

All Saints Care Limited

# The Gateway Respite

## Inspection report

580 Sticker Lane  
Bradford  
West Yorkshire  
BD4 8RD

Tel: 01274737258  
Website: [www.allsaintscare.co.uk](http://www.allsaintscare.co.uk)

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## Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service responsive?	Inadequate ●
Is the service well-led?	Inadequate ●

# 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 18 people were using the service.

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

People were not safe. Risks to individuals were not always assessed and appropriately managed. Some staff were not up to date in safety related training. Medicines were not managed safely. There were insufficient staff with the appropriate skills and knowledge to meet people's needs and keep them safe. Lessons were not learned when things went wrong. The manager was familiar with safeguarding and fully understood reporting procedures. People lived in a safe and pleasant environment. The service had infection prevention and control systems in place although additional measures were being introduced to ensure staff fully understood how to prevent the transmission of infection.

The service did not have effective systems in place to involve people in making decisions about their care. Care plans did not reflect people's needs and wishes. The management team had started to improve the care planning system. Relatives were concerned because they had been unable to find out about their relatives' wellbeing; this was during the COVID-19 pandemic when everyone was feeling anxious and visiting restrictions were imposed. The service was developing social activities, but concerns were raised that people did not have opportunity to go outside even though there was an enclosed garden. When concerns and complaints were raised there was little evidence to show improvements were made.

The provider's quality management systems were not effective and did not drive improvement. Record keeping was unreliable which meant it was not always possible to monitor service delivery. People's opportunities to share their views about the service were limited. The manager who had been in post less than three weeks had started to make changes. Feedback about the manager from staff, people who used the service and relatives was positive.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection (and update)

The last rating for this service was good (published 8 June 2018).

### Why we inspected

The inspection was prompted in part due to concerns received about management of risk, staffing arrangements, communication, poor quality care and leadership. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of safe and well-led. We inspected and found there was also concerns around care planning and complaints, so we widened the scope of the inspection and included the key question responsive.

The overall rating for the service has changed from good to inadequate. 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, management of medicines, staffing, person centred care and governance.

Please see the action we have told the provider to take at the end of this report.

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](http://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 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Is the service safe?**

The service was not safe.

Details are in our safe findings below.

**Inadequate** ●

### **Is the service responsive?**

The service was not responsive.

Details are in our responsive findings below.

**Inadequate** ●

### **Is the service well-led?**

The service was not well-led.

Details are in our well-Led findings below.

**Inadequate** ●

# 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 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 registered manager had resigned from their post on 12 August 2020. A new manager commenced on 24 August 2020 and said they would be submitting an application to register with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

This inspection was announced. We gave two hours' notice before the first site to the service because we needed to check the arrangements in place for preventing and containing transmission of COVID-19 prior to entering the building, and we announced the second site visit from the service's car park.

### What we did before the inspection

We reviewed information we had received about the service which included concerns shared with us and 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 two people who used the service and two relatives about their experience of the care provided. We spoke with nine members of staff including the manager, team leader, senior care workers, care workers and housekeeping. Discussions with people who used the service, relatives and staff were conducted either on site or via telephone calls.

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

### After the inspection

We continued to seek clarification from the manager to validate evidence found. We looked at training data, quality assurance records, policies and an action plan sent to us after the inspection. We spoke with a relative and a representative of the provider.

# 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 good. At this inspection this key question has deteriorated to Inadequate: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not appropriately assessed or managed which placed them at risk of harm or injury. Care records did not accurately reflect when people were at risk. For example, one person's health had deteriorated, and they did not get out of bed. Their care records stated they were totally independent when mobilising and liked to walk around on their own.
- People's safety was not appropriately monitored. Records such as repositioning and observation monitoring charts were not properly completed. Some people's food and fluid intake was recorded but there was no analysis to make sure they had enough to eat and drink.
- Some staff were not up to date in safety related training. One person said, "I don't feel safe here anymore due to lack of trained staff." One relative told us, "I do have concerns and have lost all confidence in the care (name of person) is receiving."
- The service did not have an effective system for making sure staff knew how to support people in the event of a fire.

The provider failed to assess or manage risks associated with people's care. 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.

- The manager had recognised risks to people were not always effectively managed and had started to introduce measures to keep people safer. For example, people's weight was being monitored.
- People lived in a safe environment. The service was decorated and furnished to a high standard. Checks had been carried out to make sure the building and equipment was safe.

