Mr Paul Nicholas Mould

Quarry Bank Residential Home

Inspection report

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Date of inspection visit:
14 January 2019
22 January 2019
28 January 2019

Date of publication:
19 March 2019

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

About the service: Quarry Bank Residential Home offers accommodation and care support for up to 23 older people and people with a dementia related condition. At the time of the inspection there were 17 people using the service.

People's experience of using this service:
People did not receive a service that provided them with safe, effective, compassionate and high-quality care. Care and support was not tailored to meet people's specific needs.

Risk management was ineffective and placed people at risk of harm. Staff were not recruited safely or trained appropriately.

People's human rights were not always upheld as the principles of the Mental Capacity Act 2005 were not adhered to. People were not empowered to make choices and have control over their care. People were not provided with support that was personalised to them. Staff did not always gain consent from people before delivering support and people's privacy and dignity was not always upheld.

The service was not well led and there was an ineffective quality assurance system in place. During this inspection we found multiple failings at the service and risks to people had not been mitigated. We identified eight breaches of regulation. Seven of these were persistent breaches which were found at the last two inspections, which demonstrates learning and improvement had not taken place.

Rating at last inspection: The service was last rated as Inadequate (published 7 November 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Follow up: At the last inspection the service was rated 'Inadequate.' At this inspection the rating remained the same. Therefore, the service remains in 'special measures.' Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.

Enforcement: We issued a notice of decision to cancel registration and the service is now closed.

Full information about CQC's regulatory response can be found at the back of this 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? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our Caring findings below.	**Requires Improvement**
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**

Quarry Bank Residential 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
Two inspectors conducted the first and second day of the inspection. On the third day there was one inspector.

Service and service type:
Quarry Bank Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

It is a condition of the provider's registration that they have a manager registered with CQC. There was no registered manager at the time of our inspection. The registered manager had left the service following a period of absence and a senior member of staff had been promoted to manager. The provider informed us this person would be applying to become the registered manager. Within this report they will be referred to as the manager.

Notice of inspection:
This inspection was unannounced.

What we did:
Prior to the inspection we reviewed any notifications we had received from the service. A notification is

information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We used this information to help us plan our inspection.

During the inspection we spoke with two people who lived at the service, two visitors, three care staff, the chef, the manager and the provider. We spoke with one visiting professional. We completed a tour of the environment. We observed how staff interacted with people who used the service throughout the day and at meal times. We used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records in full, containing care planning documentation and daily records. We looked at records for two staff members, relating to their recruitment, supervision and appraisal. We viewed records relating to the management of the service, including any audit checks, surveys and the provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
• At our last inspection in September 2018 we found areas within the home were unsafe. Concerns were identified in relation to infection control, fire safety, maintenance of equipment, and risk assessments. At this inspection we found many of these risks remained.
• Risk assessments for specific health needs had been added to care plans. The manager had printed off information leaflets to go along side these assessments for staff to read. However, these updated assessments did not inform staff of the risks associated with the persons specific health condition or provide information to mitigate the risks to people.
• Improvements had been made to fire safety. Fire drills had been completed. Not all staff had taken part in one of these at the time of our inspection. Personal Emergency Evacuation Plans (PEEP's) were now in place for all people at the service. However, some information within them was incorrect which continued to put people at risk of not receiving the care and support they would require in an emergency.
• Care plans and risk assessments were not in place for people who received respite care at the service. This meant these people were at risk from receiving incorrect care, as no clear documentation was available to ensure people received safe appropriate care or to inform staff of people's needs, preferences or changes to these.

Systems and processes to safeguard people from the risk of abuse
• People and staff continued to be at risk of harm due to poor information recorded in people's care plans. At our last inspection we identified that behaviour management plans for people did not contain appropriate guidance for staff to manage distressed or physically aggressive behaviours. Three of 25 staff had completed dementia awareness training, which included challenging behaviour training. Care plans and risk assessments had not been reviewed, changed or updated following our last inspection. The provider and manager informed us that they were seeking support from the local authority to address this.
• Staff had recently completed safeguarding training and were able to tell us what action they would take to reduce the risk of harm to people.

Using medicines safely
• We observed poor practice in relation to the administration of medication. The medication trolley was left open with medication on the top of it whilst staff assisted people with their medicines. Another member of staff was present by the medication trolley; however, staff were distracted by people within the area which meant that medication could have been accessed by anyone.
• It was not clear from the medicines administration records that staff had applied people's prescribed creams as required.
• Staff from the NHS medicines optimisation commissioning team had visited the service, to achieve further understanding of best practice in relation to medicines management.

• Protocols were in place to guide staff on when to use medicines which were prescribed for use 'as and when required'.
• Staff had received medication training and their competence had been checked by the manager, yet poor practice remained.

The failure to adequately manage risk to people and the lack of robust medicines systems and practice was a continued breach of Regulation 12 (Safe care and treatment) of the Regulations 2014.

