found that they provided a clinic twice a week and would see anyone who was unwell. They also told us that they sent their nurse practitioners to the home if staff were struggling to obtain bloods or needed assistance. Also we found that the local consultant for spinal injuries visited once per week. We found that a consultant psychiatrist and the nursing from Walkergate Hospital were available if staff needed advice. This meant that people obtained the health and social care that they needed.

Requires improvement

Is the service caring?

Our findings

Staff we observed showed a caring and compassionate approach to the people who used the service. Staff spoke with great passion about their desire to deliver high quality support for people and were extremely empathetic. We found the staff were warm, friendly and dedicated to delivering good, supportive care. However we observed and found that when people's needs were outside their scope of expertise they were unable to successfully meet these individual's needs.

We observed one person became very distressed and was repeatedly shouting out but all bar one staff member actively avoided this person and appeared scared of them. We also found that another person regularly made unsubstantiated allegations about the staff and again all bar one staff member were reluctant to work with this person. The staff member who did go to the distressed individual was able to reduce their anxiety and also was comfortable working with the other person.

We also observed that one person lay asleep on the corridor floor but staff did not go to the person to assist them to move to a more comfortable place. We were told that this person could become distressed if woken so staff were reluctant to do this yet the position they were lying in was problematic as people walking by could trip over them.

We found that the lack of appropriately trained staff had led to there being a lack of compassionate and considerate care for people who displayed challenging behaviour. We found the staff that had no previous experience of working with this client group appeared anxious and lacked the confidence to work with people. We found that the registered provider had failed to identify the need for staff toi have this skill set before commencing the operation of the home.

Since opening the home has supported people with very challenging behaviours and this had led to staff, including the registered manager being assaulted and the police being called. Despite these incidents staff had not received any training around the use of physical interventions, working with people who display challenging behaviours or working with people who have complex mental health needs and personality disorders. This lack of appropriate training and failure to employ registered mental health nurses had led to staff avoiding the people who displayed behaviours that challenged.

This was a breach of Regulation 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The home is said to be specifically designed to meet the needs of people with complex physical health conditions. However lt was noticeable though that despite this service design the registered provider had not ensured the door bells to each unit were at wheelchair height and provided not assisted technology such as sensors to automatically open people's bedroom doors as they came up to them. Thus people were always placed in the position of having to call for assistance. This meant the provider did not actively promote people to be as independent as possible.

Also we found that although the staff were very skilled at working with people who experienced breathing difficulties only one floor had been set up to supply oxygen, which meant this service was limited because of the available resources. So only ten people could be accommodated at the service yet a further 30 places could have been available if this equipment was in place.

People we spoke with said that improvements were needed as although staff were caring at times there were insufficient staff at times to meet their needs. Other people told us they were very happy with the care and support provided at the service.

People said, "I get looked after very well", "I like living here it is much better than where I lived before" And "The staff are all nice nothing is to much trouble for them but I think sometimes they are short staffed." And, "The staff are nice and the food is very nice and we have plenty choice each day." And, "Me and the staff joke about all sorts of things."

Observation of the staff showed that they knew the people very well and for the people with complex physical health conditions and the children could anticipate needs very quickly; for example assisting the children to enjoy playtime and people to meet their care needs. The staff

Requires improvement

Is the service caring?

were skilled in communicating with people who experienced difficulties. Staff could readily interpret what people said and always checked that they had heard before moving away.

The registered manager and staff that we spoke with showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people very well, including their personal history preferences, likes and dislikes and for the majority of people had used this knowledge to form very strong therapeutic relationships. We found that staff worked in a variety of ways to ensure people received care and support that suited their needs.

The staff we spoke with explained how they maintained the privacy and dignity of the people that they cared for and told us that this was a fundamental part of their role. Staff said, "I always treat people with respect." We saw that staff knocked on people's bedroom doors and waited to be invited in before opening the door. The service had policies and procedures in place to ensure that staff understand how to respect people's privacy, dignity and human rights.

People were seen to be given opportunities to make decisions and choices during the day, for example, what to have for their meal, or where to sit in the lounge.

The environment supported people's privacy and dignity. All the bedrooms we went into contained personal items that belonged to the person such as photographs and pictures and lamps.

The registered manager had ensured people had access to advocacy services where appropriate. Advocates help to ensure that people's views and preferences are heard.

Requires improvement

Is the service responsive?

Our findings

People told us how the staff provided a service that aimed to meet their needs and felt the home provided a personalised service. However this was compromised at times by the ability to access staff and the staff's lack of skills around working with people who displayed behaviours that challenge.

The registered manager discussed how they had worked with people who used the service to make sure the placement remained suitable. They discussed the action the team took when people's needs changed to make sure they did everything they could to make the service a supportive environment and ensure wherever possible the placement still met people's needs. They also discussed the admission criteria and how they were able to determine when people's needs could not be met. However we found that four placements had been terminated in recent months and this had occurred because staff did not have the skills to meet the needs of people who displayed behaviours that challenge.

