

All Saints Care Limited

The Gateway Respite

Inspection report

580 Sticker Lane
Bradford
West Yorkshire
BD4 8RD

Tel: 01274737258
Website: www.allsaintscare.co.uk

Date of inspection visit:
15 June 2021
16 June 2021

Date of publication:
13 August 2021

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

The Gateway Respite is a residential care home providing personal and nursing care to older people, people living with dementia and people with physical disabilities. The service provides short term and long-term care and accommodates up to 28 people in one adapted building. At the time of the inspection 14 people were using the service.

People's experience of using this service and what we found

People were not always safe. Risks to people were assessed but care was not always delivered as detailed in their risk assessments and care plans. There were not enough staff available to meet people's needs and keep them safe. Improvements had been made in relation to managing medicines and safe systems were in place. The manager and staff understood safeguarding procedures and reports to the local authority were made as needed. Systems were in place to make sure people lived in a safe and comfortable environment.

Some people told us their relatives were at risk of social isolation due to spending long periods of time alone in their rooms. People were not always supported to engage in meaningful activities. One person who used the service told us there was not anything to do during the day. People were not able to access the enclosed garden area independently and one family member told us their relative was very rarely supported to go into the garden. People gave us mixed responses in relation to how the service communicates with them. Some felt there had been improvements whilst others felt they were not responded to.

Systems for auditing quality and safety within the service had been improved but had not identified issues we found during the inspection. People had mixed views about the management team. Some expressed confidence in the manager and felt they had been effective in making improvements whilst others had concerns about the management team.

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 found the service had robust systems in place.

Care plans had been improved. They contained more detail and had been reviewed monthly. End of life plans had also been introduced.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was inadequate (published 5 December 2020).

Why we inspected

We undertook this focused inspection to check they had followed their action plan and to check if they now

met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements.

The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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

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, staffing, person centred care and governance.

At this inspection, not enough improvement had not been made and the provider was still in breach of regulations 12 (Safe Care and treatment), regulation 9 (Person centred care), regulation 18 (staffing) and regulation 17 (Good governance). Please see the action we have told the provider to take at the end of this report in relation to regulations 9, 18, and 17.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Gateway Respite on our website at www.cqc.org.uk.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place or keep services 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, 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?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

The Gateway Respite

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 Respite 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 manager registered with the Care Quality Commission. The manager said they were in the process of registering with the Care Quality Commission. This means that, once registered, 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 on our arrival from the service's car park. We do this to check the COVID-19 status of the service before entering.

What we did before the inspection

We reviewed information we had received about the service which included feedback from the local authority. This information helps support our inspections. We used all of this information to plan our inspection.

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.

During the inspection

We spoke with five people who used the service and seven relatives about their experience of the care provided. We spoke with seven members of staff including the manager, senior care workers, care workers, the chef and activities staff. Discussions with people who used the service and staff were conducted on site. Discussions with relatives were conducted either on site or via telephone calls.

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service were reviewed.

After the inspection

We continued to seek clarification from the manager to validate evidence found. We looked at records including training data, quality assurance records and feedback from people who use the service and their families.

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 manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people were not appropriately managed which placed them at risk of harm or injury.
- One person's care plan stated they should be observed for thirty minutes after eating their meal as they tended to store food in their mouth which put them at risk of choking. We observed the person was alone in their bedroom with a large amount of food still in their mouth. This meant they were significantly at risk of choking.
- A further two people being cared for in bed had been left alone to eat their meal. They also had food stored in and seeping from their mouths.
- We saw another person being cared for in bed whose Malnutrition Universal Screening Tool (MUST) identified them as being at high risk of malnutrition, unable to comfortably reach their meal which was on a bedside table away from the bed at both breakfast and lunch. The person was unable to communicate their wishes to us but, as we passed their room, pointed to their lunchtime meal for some assistance. They were alone in their room.
- One person, whose (MUST) identified them as being at high risk of malnutrition, left the dining room several times at lunch time. Staff brought the person back to the dining room and sat them in a lounge chair with a small table in front of them and although they encouraged the person to eat their meal, they ate very little. The person's care plan for eating and drinking stated "(Name) has difficulty in sitting for long periods, to be offered finger foods". This did not happen and meant the person was at risk of not receiving the nutrition they required.
- One person being cared for in bed did not have their call bell within their reach. Staff said they should have had it close to them.
- People we spoke with gave mixed responses about whether they felt they, or their relative, were safe at the service. Some family members expressed concerns about their relative being at risk of social isolation.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

