All Saints Care Limited

The Gateway Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 16 and 17 February 2016. A further visit was made as part of the inspection on 17 March 2016 after we received information of concern about the service. The evidence from the additional visit has been included at the end of each relevant domain within this report. All visits were unannounced. This was the first inspection of this service since it's registration with the Care Quality Commission in October 2015.

The Gateway Care Home provides personal care for up to 92 older people, some of who may be living with dementia or have a physical disability. Accommodation is provided in single en-suite bedrooms over three floors. There are passenger lifts to all floors. Each floor has its own dining room, lounge areas and bathrooms. The main kitchen is situated on the ground floor.

The home does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to 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.

Staff had an understanding of safeguarding and told us about events in the home which they understood should be reported. However we found safeguarding incidents had not been referred to the local authority safeguarding team. Risks to people were not well managed which meant people were at risk of harm and poor standards of care. Staff failed to answer call bells.

Medicines were not managed safely and some people had not received their medicines as prescribed.

There was a lack of appropriate personal protective equipment such as gloves and aprons for staff to maintain effective infection control procedures. Staff hand washing facilities were not in place as required.

Staffing levels often fell short of those the provider's representative had told us were in place and were often insufficient to meet the needs of the people living at the home. Staff had not received the training and support they needed to fulfil their roles. Staff recruitment processes were safe but staff turnover levels were very high.

The legal framework relating to the Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS) was not understood by all staff and was not being followed, although some applications had been made for DoLS authorisations these were not being prioritised based on need or risk.

Food at the home was good and choice was available. However people were losing weight and were not receiving the diet and fluids they needed to maintain their health.

People said staff were good and we witnessed some caring interventions. However, we found some

practices undermined people's privacy and dignity and showed a lack of respect.

Care records were not sufficient to make sure people's needs were met. Care was not planned or delivered with a person centred approach.

Some activities were provided but were not research based to make sure they were appropriate. Some activities involved using toys designed for very young children which could be demeaning to people living at the home.

We found management systems were not robust.

We identified 12 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.
You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems for managing medicines were not safe.

Systems and processes were not in place to keep people safe.

There were not enough staff available to meet people's needs safely.

Is the service effective?

Inadequate

The service was not effective.

Staff had not had the training or support they needed to fulfil their roles.

People's healthcare and nutritional needs were not met.

People's consent to care and treatment was not sought and people were deprived of their liberty without lawful authorisation.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and patient in their approach to people but lacked the skills and knowledge to support people living with dementia.

People's privacy and dignity needs were not always met.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not planned or delivered in a person centred manner and people's healthcare needs were not always met.

People had little access to appropriate meaningful activities.

Complaints were not managed well.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective leadership and management.

Poor governance systems meant issues were not identified or resolved.

Opinions of people involved with the service had not been sought.

The Gateway Care Home

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 was planned to check 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.

This inspection took place on 16 and 17 February 2016. A further visit was made as part of the inspection on 17 March 2016 after we received information of concern about the service.

The inspection team consisted of five adult social care inspectors and an inspection manager over the three visits.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. On this occasion we had not asked the provider to complete 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.

On during our inspection we spoke with five people who lived at The Gateway Care Home, four visitors, the provider, two managers, the deputy manager, a team leader, two senior care assistants, four care workers, the activities organiser, the chef and a district nurse. We also spoke with a person acting as a consultant for the service. This is a person who advises the provider about the running of the service. This person also arranged the delivery of training for the service through their own company.

We spent time observing care in the lounges and dining room and observed the midday meal. We looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; seven people's care records, three staff recruitment files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We asked people living at the home about how they received their medicines. One person said "The staff who give medication have to break off to do other things. I've had a mistake with cream when they gave it to someone else" They also said "I get my medication ok when I first come down. If I don't ask them for them I don't always get them. I find it difficult getting my last tablets of the day". They went on to say "It takes all morning for them to give out the tablets and then they have to start again".

We looked at how people's medicines were managed by the service. We found medicines were stored within locked treatment rooms. Medicines were administered from lockable trolleys. Medicines classified as controlled drugs were stored correctly; however, we found there were two controlled drugs registers in use for no apparent reason and this could lead to mistakes. We checked a random sample of controlled drugs stock against the records and found there were correct. However, in one person's records we saw a pain relief patch which should have been changed every Friday had been missed one week. It had not been changed until Sunday when the person had raised it with one of the staff. This meant the person was likely to have experienced unnecessary discomfort.
The medicines fridge was in the treatment room, we found the temperate checks which should have been recorded every day had not been recorded since 21 January 2016.

We looked at people's medication administration records (MARs). Some people had printed MARs which included information about their medical conditions and any known allergies, there were also photographs to help staff identify people. We found other people had hand written MARs and no photographs. When MARs are hand written they should be checked and signed by two staff to reduce the risk of transcribing errors. We found this was not consistently done, in some cases the handwritten MARs had not been signed and in others they had only been signed by one person. We also found the amount of medicine received into stock was not always recorded which meant it was not possible to check the stock balances against the administration records.