Staffing and recruitment

- There were not enough staff with the right skills to keep people safe. The service had a high number of agency and new staff who did not know people well and lacked familiarity with the service. For example, staff did not know where one person's room was, and we were given incorrect information about people's names. One person received additional funding because they required one to one staffing support. However, the allocated worker also supported other people.
- People were concerned about the staffing arrangements and high turnover of staff. One person said, "There appears to be more agency staff than permanent staff." A relative said, "I'm not confident they know what they are doing." A member of staff said, "It's a demanding service and for the staff it's not good." They described recent shifts and said, "Some agency staff have never been to the home or done care before and others do not know what they are doing."
- Systems to make sure staffing was safe were not effective. The service used a dependency tool to help

calculate the staffing requirements. However, this was not used consistently. Staffing rotas were not accurate.

The lack of sufficient, competent staff meant people were not safe. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service was taking action to provide a stable workforce. The manager acknowledged recent staffing changes had created problems, but they hoped to address this shortly; four candidates had successfully gone through the interview process and were waiting for pre-employment checks to be completed.
- The provider told us the exceptional circumstances arising as a result of the COVID-19 pandemic had impacted on their staffing situation.
- Recruitment checks were completed before staff commenced employment.

#### Using medicines safely

- Medicines were not managed safely and people did not always receive their medicine as prescribed. For example, one person should have received their medicine between 30-60 minutes before food, but it was given after their breakfast and staff did not always record variable doses. The amount of medicines in stock did not always tally with the administration records.
- Topical medicines were not appropriately managed. Topical medication administration records (TMAR) were not always in place and we were not assured people were receiving these medicines. One person had five creams prescribed but only two were recorded on their TMAR. Another person had a lotion in their room which was prescribed for someone else, which indicated staff had used it for the wrong person.
- Several medicines were prescribed on 'as required' (PRN) basis. There were no protocols available to support the safe use of these medicines.

The provider did not 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.

#### Learning lessons when things go wrong

- Safety concerns were not consistently identified through the provider's systems and processes. There was a lack of evidence to show investigations or reviews were carried out. For example, only one out of 14 accident/incident report forms for August 2020 had been reviewed by a manager.
- When events happened, there was little evidence to show action was taken to improve safety. A monthly analysis was completed but this did not include all events and the section to identify themes and trends was limited.

The lack of learning and improving care meant people were at risk of receiving poor quality care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had developed a new accident and incident analysis format and said a more robust system would be used by the end of September 2020.

#### Systems and processes to safeguard people from the risk of abuse

- The manager was familiar with safeguarding and fully understood reporting procedures.
- Staff we spoke with were clear they must report all concerns to the management team. However, not all had completed safeguarding training since commencing employment. The manager confirmed all staff would be receiving safeguarding training and they would prioritise who should attend.
- The service had information about safeguarding people from abuse and a record of incidents that had

been reported to the local safeguarding authority.

#### Preventing and controlling infection

- The service was accessing COVID-19 testing for people using the service and staff, and promoting social distancing rules.
- The provider was promoting safety through the layout and hygiene practices of the premises. Additional measures had been introduced to ensure the environment was COVID-19 safe. Hand sanitisers were located throughout the building although two were empty, which meant there was an increased risk of spreading infection in those areas.
- The service had guidance around infection prevention and control although the provider's policy was not up to date; the manager agreed to ensure this was updated.
- Staff were using PPE effectively and safely but not all had received infection prevention and control training; the manager and senior care worker had attended specific COVID-19 training and were planning to cascade to all staff.

# 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 good. At this inspection this key question has deteriorated to inadequate: This meant services were not planned or delivered in ways that met people's needs.

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

- The service did not have effective systems in place to involve people in making decisions about their care. Assessments were not carried out when people's capacity was in doubt. Before the inspection, concerns were raised that people were going to bed early. At 20.20, during a site visit, we found seven people were still in communal areas. The provider said people had chosen to go to bed. One member of staff told us people who required support from two staff went to bed before the night staff arrived. One person told us they could not decide when to go to bed or get up. They said, "They come too early to get me up." Another person said, "I can choose when I go to bed and when I get up."
- People's care plans did not reflect their current needs and wishes. They lacked detail about the support people required from staff. For example, one person displayed behaviours that challenged but there was no guidance for staff about how to support them. Staff were unsure what to do when the person started swearing. Their care plan was last reviewed in December 2019.
- The service did not engage people in planning their end of life care or record their wishes. Some people had forms stating a decision had been made to not attempt resuscitation, however, these had not been fully completed which meant the record could be deemed invalid.