- Risk assessments had been reviewed regularly. For example, a person who was cared for in bed required more frequent positional changes to prevent further skin damage. Changes were made to reposition the person every hour instead of two hourly.
- People lived in a safe and pleasant environment. Checks had been carried out to make sure the building and equipment was safe.

Staffing and recruitment

At our last inspection the provider had failed to make sure there were sufficient numbers of competent staff available to make sure people were supported safely. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- There were not enough staff available to make sure people were supported with their meals safely.
- One person was walking around alone. They told us they were looking for someone to help them to go outside. No staff were available to support the person to go out.
- Another person spent long periods of time walking about alone. Inspectors had to alert staff that the person had been incontinent.
- One person told us they did not think some of the agency staff had the training or skills to keep them safe.
- When we asked a person who uses the service if there are enough staff they said, "No but the night staff get me up." They went on to explain if they do not get up early the day staff can be very busy, and they have to wait a long time."
- Cleaning staff were not available after 2.30pm and kitchen staff were not available after 4.30pm. This meant care staff would need to undertake any tasks needed in these areas.

This was a continued breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had recognised a need for more care staff between 4 and 10pm and an extra member of staff had been provided.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe use of medicines. This 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of this section of regulation 12.

- Peoples medicines were mostly managed safely. However, medicines related records were not always completed. On the current MAR chart for one person, a thickener to be added to fluids to ease swallowing problems was still listed as prescribed. However, a letter from their GP confirmed this should have been

discontinued ten weeks prior to the inspection.

- Handwritten MARs were not always signed by two members of staff to confirm dosage instructions had been transcribed accurately.
- There were no records of people's preferences to indicate how they wanted their medicines to be administered.
- Detailed guidance specific to each person on how to administer medicines prescribed to be given as and when people required them (PRN) had been updated since our last inspection.
- Instructions for medicines which should be given at specific times were available.
- There were appropriate arrangements in place for the management of controlled drugs.

Systems and processes to safeguard people from the risk of abuse

- The manager understood safeguarding procedures and reported concerns appropriately.
- The manager made safeguarding referrals in relation to the issues we had observed in relation to people being supported to eat safely.
- Staff had received training in safeguarding and knew what to do if they had concerns about people's safety.

Preventing and controlling infection

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

Learning lessons when things go wrong

At our last inspection there was a lack of learning and improving care. This was a breach of Regulation 17 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 this section of regulation 17.

- The manager analysed safeguarding events and liaised with the local authority safeguarding team for feedback about referrals they had made.
- Accident and incident reports were reviewed by the manager who completed a summary of steps taken in relation to the incident, any lessons learned and if there was a trend of similar incidents. Where the review indicated the need for review of the person's care plan it had been completed.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

At our last inspection the provider had failed to make sure people received person centred care. This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this section of regulation 9.