When people are prescribed medicines to take "as and when needed" (PRN) it is good practice to have guidance in place to make sure staff know when to administer the medicine and to make sure it is used consistently. These are commonly referred to as PRN protocols. There was a file for PRN protocols but it was full of blank forms which meant there was no guidance in place for staff. In addition, we found some people had variable doses of PRN medicines prescribed. For example, people could have one or two Paracetamol up to four times a day. In addition to an absence of guidance about how many tablets should be administered we found staff were not recording how many tablets had been administered. This meant the stock balances could not be checked accurately against the records. In one person's records we found there was a discrepancy of between 27 and 54 tablets between the recorded stock balances and those signed for as given.

We found people were receiving medicines which were not on their current MARs. For example, one person had been administered antibiotics which had been prescribed for them but were not on the MAR and another person was receiving oxygen therapy which was not on their current MAR.

We found one person had a box of prescribed pain relief tablets in the medicine trolley but this medicine was not the MAR. In the daily care records we saw the person had been asking for pain relief but it had not been given because it was not on the MAR. A handover record for this person said 'up all night with back pain said no medication'

We found examples of people who not received their prescribed medication because it had run out and a new supply had not been ordered on time. We found one person had missed most of their medicines on the day before the inspection and the new supply had still not been received by lunchtime on the day of the inspection. We found another person had a tablet which was to be taken once a week, on Saturday. It had not been administered on the Saturday prior to the inspection because there was none in stock. There was still none in stock on the day of the inspection which was Tuesday.

The dispensing instructions for some medicines stated they should be given at particular times in relation to food. We found there were no systems in place to make sure this happened. Medicines which should be given 30 to 60 minutes before food were given at the same time as other morning medicines. This was typically between 8.30am and 10.30am depending on where the medicine round started and how many times the senior carer was interrupted. One senior carer was responsible for administering all the medicines, on the day of the inspection there were 34 people living on the home and they were accommodated on three floors. On the second day of our inspection we saw morning medicines were still being administered at 11.30am.

There was no system in place to make sure topical medicines, cream and lotions, were managed correctly and safety. On the MARs we saw when creams had been prescribed the only instructions were they should be administered by staff. There was no other information to guide staff on when and where to administer the creams and there were no signatures to show they had been administered. There were body map forms, which are used to provide details of where to apply creams and when, with the MARS but they contained no information to guide staff on how to use the creams. We saw a number of creams in people's bedrooms which had the dispensing pharmacy label removed. This meant it was not possible to see who the cream had been prescribed for. We saw in one person's hand over notes they were 'not happy as no cream Piroxicin.'

We looked the records of one person who was receiving Warfarin. The person had regular blood tests and the dose was adjusted. The person had a "Yellow Book" which was their individual record of how much Warfarin they should receive. We found staff were following the instructions correctly, however, when the dosage required a half tablet they had no accurate way of halving the tablet, they simply had to break it half as best they could. This meant they could not be sure the person was getting the exact dose on every occasion.

Staff told us none of the people living at the home were being administered medicines in a disguised or hidden form.

Two people who lived at the home were administering their own medicines. One person had signed an agreement to keep the medicines safely locked away, the other person had not. There were no documented risk assessments and there was no information about how staff were supporting or monitoring the process of self-administration. We saw the medicines policy stated 'Risk assessments will be put in place on an individual basis for customers who require support with the ordering, storage or administration of their medication.'
When we looked around we saw one of the people who was administering their own medicines had a large quantity of tablets which they told us they were no longer taking. These medicines were in an unlocked

drawer and were visible to anyone entering the room. The person told us they did not always lock their bedroom door when they went out. The deputy manager was with us when we found these tablets. When we returned the next day we found these tablets had not been moved.
The provider's medication policy did not make any reference to NICE guidelines on managing medicines in care homes, published in March 2014. On the first page of the providers medication policy there was a reference to another organisation unrelated to The Gateway care home.

The senior care worker who was administering medicines on the day of the inspection told us they had done training on the safe management of medicines with a former employer. They had not received any training on medicines at The Gateway Care Home but they had shadowed another senior care worker before being allowed to administer medicines unsupervised. We asked for details of all the staff who had been trained on the safe management of medicines and the list showed four staff who worked at the home were training in the safe management of medicines. Two were care workers, one was a night senior carer and the other was a team leader who was mainly office based.

We were given a copy of a medication audit carried out in the home and dated 11 February 2016. The audit guidance notes referred to the National Minimum Standards and regulations which are no longer in force. The audit also referred to the Royal Pharmaceutical Society guidelines for managing medicines in social care. These guidelines are no longer used in care homes; they were replaced by the NICE guidelines in April 2015 when the new regulations came into force. The audit had not been given a score although there was provision for this on the audit form. The audit checklist had been ticked "yes" to show fridge temperatures were recorded daily. However, when we looked at the fridge temperature records we found they had not been recorded since 21 January 2016. The audit checklist has been ticked "yes" to indicate all external medications and nutritional supplements were recorded on the MAR charts. We found this was not the case on the MARs we reviewed. We therefore for concluded the providers audit was ineffective.