We found that the care records reflected people's current physical health care needs. We found that each person had a detailed assessment, which highlighted these needs but improvements were needed to ensure they accurately captured people's needs associated with their mental health. The assessment had led to a range of support plans being developed, which we found from our discussions with staff and individuals met the needs of people with physical health care needs but again not their mental health needs. We found that at times as people's physical health care needs changed their assessments, support plans and risk assessments were not updated.

We discussed the problems in the care records with the registered manager and that they related to the staff not being equipped with the skills needed to develop appropriate plans for people who displayed challenging behaviour. They told us this issue had been raised with the registered provider and some training was planned in the New Year but none had yet been provided.

This was a breach of Regulation 12 (Safe care and treatment) and 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff were also able to show us the complaints policy which was in the office on all floors. We looked at the complaint procedure and saw it informed people how and who to make a complaint to and gave people timescales for action. People told us that they knew how to raise a complaint and found that these were looked at but it took a long while to get a response and resolutions were not sustained. We were also told that the registered manager preferred people to raise concerns rather than make formal complaints. Staff were able to explain what to do if they received a complaint but commented that they rarely received them. However, we found that people had raised concerns with the staff but these were not treated as complaints.

We saw that when complaints had been made in the last 12 months the registered provider had thoroughly investigated and resolved them. But as people's concerns were not treated as complaints these had not been investigated. We found that the registered manager needed to improve the system used for identifying and raising complaints.

We saw that people were engaged in a variety of activities. From our discussion with the activity coordinator, physiotherapists and occupational therapists we found that the activities were tailored to each person. People told us that these staff were fantastic at their job.

People said, "The staff look after me well they talk to me and are good fun I go to the gym each day in a morning and after dinner." And, "The staff help me all the time but they encourage me to do things for my self." And, "I have physio each day it is doing me good I think."

We found people were engaged in meaningful occupation at various points throughout the day. We observed people engaged in arts and crafts projects and most people went to the gym. Other people went to college or out into town. All the people we spoke with were told us that they enjoyed the activities that were on offer.

We saw that staff promptly responded to any indications that people were experiencing problems or their care needs had changed. We saw that the nurses routinely discuss people's needs with the visiting GP and consultant for spinal injuries.

Inadequate

Is the service well-led?

Our findings

On the 8 December 2015 the local media reported that Kiero Limited had gone into administration and we were contacted by the local authority and registered manager who also informed us of this development. On the 9 December 2015 the administrator formally notified us that they were now overseeing the operation of the home but prior to this the registered provider had not informed us of the difficulties they were experiencing or that the home was going into administration. The registered provider has during this period contacted us about other matters such as a registration application on 4 December 2015 but not to notify us of that they were going into administration. We found that the lack of information sharing with us, local commissioners and more importantly the people who used the service showed a lack of candour and a failure to be open and transparent.

We found that the registered provider had altered the type of service they intended to provide. Since opening in 2014 they had added children's services and commenced accepting people who were detained under the Mental Health Act 1983 (amended 2007) and on section 17 leave to the home. We had not received updated statement of purposes when these changes occurred. In terms of the children's provision, in February 2015 Ofsted informed us this was being provided and our registration team visited to home with the Ofsted inspector to confirm that this was not impacting on the service or that the home now needed dual registration.

The registered provider suggested this lack of notification was related to a problem with CQC systems. However we have received other notifications such as changes to registered manager over the course of the year. The only amended statement of purposes we received were in August, September and October 2015, which related to the removal of diagnosis and screening procedures from the registration and that the registered provider intended to seek to add more places at The Gateway. This was the first document that they referred to the children's provision and providing services for people on section 17 leave from mental health hospitals.

At registration the statement of purpose stated "The Gateway provides a specialist 'Step Forward' rehabilitation service catering for people with brain and spinal injury and a range of other complex neurological conditions and disabilities. The service also benefits from a medium stay facilities specialising in the care of clients with neurological conditions, some of whom may require end of life care; and state of the art health club facilities on site, which include a large hydrotherapy pool gym, café,, beauty and holistic therapies which provide a valuable social context. The centre also an information centre where clients their family and visitors can obtain information and support."

When we first started the inspection in November 2015 the registered manager told us that the registered provider was making bids to provide services to allievate winter pressures for local Trusts and also to operate a learning disability service. Later the registered provider told us they were reviewing the service and had not completed any tenders. The home is not registered to provide services for people with a learning disability and we had not been requested to add this to their service user bands, therefore no tenders to provide learning disabilities services could be completed until this had been change had been made.

This was a breach of Regulation 20 (1) (Duty of Candour), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and of Regulation 12 (Statement of purpose) and Regulation 15 (Notice of changes) of The Care Quality Commission (Registration) Regulations 2009.