- Government guidelines in relation to Covid-19 has meant people were able to have more frequent visits from their relatives and we saw staff supporting visitors to make sure this was done safely.
- There were not enough staff available to spend time with people cared for in bed which meant they were often isolated for long periods.
- One family member told us "They don't motivate (relative), (relative's) in the room too long, (relative) needs to be out and getting out of (their) chair. (Relative) needs to be talking to people". Another family member told us "(Relative's) left a lot in (their) room. They went on to say it was affecting their relative's wellbeing.
- The activity coordinator told us there is an activity plan for people. However, nothing had been recorded for people who were cared for in bed.
- People were not able to access the garden independently. One family member told us their relative had only been supported into the garden on two occasions. On the day of the inspection the garden area was untidy with furniture not arranged for use. There was also a staff smoking area near the entrance to the garden where we saw an overflowing ashtray and cigarette ends and other rubbish on the floor. The manager sent us photographs of the garden which had been attended to later in the day.
- Government guidelines in relation to Covid-19 has meant people were able to have more frequent visits from their relatives and we saw staff supporting visitors to make sure this was done safely.

This was a continued breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Two activity coordinators had been employed recently and a small group activity took place during the morning which involved three people. However, one of the people did not engage with the activity. We saw another person having some one to one time with the activity co-ordinator.
- A new interactive activities board was delivered during our inspection.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection the provider had failed to provide appropriate care, support people to understand the care choices and design care to make sure people's needs were identified and met. This was a breach of Regulation 9 (Person centred care) 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 this section of regulation 9.

- Care plans had been improved following the outcome of the previous inspection. They contained more detail and had been reviewed monthly. Where people lacked capacity to make some decisions, we saw relatives had been involved and best interest decisions were recorded. For example, Consent to care and treatment forms had been signed and dated by a person's relative.
- End of life care plans had been introduced following the last inspection of the service. For example, one person had a funeral plan in place which gave information to staff about the persons wishes when they approached the end of their life. Another person's care plan showed evidence that their end of life wishes had been discussed with relatives and the relative had dated and signed the record.
- There was evidence of completed 'Do not attempt resuscitation' (DNAR) orders that had been discussed with relatives, where people lacked capacity.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans included a section which identified people's communication needs. For example, one care plan stated that flash cards would be used to gain the persons wishes. It also gave instructions to staff to "Speak quietly and calmly" giving the person time to respond to questions. The plan had been reviewed monthly.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to improve care in response to complaints or concerns. This contributed to the breach of Regulation 17(Good governance) 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 this section of regulation 17.

- Documentation was in place to show that the manager followed up and responded to complaints made to the service.
- One relative told us they didn't know what was happening with a complaint they had made.

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 now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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;

At our last inspection the provider had failed to make sure systems for auditing the safety and quality of the service were effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Although we found some improvements had been made since the last inspection, shortfalls were identified at this inspection and the provider remained in breach of four regulations across three key questions. Although the overall rating has improved to requires improvement, the service remains in special measures.
- Auditing systems had failed to identify issues in relation to people's safety, staffing and supporting people to avoid social isolation
- There had been some improvement in systems and processes for monitoring quality and safety. For example, medicines audits had been effective in driving improvement and audits not in place at the last inspection including mattress, 'Deprivation of Liberty Safeguards' (DoLS) and infection control audits had been completed.
- The service did not have a manager registered with CQC. The manager was in the process of applying to CQC for registration. The manager told us they were well supported by the provider.

Failure to identify issues through quality assurance processes meant people were at risk of receiving poor quality care. This was a continued breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems were in place for obtaining the views of people who used the service and their families. Results of recent satisfaction surveys were generally positive.

- We received mixed responses from people who used the service and their family members in relation to the management of the service. Some people felt the manager was making positive improvements, one said, "I've met the manager, I'm in contact and (manager) seems very caring and approachable". However, others felt communication was poor. One person said "No, I don't get follow-ups, I don't get phone calls. Trust is gone."
- One person told us they couldn't speak out because they were "scared (the service) will lose more staff if I say something."
- One person expressed concerns about the conduct of the provider.
- Care records showed the service sought advice and support from other agencies and health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive the person centred care they needed to avoid isolation.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for auditing quality and safety had failed to identify issues that meant people were at risk of receiving poor quality care.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available to make sure people's needs were met safely.

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 Systems were either not in place or robust enough to demonstrate safety was effectively managed

The enforcement action we took:

Warning notice