This demonstrated medicines were not properly and safely managed and this was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked if Personal Emergency Evacuation Plans (PEEPs) were in place for people living at the home. The deputy manager provided us with a large folder containing the PEEPs. However we were unable to understand the information on the PEEP and could not easily find individual ones. These would not have been helpful to staff in the case of emergency.
None of the en-suite bathrooms we looked in contained liquid hand wash, or paper towels. The deputy manager said they were not provided in any of the en-suite rooms. They told us they had requested these of the provider but they had not been supplied. Prior to our inspection we had received information of concern about a lack of provision of gloves and aprons. We found there were no gloves or aprons available in any of the en-suites or bathrooms we looked in. We asked the deputy manager where they were kept. They showed us a store cupboard but no gloves or aprons were stored there. We asked a member of care staff on the first floor if they had any available to use. They showed us a box with a small number of gloves and a roll of red aprons on the laundry trolley. We asked the deputy manager if there were any stored elsewhere. They said they didn't think so. This meant there were insufficient supplies of gloves and aprons for staff supporting people that day.
We spoke with a district nurse who told us there had never been any hand wash facilities in people's rooms. They said they had to use their own hand sanitiser after delivering care to people.

This meant staff were unable to maintain appropriate infection control procedures and was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection we saw a large number of gloves had been delivered.

We asked people if staff responded to the call system promptly. One person said "They work hard – too hard. Answering the buzzer can take up to half an hour before someone comes. It's a bit lax"

We met with a person in their bedroom on the second floor of the home. The person was not independently mobile and used a wheelchair. There were no staff deployed on the second floor. We asked the person if they ever used their nurse call. They said they didn't and said "They won't come anyway." We tested this by pressing the call bell. No staff responded to the call, so after 20 minutes we pressed the call button again. This turned the call into an emergency call and staff did respond within two minutes. The staff responding were the deputy manager who said they had heard the buzzer from the room next to the office where pagers were kept and a care assistant from the ground floor. The care assistant from the ground floor said it was the responsibility of the staff from the first floor to answer any calls from the second floor. The deputy manager said they were unaware of this. We found neither of the staff working on the first floor, nor the senior care assistant who was administering medicines on the first floor, had pagers with them. Pagers were the only way staff were alerted to a call bell. This meant none of these three staff would be aware of a person calling for help.

This was a breach of Regulation 12(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we had received concerns about staffing levels at the home. We asked the provider to look into these concerns. On 8 December 2015 a representative of the provider told us there were 18 people living at the home at that time and five staff were on duty per shift with three staff on nights.
We looked at staff rotas dating back to 25 January 2016. Rotas showed a number of occasions when the staffing levels had fallen below the levels we had been told about. For example between 25 and 31 January there were only two staff on night duty. Records showed there were 27 or 28 people living at the home, using all three units on those dates. We also noted a number of day shifts where staffing numbers had fallen below those we had been informed about. For example on two occasions there were only three staff on duty on the afternoon/evening time. At the time of our inspection the usual staffing levels for night time were three carers.
The deputy manager told us that approximately half of the people living at the home needed two staff to support them with personal care needs. This meant that with only two or three staff on duty covering three floors, only one person who required the support of two carers to meet their needs would be able to receive assistance. It also meant there had been a number of occasions when there would be no staff available at all on two of the units of the home.
One member of staff told us "There are 4 carers on this evening – 2 upstairs and 2 downstairs. 1 staff is sick for this evening and they haven't organised cover for them. When one person has a break, this leaves one staff" "I was promised there'd be plenty of staff"

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us about a number of incidents that had occurred between people who lived at the home. However we could only find evidence of three referrals having been made to the local authority safeguarding team. The deputy manager was unable to identify, from the paperwork available, what incidents the safeguarding referrals had been made in relation to. We asked staff if they knew how to make a safeguarding alert themselves. They said there was information about this in the staff room. However none of the staff who expressed concerns to us about the safety of people living at the home had done this.

Staff told us that one person who lived at the home displayed behaviour that challenged and had been involved in a number of altercations with other people. Staff told us they knew that such incidents should be reported to safeguarding. The deputy manager could not confirm that safeguarding referrals had been made.

Staff told us that one person had been moved to another unit of the home due to their challenging behaviour which had resulted in concerns from other people and their relatives. We looked at this person's care records to see what had been put in place to protect this person and other people living at the home. We were unable to find any evidence of risk assessments or of any plan of care to support and protect this person and others. The deputy manager confirmed they were not in place.

We spoke with a visiting district nurse who told us about an incident where staff had neglected to provide the care the person needed. We asked the deputy manager about this and they confirmed the district nurse had reported it. The deputy manager could not confirm the incident had been referred to safeguarding.

We found documentation relating to an allegation made by a member of staff at the home that staff had not been giving one person their prescribed medicine. There was no evidence of this incident being reported to safeguarding.

We saw from daily records that a number of accidents had occurred in the home. We saw accident reports had been completed but did see any evidence to suggest that any monitoring of accidents was in place to identify any themes or trends for which actions put be put in place to reduce the risk.
This meant that systems were not in place to make sure people who lived at the home were safe.

This was a breach of Regulation 13(1,2,3,4(d)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at three staff recruitment files. We found appropriate checks, including the criminal record Disclosure and Barring Scheme (DBS) checks and two references had been taken prior to people commencing work at the home.

We saw from records that 43 members of staff had left the service since it opened in October 2015. When we asked about this the deputy manager told us that approximately 40 of these staff had been dismissed. However we noted two staff had been re-employed following dismissal. We did not see any records to show how this had been managed or any strategies put in place to monitor these staff to make sure they were working safely.

Additional information from visit conducted on 17 March 2016.