Staffing and recruitment
• We checked recruitment records for two newly recruited staff. We found that recruitment paperwork was still not robust. At the last inspection we highlighted the importance of checking people's employment history and suitability to work with vulnerable adults. We found that this was still not being appropriately checked.
• Disclosure and Barring Service (DBS) checks were in place prior to staff starting work. The DBS carry out a criminal record and barring check to help employers make safer recruiting decisions. One DBS record we looked at contained criminal convictions which the provider had not explored or implemented an action plan to mitigate any risks to people. This DBS had been sought by a previous employer and the service had not re-applied to complete their own checks to assess this person's suitability to work with vulnerable people. The other DBS record we looked at had also being completed by a previous employer, five months before the staff member had started working at the service. The provider had not conducted their own check to see if there had been any more recent convictions.

This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• Cleaning schedules were now in place; however, these did not identify deep cleaning of any areas within the building. Areas of the service were still unclean and smelled unpleasant.
• At our last inspection we identified areas within the premises that were not safely maintained. We saw no improvements had been made to address inadequate washing facilities in bedrooms, loose flooring, dirty fixtures and fittings in bathrooms, bins without lids or bags in them, broken radiator covers and multiple carpets which still required replacing.
• Some improvements had been made in people's bedrooms. Mattresses which had been identified as an infection control risk at last inspection had been replaced and the rooms had been decorated by the provider.
• The provider and manager had no documented action plan with timescales to address the remaining work required at the service to ensure the safety of people residing there.
• We observed staff wearing personal protective equipment when required, such as disposable gloves and aprons .

This was a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• Following our last inspection, we asked the provider to immediately address the significant risks we had identified related to people's safety. The provider had implemented check lists for the manager to complete to ensure people's safety. These check lists failed to identify continued risks within the environment. Where risks had been identified, such as inadequate washing facilities in bedrooms, loose flooring and broken

radiator covers, no control measure were put in place.
• The manager had designed a template to monitor accidents and incident within the home. This had not been implemented at the time of our inspection, so the provider and manager were unable to identify any patterns or trends. This exposed people who used the service to continued risk.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's assessments were not detailed, up to date or reviewed on a regular basis.
• We observed care and support being delivered in a way that did not meet best practice guidance., For example, moving and handling techniques were unsafe for both people and staff.

Staff support: induction, training, skills and experience
• Staff were not adequately trained or supported to carry out their role effectively.
• Staff had received some training following our last inspection in safeguarding and medication management. Some staff confirmed they had still not attended mental health, dementia, challenging behaviour or Mental Capacity Act (MCA) training. This was important due to the care needs of people who used the service.
• The manager gave us an up to date training matrix. This identified planned training including dignity and moving and handling training, which was to be confirmed by the local authority as the provider had asked them to source this training. We asked if any training had been arranged for staff in relation to the MCA and challenging behaviour and were told they were working with the local authority to arrange further training in these areas.
• The manager had devised a template to monitor and plan staff supervision. A new supervision and appraisal form had been produced to identify aims and objectives and monitor staff performance. At the time of the inspection these forms had not yet been implemented.
• Staff told us they felt supported by the manager and provider. One staff member told us, "I can talk to them about anything, they are very supportive."

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

Supporting people to eat and drink enough to maintain a balanced diet
• People had care plans and risk assessments in place to identify their dietary requirements. These were inconsistent and not followed by staff. For example, a nutritional risk assessment we saw stated the person was medium risk and required weighing weekly; their food and fluid intake was to be recorded for three days. The care plan for this person stated this person required weighing fortnightly and food and fluid needed to be recorded. There were no records of this person's food and fluid being monitored and weight records showed this person was weighed monthly. This person had lost weight and we saw no evidence of this person being referred to health professionals to seek advice or support.
• We observed lunch on the first day of the inspection and saw people who required support with their meal

were left unattended. On the second day staff remained in the dining room and supported people to eat their meal.
• People told us they enjoyed the food at the service. One person said, "I like the food here."

Staff working with other agencies to provide consistent, effective, timely care
• The service was working with the quality development monitoring team (QDMO) within the local authority to improve the care provision for people.

Adapting service, design, decoration to meet people's needs
• At our last inspection we found the service required a considerable amount of refurbishment work as the provider had failed to maintain a suitable environment for people to reside in. At this inspection we saw some improvements had been made, however many areas within the service still required attention.
• Redecoration of the lounge area has been started on our second day of the inspection. The provider told us that refurbishment work was being completed on a night while people were not using the area, so it was a slow process.
• It was evident that no improvements to the outside environment had been completed. The property was next to a main road and the garden was not secure. It was open plan with no security for those people living with dementia. All pathways were gravel which would make it difficult for people with reduced mobility to walk over. People could not use the outside area as they were unsafe.
• The service did not provide a stimulating environment for people. There was a lack of reminiscence areas, memorabilia or adaptions to the environment. Sensory stimulation can improve thinking skills and help people to maintain an interest in their environment.