Failure to provide appropriate care, support people to understand the care choices and design care meant people's needs were not identified and met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team were reviewing and updating people's care plans. The manager sent an action plan which stated they were updating the contents for all care files, introducing reviewing sheets and short-term care plans, completing mental capacity assessments and best interest decisions.

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

- The service did not actively support people to maintain relationships. Visiting restrictions were imposed due to the COVID-19 pandemic and three relatives told us they had been unable to find out about their relatives' wellbeing. A relative told us they had contacted the service because they had concerns but had not received a call back from the manager as promised. Another relative said a window visit was arranged in June 2020 but they were concerned because the person looked, "An absolute mess with food down their clothes, unshaven and looking dirty."
- The service was developing social activities, but concerns were raised that people did not have opportunity to go outside even though there was an enclosed garden. One person said, "I use to be able to get a member of staff to push me around the garden but not anymore as they are too busy, they don't even

have time to stop and chat to me." The manager said they were arranging to have the grass cut which was overgrown.

Failure to involve relevant person's in people's care and reflect people's preferences meant care was not appropriate. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- An activity co-ordinator had recently started working at the service; they were observed to spend time with people and their interaction was friendly and caring.

#### 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.

- People's care records had basic information about their communication needs. The manager said as they developed the care planning process, they would ensure they included how people should receive information in a way they could understand.

#### Improving care quality in response to complaints or concerns

- When concerns and complaints were raised there was little evidence to show improvements were made. The manager said they had not been able to locate any complaints' records because the file was empty. CQC were aware some relatives had raised concerns about the service and were unhappy with the response. This meant we could not be assured complaints were dealt with in an open, transparent and timely way.
- The service investigated concerns shared by CQC in July 2020. Their response covered some elements of the concerns well, but other parts lacked detail and accuracy.

The lack of an effective system to monitor and improve the quality and safety of services provided meant people were at risk. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection a Human Resources representative of the provider told us sensitive information that related to one complaint investigation was held centrally. The manager was not aware of this during the site visit.

# 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 good. At this inspection this key question has deteriorated to inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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;

- Significant shortfalls were identified at the inspection. The provider was in breach of four regulations across three key questions; the service has been rated inadequate overall and placed in special measures.
- Systems and processes for monitoring quality and safety were not effective. The management team undertook a range of audits, but these did not include all key areas; there were no mattress or infection control audits, and medicine audits for August 2020 could not be located. A provider audit completed at the end of July 2020 identified a number of significant issues but many of these had still not been addressed, such as a lack of complaints records and legal processes to protect people; these are called 'Deprivation of Liberty Safeguards'.
- Systems did not enable the provider to have a clear overview of what was happening in the service. For example, the training matrix did not evidence the training that staff had completed, and the staffing rotas did not reflect who had been working at the service.
- Records were incomplete and unreliable which meant it was not always possible to monitor service delivery. For example, a monthly incident analysis from August 2020 was not signed and the investigation completed section was blank and care records were not accurate. Relatives communication records were not kept up to date.

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

- People who used the service and relatives were not listened to. The inspection was triggered because we received multiple concerns about the service. Some concerns had been shared with the provider in July 2020, but this did not drive improvement. Similar issues were highlighted during the inspection and included poor quality care, staffing arrangements, management, communication and safety.
- People's opportunities to share their views about the service were limited. The manager located some survey responses but did not know when these were completed and people we spoke with could not remember filling in questionnaires. One person said, ""We never got asked for feedback very often and any suggestions made were ignored.""

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service did not have a manager registered with CQC. The registered manager had resigned from their post on 12 August 2020. A new manager commenced on 24 August 2020 and told us they would be submitting an application to CQC.
- The manager shared information about systems they were introducing and an action plan. They said the provider had been very supportive.
- People told us the manager was making positive changes. One person said, "The new manager has listened to me and I hope she does try to put things right." One relative said, "The manager is a breath of fresh air. Although I have not physically met her the home is a different world. We now get pictures showing us what [name of relative] is doing." A member of staff said, "She is very approachable, really nice and going to improve a hell of a lot."
- Systems were being introduced to obtain views of those who were involved in the service. Two staff meetings were held in September. A keyworker system was being introduced so people who used the service had named staff who would have regular contact. Senior staff were being allocated the responsibility of having weekly communication with relatives.
- Care records showed the service consulted other agencies and 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  The provider failed to identify and meet people's needs.
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider failed to assess or manage risks associated with people's care. The provider did not ensure the proper and safe use of medicines.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The provider's governance framework failed to ensure safe quality care was delivered.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  The provider failed to ensure there were sufficient, competent staff