Prior to our visit we had received information of concern that people who were assessed as requiring one to one support in order to help them manage risks associated with their condition were not receiving this support and risks were subsequently not being managed. We saw one staff member was on the rota for six hours a day to provide one to one support. When we spoke with staff they told us one person had received the one to one support during the day but this was not available in the evening. However, the person staff identified as receiving the one to one support was not the person who should have been in receipt of this additional staff support.
When we asked the deputy manager about funding arrangements for one to one care they confirmed one person should have been receiving 15 hours a day additional one to one support. They were unclear about the funding arrangements for another person. We found one to one support had only been provided in the

three days leading up to our visit, only for six hours per day and this was shared across three people who used the service. This meant the provider had failed to provide the support the person had been assessed as needing in order to keep them safe.

We reviewed the accident and incident analysis and found this had not been completed fully. We found one person who should have been in receipt of one to one support had fallen four times and been involved in one incident with staff where a staff member had been physical assaulted between 13 February and 12 March 2016. When we reviewed other records we found this person had fallen on another three occasions during this period but this had not been included on the accident analysis.
Where incidents had taken place we asked for the incident reports and risk assessments to reduce the possibility of any reoccurrence. The managers and deputy told us they were not available and acknowledged this was an area of shortfall.

Prior to our visit we had received information of concern regarding a puppy at the service that had caused a person to fall over them. At the visit we noted the puppy was present. We found one person had sustained a skin tear whilst petting the puppy. The manager told us the puppy was due to start puppy training on the day following our visit. They told us though well intentioned the decision by the provider to buy a puppy had perhaps been a mistake as this risks associated with dealing with an untrained puppy had not been considered.

During a tour of the premises we spoke with one person who we had found at our previous visit had been made to wait for excessive periods of time when they pressed their call bell. On this occasion when we pressed the call bell staff responded in a timely way. Staff we spoke with told us all staff on duty now carried pagers and this had reduced the risk of people having to wait for support.

Throughout the building we found low energy light bulbs were in use. These took time to adjust to the required level of brightness after being turned on. This risked some people with visual impairment or living with dementia with impaired visual perception having greater difficulty on first entering rooms until the light was of a sufficient brightness to allow them to identify obstacles and trip hazards.

We noted some vacant bedrooms were unlocked and had debris in including soiled tissue on windowsills and sinks. In one room the toilet had been used and left over a sustained period causing a crust to form in the bowl. This had caused an offensive odour that was noticeable on the corridors. The manager told us all vacant rooms should have been locked and all toilets should be flushed on a weekly basis. This had not happened in this case. The second floor sluice room also had an offensive odour.

We were approached by a person asking us for a toilet roll for their ensuite. When we looked in their ensuite we saw the toilet roll had run out and the person had been trying to use the cardboard middle of the roll to wipe themselves. We saw a cardboard bed pan had been placed in the person's toilet. When we asked staff about this they said "They must have been trying to get a urine sample." The cardboard bed pan was overflowing with liquid.

We saw a carpet cleaner had been left in the corridor with two bottles of chemicals on it. This was in a place where people who lived at the home would be able to access it without staff knowing.

These findings caused us to ask about arrangements for domestic staff. We were told there were no staff employed by the service but domestic staff were employed by the provider's cleaning company. It was not clear from speaking with the deputy manager and a team leader how staff were deployed and what checks were done at the service to evidence people had been through appropriate checks to work with vulnerable

people.

Prior to our visit we had received information that medicines were not being administered as prescribed in that medicines prescribed to be taken at night were being administered at the same time as medicines prescribed to be taken at tea time. We had confirmation from numerous sources that administering medicines in this way had been an instruction from the manager.

We looked at Medication Administration Records (MAR) and saw that on several occasions the signature of administration for night time medicines was the same as that for medicines administered earlier in the day. As day time staff finish their shift at 8pm, this meant night time medicines had been administered before 8pm.
We saw the medicine trolley on the ground floor was being stored in the treatment room behind the main office. We saw the digital thermometer recorded the temperature of the room at 26 degrees C. We looked at a number of medicines stored in the trolley and saw the storage instructions were to be stored below 25 degrees C. We looked at the room temperature records and saw they had been recorded on only two days in the current month, 11th and 15th March. We saw the room temperatures on 11 March had been recorded as 29 and 30 degrees C. This meant tablets were not being stored safely and the therapeutic effect of the tablets could have been affected by inappropriate storage.

Inadequate

Is the service effective?

Our findings

We looked at the training records for staff working at the home. We noted that not all of the staff working at the home were on the training record. The training record showed that all care staff were following the care certificate programme. This included basic training in areas including equality and diversity, person centred care, privacy and dignity, safeguarding adults, nutrition and fluids and dementia awareness. The deputy manager told us that practical moving and handling training had been provided in the home. This was not detailed on the training record we were provided with.

The service is advertised as a specialist service for people living with dementia. We asked the deputy manager what the care certificate training in dementia awareness entailed. They said it was a page of information for staff to read. The deputy told us they had delivered some training to staff in dementia awareness but told us they were not a trainer and had got all of their information from the Internet. We witnessed incidents during our inspection of staff struggling to respond to, or support people living with dementia. For example we saw two people in a state of distress because they wanted to leave the home, one person thought their children were waiting for them. When we brought this to the attention of staff they initially ignored the person. When we told them the person needed some support, staff walked with them along a corridor but failed to offer any support. The person came back to us still in distress as they were worried about their family. The other person was asking where the door was because they wanted to go home. We overheard a member of staff saying "the door is locked" and did not stay with the person to try to ease their distress.
We did not see any evidence of staff having received specific training about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Training records showed that only three members of staff working at the home had received training in administration of medicines. We found that the staff administering medicines on both days of our inspection had not received training in this since starting work at the service.

