All Saints Care Limited

The Gateway Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Gateway Care Home is a residential care home providing personal and nursing care to older people, people living with dementia and people with physical disabilities. The service accommodates up to 92 people across three separate floors, each of which have separate adapted facilities. At the time of the inspection 65 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 appropriately assessed and managed. Medicines were not managed safely. Lessons were not learned when things went wrong. Safeguarding procedures were not consistently followed. There were sufficient staff to keep people safe and they usually worked in the same unit, so people received continuity of care. People lived in a safe, clean and pleasant environment.

The provider's quality management systems were not effective and did not identify areas where the service needed to improve. The provider and registered manager did not demonstrate they understood their legal responsibilities. People who used the service, relatives and staff provided consistent positive feedback about their experience. The management team were responsive to the inspection findings and shared plans to improve their systems and processes.

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

Rating at last inspection
The last rating for this service was good (published 4 January 2018).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about management of medicines and governance arrangements. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with assessing and managing risk to people who use the service, safeguarding people from abuse, failure to consistently report significant events to the relevant agencies, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We also looked at infection control and prevention measures the provider had in place. As part of CQC's response to the coronavirus pandemic we are conducting a review of infection control and prevention measures in care homes.

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, governance, safeguarding people from abuse. Please see the action we have told the provider to take at the end of this report.

We have identified a breach in relation to failure to notify CQC about significant events at this inspection. We reviewed our regulatory response outside of the inspection process and decided not to take any further action. We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic.

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 work alongside the provider and 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Gateway Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Three inspectors and an Expert by Experience carried out the inspection. One inspector specialised in medicines management. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Gateway Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered 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 one hour's notice of the inspection because we needed to check the arrangements in place for preventing and containing transmission of Covid-19 prior to entering the building. Inspection activity started on 12 August 2020 and ended on 18 August 2020. We visited the service on 12 August 2020.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with ten people who used the service and two relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, registered 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 and zoom calls.

We reviewed a range of records. This included six 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 provider and registered manager to validate evidence found. We looked at policies, quality assurance records and an action plan sent to us after the inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The provider did not consistently follow safeguarding procedures. Some safeguarding incidents between people who used the service had occurred which were not reported to the local safeguarding authority and CQC. For example, one person grabbed another person, pulled their hair and shouted at them. This meant other agencies did not have oversight of what was happening in the service.
- Systems did not always protect people from potential abuse and neglect. Investigations were not always carried out when people were harmed. For example, one person was injured when they fell out of bed. A sensor mat should have been used to help prevent this from happening but there was no investigation into the accident, and it was not reported to any other agency.

The provider did not ensure systems, processes and practices safeguard people from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received safeguarding training and knew how they should respond to allegations of abuse and raise whistleblowing concerns.
- People told us they felt safe and would speak to staff or management if they had any concerns. One person said, "If I needed to, I would talk to the carers or the manager who pops in to see me."

Assessing risk, safety monitoring and management

- The service did not always assess and manage risk. Care records did not explain how to keep people safe. For example, one person frequently showed signs they were distressed and displayed behaviours which may challenge but there was no guidance for staff about how to support and manage the person.
- The service did not always review or update people's care plans or assessments after serious events. For example, one person fell over twice at the beginning of August 2020 and went to hospital because they sustained an injury; their risk assessment had not been updated since June 2020.
- Incidents were not always monitored. Staff did not always complete an incident form when people were aggressive towards staff. This meant the management team could not review what had happened and decide if new approaches were required.

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.

- 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. People told us they felt safe and secure. Comments included, "I think security is good" and "It's very safe here, they don't let people wander in and out. They monitor who comes in."

Learning lessons when things go wrong

● The service did not have effective arrangements in place for learning when things went wrong. The management team had taken some actions, but these did not achieve the required improvements in a timely way. For example, a high volume of medicine errors continued over a period of months.

● Accidents and incidents were not appropriately monitored and potential to identify themes and trends was limited. A monthly analysis was completed but this did not include all events and there was a lack of detail.

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.

Using medicines safely

● The service was not always responsive when medication errors occurred. Since March 2020, a high number of errors were reported to the local safeguarding authority; measures to reduce the risk of repeat events were not effective.

● People did not always receive their prescribed medicines as intended. One person was discharged from hospital but a change to their medicine was not acted upon by the service for one week.

● Systems for making sure special instructions were followed such as 'before food' were not robust. Records did not always clearly show that these were given correctly.