We gave feedback on 5 November 2015 highlighting that we had not received statutory notifications about a number of events. The registered manager stated that they had sent us notifications such as when they were assaulted, when people who used the service raised concerns about their treatment and when the police were called so we asked that evidence was provided to confirm this assertion. The registered provider again questioned whether this was to do with CQC's systems rather than their failure to report. Prior to completing the finalised report we provided the registered manager with the relevant regulations and they confirmed that they had not been submitting all of the required notifications.

On 23 November 2015 the registered manager provided us with nine copies of the notifications, which they told us had been sent but were not on our system. These dated back to February 2015 and covered incidents of shortages of staff, the police being called and accidents and other than one related to staff shortages they were already on our system. None of the copies of notifications they supplied were in relations to the allegations one person made, the assaults on staff and the registered manager and other such

incidents. Post March 2015 other than three notifications about Deprivation of Liberty Safeguard (DoLS) authorisations and an email stating two notifications were being made, that were never received. Following receipt of a copy of regulations the registered manager submitted a wide range of notifications that had been missing.

The registered provider failed to meet Regulation 18 (Notifications of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

Albeit the provider had systems for monitoring and assessing the service we found that these had not assisted the registered manager to identify gaps in the care practice or make improvements. In June 2015 the registered manager had noted issues such as the care record templates not being compliant with the requirements of the Mental Capacity Act 2005 and the medication policy not being suitable for this service. However, the registered providers systems for changing these were so cumbersome that the actions that had been requested still had not resulted in changes.

The registered provider systems for changing practices we found was modelled on those used by NHS Trusts so involved request for policy and document changes to go to a board on a quarterly basis but as the provider only operated two services this model was inappropriate. The services were radically different in design and the policies for medicines were completely tailored to their other service so had staff needing to go to the top floor to obtain controlled drug, which was impractical. We found that for this and other policies did not match the layout and operation of The Gateway.

Alongside this, the audits failed to identify when care records were not accurately reflecting people's needs; that Deprivation of Liberty Safeguard (DoLS) authorisations had expired and that authorisation documents were not kept in the care records' and conditions from community treatment orders and DoLS needed to be reflected in the care records.

We found that the registered manager clearly understood the principles of good quality assurance but they did not actively monitor the service and use the information to make improvements. Despite problems with recording practices being repeatedly highlighted by visiting professionals the registered manager had not rectified the problems. They did identify issues but the sytems they had in place failed to ensure practices were improved. The registered manager told us they expected the nurses to be accountable for the practices. Therefore the registered manager had delegated all of the audits to the nurses and expected them to check that improvements were made and sustained. We found no evidence to show that the registered manager checked themselves that action was taken.

Also we found the registered provider's governance system failed to recognise that staff lacked the skills and knowledge for the specialist mental health services being advertised. This had led to staff being unable to meet the needs of people whose behaviours may challenge and to lack the skills needed to work with people who maybe impulsive or have difficulty regulating their emotions.

The registered manager had raised this gap with the registered provider but action had not been taken in a timely manner. No registered mental health nurses had been employed and although plans had been made to provide this training this was not until the New Year. The training we found that was planned was far to basic and superficial to actually enable staff to work with people who had the complexity of needs associated with their mental health.

For a service to advertise as a specialist for treating any health related conditions as a part of the service design it would be expected that they ensured staff had the capabilities needed to provide this specialism. It was noticeable that they had provided a wide range of very specialised training for staff working with people who had complex physical health care needs and children. So it was difficult to understand why this approach had not been adopted in relation to services they provided for people with acquired brain injury and neurological conditions.

This was a breach of Regulation 17 (Good governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On the whole people we spoke with who used the service spoke highly of the staff and the registered manager. They told us that generally they thought the home met their needs but improvements were needed.

We saw that the registered manager held meetings with the people who used the service, relatives and staff, which provided a forum for people to share their views.

Inadequate

Is the service well-led?

The staff we spoke with had a pride in the home that they work in. Staff said, “I am proud to work here and this it is a very good home” And, “I love working here.” And, “I think I was very lucky to get a job here as it is really stretching me and I have learnt so much.” All the staff members we spoke with described that they felt part of a big team and told us they found the registered manager was very supportive.

However, we observed that when staff asked the registered manager or assistant manager for additional support or undertake tasks this was not acted upon. Also during all our visits we found that the registered manager predominantly remained on the administration floor rather than on the units.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Staff did not have the skills and experience to meet the needs of people who had complex mental health needs.** **Regulation 12 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Staff were not raising safeguarding alerts around the impact of staffing levels on people's ability to receive their personal care in a timely manner.** **Staff were not ensuring that people were not inappropriately subject to deprivation of liberties or that DoLS authorisations were sought.** **Regulation 13 (1) (5)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **People who use services and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place.** **Regulation 17 (1)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of suitably qualified and experienced staff to consistently meet the needs of people who used the service. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The registered provider failed to act in an open and transparent manner around the proposed changes to the operational structure of the home. Regulation 20 (1)