Staff we spoke with told us they did not feel supported in their roles and could not tell us about any effective supervision or support they received.

This was a breach of Regulation 18(1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a training plan that showed further training had been planned.

People told us they enjoyed the food and we saw there was a wide range of meals available. Menus were displayed and available in pictorial form to help people living with dementia in making a choice. We spoke with the chef who demonstrated a good understanding of nutritional requirements, particularly in relation to fortified meals. They explained how meals were fortified with cream and butter to add extra calories and described drinks and snacks which were available for people to have between meals to boost their nutritional intake, including home baked cakes and biscuits. However, although plentiful supplies of food

and drinks were available to people we found evidence which showed people's nutritional needs were not being met or monitored by staff. There was a lack of communication between staff which meant the kitchen staff were not fully informed about people's individual requirements. Although individual diet sheets had been devised these had not been completed by staff so the chef was unaware which people were nutritionally at risk.

We looked at weight records and found for 11 people there were no weights recorded. A further 11 people had lost weight in recent months. Eight of these people had not been weighed since December 2015 and two since November 2015. Yet we questioned the accuracy of the weights recorded as one person's records showed their weight had increased by over 6kgs in a five day period. When we looked at this person's care records their daily records showed a poor diet and fluid intake and this was confirmed by a staff member we spoke with. The nutritional care plan noted the person had a poor appetite and weight loss and advised the person should be weighed monthly yet the records showed they had not been weighed since 21 November 2015. There were no food and fluid charts in place for this person. We saw this person in their bedroom at 12.05pm. There was an empty glass on the table in front of them and a jug of water on the chest of drawers out of reach. The daily records for the day of our inspection written at 13:56 showed the person had had porridge and 200mls coffee and no lunch.
Another person's weight records showed they had recently lost almost 5kgs over a 17 day period. Food and fluid charts were in place, however these were poorly recorded. For example, the fluid balance charts for the four days prior to the inspection showed the total daily fluid intake varied from 80mls to 970mls. There was no target fluid intake and no staff signatures to show the information on the charts had been monitored or reviewed. 'Water for Health - Hydration Best Practice Toolkit for Hospitals and Healthcare' by the National Patient Safety Agency and the Royal College of Nursing, dated August 2007 states, "A conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day". The food charts lacked detail, for example one entry stated '1/2 plate of lunch eaten', and there was no evidence of review of these records by staff.

We looked at the care records for a person who had recently been admitted to hospital from the Gateway Care Centre with severe dehydration and had been readmitted to the home ten days prior to our inspection. The senior care staff member told us this person's food and fluid intake and output was being monitored as they had a poor appetite and were not drinking very much. We saw this person at 10am and they were in bed. There was no drink available, just a bottle of Ribena on the bedside table. We checked again at 11.25am and found a feeder cup of juice on the bedside table but this was out of the person's reach. We looked at the food and fluid charts and found these were poorly completed. For example, there was no food intake recorded on 11, 12 and 14 February 2016, on 13 February 2016 the record showed the daily intake was ready brek and three bowls of jelly and custard and on 15 February 2016 the only intake recorded was a bowl of porridge. We looked at the daily records which showed very little food and fluid intake since the person had been discharged from hospital. We asked the deputy manager for previous food and fluid charts and they said they were unable to find them. There was no recent weight record for this person, although the last record in December 2015 showed the person had lost weight. We saw new food and fluid charts were put in place during our inspection however when we checked these at 5pm we saw only 340mls of fluid had been recorded and the last entry was at 9.15am. Although the Speech and Language Therapist (SALT) team visited this person on the day of our inspection we were concerned that no other healthcare professionals had been contacted regarding this person's poor nutritional intake.

We saw one person had been served their lunch in their bedroom. However we saw the full meal still on their table after lunch had finished. The person was not in their room at that time. When we asked staff about this they were not aware this person had not eaten any lunch. This person's weight records showed they had lost weight between November and December but had not been weighed since.

This meant people were not receiving the nutrition they needed and was a risk to their health. Following the inspection we made safeguarding referrals to the Local Authority safeguarding team.

This was a breach of Regulation 12, 2(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were informed during the inspection of a situation where a person who lived at the home had been admitted to hospital. The hospital contacted the home to tell them they had sent the Do Not Attempt Resuscitation (DNAR) for another person and therefore would have to resuscitate if the need arose. This meant that in the absence of the correct DNAR, the wishes of both people would not have been met should the need for resuscitation have occurred.
This was a breach of Regulation 12, 2(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to healthcare services with visits from GPs, district nurses and the SALT team reflected in the records. However, it was difficult to ascertain quickly from the records when and which healthcare professionals had visited as this was often recorded in the daily records rather than in the section where healthcare visits were supposed to be recorded. This raised concerns as we could not be confident staff were contacting professionals in a timely manner when people's healthcare needs changed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The deputy manager told us none of the people living in the home had a DoLS authorisation in place. They said they had submitted applications for DoLS authorisations for four people and were planning to submit applications for a number of other people.
We saw the deputy manager had completed some capacity assessments and DoLS assessments for a number of people. We asked them manager how they were prioritising applications and they told us they were working through all the people in the home as time allowed. We were concerned that this approach was not effective in prioritising people who were at most risk of being deprived of their liberty unlawfully. For example, the information in two people's assessments showed they were repeatedly asking to leave the home and applications for DoLS authorisations had not been submitted. In another person's records we saw they had repeatedly expressed a wish to leave and although the deputy told us they had submitted and urgent application they did not appear to have considered using their powers as the managing authority to put an urgent authorisation in place.