● Important checks for managing medicines safely were not routinely completed. Stocks of controlled drugs should but were not checked weekly and storage temperatures were not tested regularly enough.

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.

● Systems were in place to ensure medicines had been ordered, received and disposed of appropriately. Medicines were stored securely, and topical creams were kept in people's rooms so readily accessible.

● Medicines administration records were usually signed by staff to confirm people had received their medicines. Appropriate codes were used to explain why people had not received their medicines as prescribed. Daily medicine counts were completed to reduce the risk of omitted doses.

Staffing and recruitment

● People told us they felt safe because staff were available when they wanted care and support. They said staff attended promptly when they used the call bell to request assistance. Comments included, "The staff are about when I need them, and they look after me" and "There seems to be enough staff about all the time night and day."

● There were enough staff to keep people safe. The provider used a formal system to help calculate the number of care staff they needed. Staff told us they usually worked in the same units and rotas confirmed this. Staff said the staffing arrangements worked well although one member of staff said it would be better if shifts were communicated to staff further in advance.

● The provider had an on-going recruitment drive to help ensure they used a consistent workforce. Regular staff often covered additional shifts and sometimes agency staff were used. The registered manager said the same agency staff worked at the service which provided continuity.

● Recruitment procedures were in place to ensure staff were suitable. Two staff who commenced employment in the last month confirmed they had attended an interview and checks were carried out before they started working at the service.

Preventing and controlling infection

● People were protected by the prevention and control of infection. Staff were using PPE effectively and safely. The provider was accessing testing for people using the service and staff.

● The provider was promoting safety through the layout and hygiene practices of the premises. The service was clean and additional measures had been introduced to ensure the environment was Covid-19 safe.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as 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 two key questions; the service has been rated inadequate overall and placed in special measures.
- Systems and processes for monitoring quality and safety were not implemented effectively and had not highlighted issues identified during the inspection. The management team carried out a range of audits, but these did not always drive improvement. For example, medicine audits had picked up some discrepancies, but errors continued. Medicine temperature records were not completed consistently. Care plans and risk assessments did not always accurately reflect people's needs but this was not picked up by the management team.
- The management team did not have a clear overview of what was happening in the service. They did not know how many accidents and incidents had occurred because their analysis was not accurate. For example, the analysis for July 2020, did not include eight medication errors, two incidents between two people and a fall which resulted in the person going to hospital.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;

- Organisational risk was not consistently managed and systems to drive improvement were not effective. Action points recorded to minimise risk and prevent repeat events were not always implemented. For example, people's care plans were not always updated when incidents occurred, such as aggression towards others and falls.
- The local authority shared concerns because the service had reported a high number of medication errors, but the provider's agreed actions were not effective in reducing risk.
- The provider was visible and spent a lot of time at the service but did not ensure safe care was delivered. The last provider audit was completed in April 2020 and 135 areas were reviewed; 13 were partially met; 122 were met and the service achieved a good rating.

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 registered manager said the exceptional circumstances arising as a result of the COVID-19 pandemic had placed additional pressures on the service, which impacted the ability of the service to function

effectively. The management team responded after the inspection and told us they were keen to improve their quality management systems. They sent us revised monitoring records such as a more structured incident form and overview sheet. These showed they were taking appropriate measures to address the shortfalls.

● Notifications about some significant events had been submitted to CQC. However, reporting of incidents and risks was unreliable and inconsistent. The provider did not always report allegations of abuse and serious injury, which meant they did not fulfil their legal responsibility.

Failure to submit required notifications meant CQC were not made aware of some notifiable events so were unable to carry out their monitoring role. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Registration) Regulations 2014.

We reviewed our regulatory response, for the failure to submit required notifications, outside of the inspection process and decided not to take any further action. We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic.

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 relative's feedback about The Gateway Care Home was positive. They told us they were happy with the quality of the service and were complimentary about the staff who supported them. Comments included, "Staff are nice and caring", "If someone said they needed to go to a home I'd recommend they came here" and "The staff are lovely, they were great after I had lost my wife recently and they are lovely with me."
● Staff felt supported in their role although some said the Covid-19 pandemic had impacted staff morale. Staff told us the management team who worked at the service on a day to basis were approachable. One member of staff said, "They all work hard." Another said, "It's a good place to work, a nice team."
● 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 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.

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 The provider did not ensure systems, processes and practices safeguard people from abuse.

Regulated activity	Regulation
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.