Staff spoken with had a good understanding of consent and people's right to refuse care and treatment. They explained how they would try to encourage people or leave people and try again in a few minutes if people were reluctant to accept support with personal care. However there was no documentation in people's care records to show they had given consent to care and treatment. We asked a team leader where consent was recorded on the electronic care record system. They said they knew it was somewhere on there

but didn't know where. When people lacked capacity to give informed consent there was no documentation to show the best interest decision making process had been followed.

This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they have received some information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) when they did their Care Certificate training but had not, as yet, received any training specifically about these topics. They had a limited knowledge of the MCA and DoLS and thought most people living in the home had a DoLS authorisation in place because it would not be safe for them to go out alone.
Although there were doors to safe garden areas we found these doors to be locked. This meant people had no access to fresh air and outside space.

This meant people were being deprived of their liberty and is a breach of Regulation 13(5) of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Although the service was for people living with dementia, there was a lack of appropriate signage to support people in their orientation around the home. Bedroom doors were all the same with only a number to differentiate between them.

Requires Improvement

Is the service caring?

Our findings

Relatives we met during the inspection spoke positively about the care provided. One relative said, "It's early days but so far, so good." Another relative said, (relative's) been here since November, we're very happy, couldn't be more content." A further relative, "Staff here are wonderful. It's a big relief to me (relative) being in here. I know (relative's) safe and wish I was in here myself."
A person who lived at the home said "They are very good staff" and "There's more good things than bad things. It's comfortable. Relatives can come at any time, even at lunch". We also overheard a person say to a member of staff "You're a lovely lady"

We observed staff to be kind and patient in their approach to people, however there were examples of staff lacking the knowledge they needed to provide appropriate care and support to people living with dementia.

We noted that some people had clearly received good support from staff with their personal hygiene and grooming. For example, ladies hair looked cared for and their clothing was smart. This is important in supporting people to retain their dignity. We also noted people's personal effects and clothing were looked after. However we found that people were not always supported appropriately to meet their privacy and dignity needs. For example we saw one person sat in a chair in their night clothes at 12.15pm and there were food stains down the front of their clothes. We asked a staff member why this person was not dressed and they said, '(person) doesn't get dressed, we have all on to get (person) out of bed'. We found nothing in this person's care plan to reflect this. We also observed mid-morning; a person in the lounge on the first floor had a food stain on their jumper. Later in the day about 4.30pm the person was still wearing the same stained jumper.

Whilst walking around the home we heard a person calling out for help. We found the person sitting in a chair by the side of their bed next to the door, which was clearly visible from the doorway, with night clothes lifted above their thighs and the bedroom door wide open. The person told us they were desperate for the toilet but did not have their call bell within reach. On another occasion we saw a person in bed with their clothing ridden up so we could see their underwear and incontinence pad. This person was clearly visible from the corridor outside their room.

We noticed a piece of paper had been taped to the inside of one person's bedroom door when we visited them in their bedroom. Written on the piece of paper in bold red letters were the words 'DNR in place.' This meant the person was not to be resuscitated in the event of collapse. This was in clear view of the person and anybody who may have been in the room. Whilst is important that staff know people's DNAR status, we considered this to be an insensitive and disrespectful action.
We saw the 'Activities room' was used predominantly by staff for taking breaks. The room was situated on the corner of two corridors and had large windows between the corridors and the room. This meant it was possible to see into the whole room from the corridor. We saw private and confidential information about people who lived at the home and in one case, a communication from a person's relative written on the whiteboard in the room. We could also see a full list of people's names and their bedrooms. This meant that people's privacy was not being respected.

We saw staff spending time doing a jigsaw with one person. The jigsaw box indicated the jigsaw was suitable for children aged two to five years. We also saw young children's toys in the home. The deputy manager told us they were intended for the use of people who lived at the home. This is not respectful of older people and could compromise their dignity.

At lunchtime we heard a member of staff say to another member of staff "You do her and I'll do him." The staff member pointed at two people whilst saying this. This kind of language is not respectful.

This was a breach of Regulation 10(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Additional information from visit conducted on 17 March 2016.

During our visit we observed interactions that showed staff, although well intentioned, did not have the knowledge and skills required to support people living with dementia. On arrival at the service whilst waiting in the entrance hall a person who used the service was at the other side of the glass door wanting to leave the building. We saw a staff member approach the person and coax them away from the door, telling them it did not open. This was not an appropriate explanation to make when it was obvious people were waiting and the person clearly understood the door to be the entrance to the building.

During the evening one person was calling out. Staff told us this was part of their usual pattern of behaviour. We heard a staff member ask the person if they needed anything and the person replied they did not. We then heard the staff member say, "Well what are you shouting for then. Stop it. I don't know she said she wouldn't shout tonight." This demonstrated a lack of understanding of the reasons the person may have been shouting and sounded disrespectful.

Inadequate

Is the service responsive?

Our findings

Care records we reviewed on the electronic care system were not person centred and did not reflect the care and support required from staff. We found generalised phrases recorded in care plans and risk assessments which were not specific to individual requirements. For example, one person's care plan for mobility stated 'requires mobility aid' there was no detail to show what mobility aid this person required or if they needed support from staff. Another person's risk assessment showed they were nursed in bed and required a hoist to transfer. There was no information in the risk assessment or care plan to show what type of sling was to be used or to guide staff as to how to move the person safely in bed. We found the same standardised phrases used in people's care plans. For example, two people's plans stated 'to drink 1.5litres of fluid each day in the form of tea 4 times each day, fluid with meals and night cap of milky drink'. Other information was contradictory. For example, one person's care plan said 'is able to wash and dress independently' then directly below stated they required assistance with washing and dressing.
Handover notes showed one person's groins were' too sore to wash'. We looked at this person's care plan which stated they had excoriated skin and a pressure ulcer yet there was no detail to show how these conditions were being treated. We mentioned this to the district nurse who told us they had not been informed of this. They said they would see the person immediately.

We found one person who had been in the home since 2 February 2016 had no care plans or risk assessments. This person's daily records showed they had had episodes of loose stools since 8 February 2016 yet there was no information to show any healthcare professional had been informed of this. The person was catheterised and the records noted from the day of admission onwards that the urine was dark. This can be an indication that a person is not drinking enough fluids. We asked staff if this person was on a fluid chart and they told us it was not needed as the person ate and drank well. The records showed this person's groins were very red and sore and stated the person 'needs cream'.

The deputy manager had told us that none of the people living at the home had any pressure sores. However we saw from records two people had pressure sores, one a grade 3 sore. This meant the sore was quite deep and had reached a stage which required notification to the Care Quality Commission. We saw the district nurse was involved in the treatment of this person, there was no information to show how the other person's pressure sore and their damaged skin was being managed or treated.
We asked one person if they could have a bath when they wanted one. The person laughed and said "only when they (staff) have time and that's not very often." We looked in the person's daily records to see if baths had been recorded. Records showed the person had been assisted to bathe only five times in the five and a half months they had been living at the home. We had noticed a strong odour around one person and looked at their bathing records. We saw the person had been recorded as having had only one bath in the six weeks they had been living at the home.

During our inspection we heard a visitor asking if the doctor had been to see their relative about a condition they had mentioned to the provider and the manager on a previous visit. We found this had not been recorded and a doctor's visit had not been requested.

This meant that people's health and welfare needs had not always been met. This was a breach Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about how they spent their time and what activities were on offer. One person said "There's very little to do. They are long days. Occasionally you get someone throwing a ball around in the lounge and that's it". We observed the activities organiser working with people in the ground floor lounge during the morning. A soft ball was being thrown to people to catch for no more than a few minutes but people appeared disinterested in engaging with this. Later on in the morning, a small group of people were encouraged to sit in the downstairs dining area with a drink of tea to reminisce. However, this was for a short period before lunch and only involved three people, two of whom left the table after a short while, after which the staff member left the room. The activities organiser told us they worked approximately four hours each day. This covered the lunchtime period which meant the time available for engaging people in activities was reduced considerably. We saw, and the activities organiser told us, they used the lunchtime period to write their notes. They told us they were doing some life history work with people and also recorded, in their own file, what activities the person had engaged in. We looked at the activity records for three people.
One person's record had three entries for the month of January 2016. One was 'Reminiscing' another was 'one to one life history and the third said the person 'had a visitor.' This indicated the person had been engaged in activities on only two occasions in the month. Another person was recorded as having engaged in four activities in a five week period. However one of these was 'Short chat.' Two of another person's activities were recorded as the person being taken back to their room as they were looking for the toilet and being helped to put their clothes on.
Whilst life history work is appropriate and important, other than this, we saw little evidence of people having been engaged in meaningful social or recreational activities.
The activities organiser told us there should be two people employed in that role and that the provider was still looking to appoint another person.

We saw it stated in the care plan for a person who was being cared for in bed to offer stimulation with radio or TV, but neither was on in the room.
We saw in both the first floor and downstairs lounge and dining areas that music was being played at one end of the room and the television was on at the other end of the room. Both were loud and very distracting. We saw this continued during the mealtimes. This made it difficult for people to concentrate on either form of entertainment and at lunchtime made the environment very noisy with staff having to speak loudly so people could hear them over the noise of the television and music. It also made it difficult for people to converse with each other at the table. This kind of environment demonstrated sensory overload and would add to the confusion and agitation of people living with dementia.

During the inspection we observed two people's relatives go to staff with concerns. However we did not see staff make any record of these concerns. We also saw from care notes two other people's relatives had expressed concerns to the staff. We looked at the complaints log file to see how the service managed complaints or concerns raised. The file did not include any information about the complaints we had seen recorded in people's care records. The only concern detailed within the complaints file was a report from a staff member relating to their concerns about medicines not being given as prescribed. There was a statement from another member of staff but no information about how the matter had been investigated or resolved. The consultant and the deputy manager told us they knew there had been other complaints but said they didn't know how the manager recorded them.

We looked at the complaints procedure which said that verbal complaints were to be talked through with a member of staff or the manager and a suggested course of action agreed upon to resolve the complaint. If

this was not acceptable to the complainant then the complaint was to be put in writing.

This meant that not all complaints made to the service would be recorded.

This was a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Additional information from visit conducted on 17 March 2016.

The team leader told us care plans had recently been transferred over to paper files rather than an electronic system. We looked at two people's files that had been completed. One file contained brief information that was not always personalised. For example in the care plan section of 'My mobility and falls risk' their expected outcome said 'assistance with personal care'. Another section of the persons care plan on 'My medication' was left blank. A further section on 'my personal safety' had their expected outcome documented as 'one to one'. These documents did not give staff sufficient information about how to support people effectively.

This person's care plan described the use of flash cards for communication as this was sometimes difficult for the person and a trigger for frustration, however on the day of inspection, although there had not been an incident, we did not observe staff using flash cards for the three hours we were on site.

When we started the inspection we asked one member of staff who was with a person who used the service, if they were the persons 'one to one' support. They told us no, and that member of staff had left at 15:00 and from that time onwards staff just 'looked out' for the person. We asked the team leader and deputy manager who had one to one support in the service. They told us they believed only one person had one to one support and they named a different person to the person who owned the care plan we were looking at. The care plan we were looking at clearly stated on the reviewed updated version of the plan on the 17 March 2016, that they received one to one support five days a week.

Care plans did not contain risk assessments for any identified area of risk other than pressure sores. Care records indicated past histories and incidents of aggression and violence but this had not been assessed.

Inadequate

Is the service well-led?

Our findings

Although we received positive feedback from people who lived at the home and their relatives about the service provided, we found systems and processes were not being followed to make sure people received safe and effective care. As detailed in other sections of this report we identified issues in many areas. These included management of medicines, keeping people safe, insufficient staffing, staff training and support, nutrition, health care, privacy and dignity, care planning and management of complaints.

At the time of our inspection there was a manager in place but they had not yet applied for registration with the Care Quality Commission. The manager was present during our inspection on 17 March.

The deputy manager, although supportive of the inspection process, told us they were not fully involved in the management of the home and was therefore not able to help us in all our questions. The provider was present throughout the first day of the inspection but did not engage with the inspection process. We also met with a person providing a consultancy service to the provider; they were also providing training services. The provider and the consultant were present for feedback on the first day but neither were present during the second day of the inspection.

Staff told us they did not have confidence in the management and leadership of the home and did not feel involved.

We saw the provider had policy documents in place. However the ones we looked at, including those relating to consent and the Mental Capacity Act were based on the old regulations which were replaced in April 2015 with by new regulations. The policies were accompanied by a record of staff signatures to show they had read the policies and this record showed these policies were being used up to December 2015. When we raised this with the deputy manager they told us there were new policy documents on the computer but added they had not been aware of this prior to the inspection.

We spoke with the maintenance person who told us they had conducted audits relating to the safety of the building including fire alarm tests and hot water tests. However when we asked to see the hot water tests they told us these had been taken over by the manager and they did not know if they had been maintained. We asked if there had been auditing of the service since its opening, the consultant said there had not. They said they were in the process of an audit but did not have any records to show us relating to this, only their rough notes.

We saw accidents and incidents were listed but there was no effective auditing within the home to identify trends or themes or look at 'lessons learnt' to prevent recurrences.

We did not see any evidence of effective monitoring of people's weights or care plans.

The deputy manager said there had not yet been any surveys or questionnaires sent out to people for them to give feedback on the quality of the service provided.

This was a breach of Regulation 17(1)(2)(a,b,e) of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Additional information from visit conducted on 17 March 2016.

Following the first inspection visit of The Gateway Care Home we had received assurances from the provider the management arrangements had been revised to ensure clear lines of accountability. At our visit of 17 March we found this had not had any impact on the chaotic nature of the service. On arrival we were greeted by a staff member who described themselves as a trainer working to support staff through Care Certificate training. On announcing the purpose of our visit they left the service for the night. At the time of our arrival a consultant who was working with the provider to help them secure improvements was at the service; however they left without engaging with the inspection team leaving a senior care staff member, who although very competent and able, was engaged in administering medicines. During the course of our visit the deputy manager and two managers arrived to support the team however the responses of the management team led us to conclude the majority of accountability was sitting at deputy manager level.

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 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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not at all times treated with dignity and respect. Regulation 10(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not in place to make sure service users consent to care and treatment was sought and recorded. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse or neglect of care.. Processes were not in place to make sure service users were not deprived of their liberty. Regulation 13 (1) (2) (3)(4)(d) and (5)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 16 HSCA RA Regulations 2014
Receiving and acting on complaints

Systems were not in place to make sure complaints made to the service were responded to and investigated appropriately.

Regulation 16(1)(2)

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 Service users were not provided with care and treatment in a safe way in relation to the proper and safe management of medicines, effective infection control procedures and failure to operate an effective call system. Systems were not in place to make sure service users health and welfare needs were met including nutritional needs and transition between services. Regulation 12 (1) (2) (a) (b)(e) (g)(h)(i).

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Opinions were not sought of people involved in the service for the purpose of evaluation and improvement of the service. Regulation 17 (1) (2) (a) (b)(e)

The enforcement action we took:

Warning notice

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate training or support to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

The enforcement action we took:

Warning notice