This was a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support
• Records showed health advice was sought when people required it.
• A visiting professional told us, "I have no concerns at this service."
• We did not see hospital passports available for people when transitioning between services. Hospital passports are communication tools to inform other health services and professionals of people's health needs.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, we found applications had been made for people who lack capacity.

• Some care plans had been signed by people and their relatives to give their consent to care and support. However, our observations showed people were not always asked for their consent before staff provided support.
• At our previous inspection we identified care plans failed to reflect the principles of the MCA. Capacity

assessments were not fully completed and the service had failed to carry out best interest's decisions for people when required. At this inspection we found the service had completed capacity assessments for some people. There was no evidence of improvement with regard to recording best interest's decisions, where these were required.
• The service had continued to fail to act within the legal principles of the Mental Capacity Act. This meant that people's rights were not being protected under this Act.

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

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity
• Three of 25 staff had received training in equality and diversity. People were clearly distressed at times and this was unnoticed by staff. They did not respond or offer reassurance to people who clearly needed it.
• The manager and staff were more focused on tasks than people's emotional wellbeing. We did not see staff engaging with people in a meaningful way for any length of time during the inspection.
• Some staff were seen interacting with people in a kind and gentle manner. People were not always given the time to understand what staff were saying to them and staff were not always clear when communicating with people about what they were asking.
• People's life histories were recorded in their care plans; however, this information was not used to provide person centred care, stimulation, or meaning activities for people.
• The service had implemented what they referred to as a rummage box. This consisted of children's toys which were not age appropriate for people who used the service.
• People and relatives told us the staff were caring. Comments included, "The staff are lovely", "I like the staff, especially the cook" and "The staff all seem caring."

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

Supporting people to express their views and be involved in making decisions about their care
• Staff at the service had a lack of understanding of person centred approaches. For example, the service had obtained new bedding and decorated bedrooms. We asked one person if they had been involved in the improvements seen in their bedrooms and were told, "No, the boss does all that."
• Our discussions with the provider about the on-going improvement works at the service showed that people were not asked their views on how they would like the service to be decorated.
• Relatives expressed concerns about the service and one relative told us, "I am not told anything unless I ask."
• Staff did not always gain consent from people before delivering support. For example, we saw one person who did not want to go through to the dining room for lunch. Staff who approached this person agreed that they could have their lunch in the lounge. Two minutes later two different members of staff approached this person, supported them to stand and walked them out of the room, within no communication as to where they were taking them or why.
• There had been no meetings for people or relatives at the service since our last inspection. One relative told us, "We have received no communication about the report from the service."

Respecting and promoting people's privacy, dignity and independence
• People were not always treated with dignity and respect. People remained in clothes that they had spilt food down and were not supported to change.
• Staff did not always recognise when people required support to maintain their dignity.
• Staff routines and preferences took priority over people's care and support needs.
• People's personal information was not treated in a confidential manner. We observed senior members of staff on the telephone exchanging personal information in communal areas of the service.

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

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans were not person centred and were not reviewed consistently or updated when people's needs changed. This meant staff did not have the information they needed to provide care in line with people's individual preferences.
• Staff recording in daily notes were repetitive and failed to accurately reflect how care was provided in line with the person's care plan.
• We saw people taking part in activities at the service. However, a visiting relative told us, "They don't usually do things like this."
• The service did not support people to pursue their interests and hobbies. One care plan we looked at said the person enjoyed gardening. When we asked the provider and manager if this person got the opportunity to do some gardening the provider and manager told us, "People at the service do not like to go outside." On the third day of our inspection, a member of staff was seen supporting this person in the garden. The staff member came and told the manager how much this person had enjoyed being outside.
• A senior member of staff had been made the activities champion and they were developing this role to provide more meaningful activities for people.
• Communication care plans were in place. This lacked information about how to communicate with people effectively. Care plans did not evidence how the provider was meeting people's communication needs or meeting the requirements of the Accessible Information Standard (AIS). This standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.
• There was no evidence of meetings or other opportunities for people to express their views about their care and the support they received. The manager informed us that they were planning to hold a residents/relative meeting in the month following our inspection.

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

Improving care quality in response to complaints or concerns
• The manager informed there had been no complaints received at the service. A complaints policy was displayed in the main entrance. This was not presented in a format for people with communication difficulties to read or understand and was not always accessible to people living at the service, as this was separated by a door.
• By the second day of inspection the manager had implemented a complaints and compliments folder to enable them to log any complaints received and detail the action taken.
• A relative told us, "I haven't made formal complaints. I have voiced things in front of the manager but they don't always respond."

End of life care and support

• Care plans contained a record of people's end of life preferences.

• Three of 25 staff had received end of life care training. At the time of inspection there was no one receiving end of life care.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The leaders of the service had a lack of understanding of the importance of promoting a diverse staff team to meet people's individual support needs.
- The provider and manager did not demonstrate positive, person-centred values; they often referred to people in a disrespectful manner. Person-centred care was not promoted in the service and people did not always receive high quality care.
- There was a negative, task focused culture in the service. People were not always treated respectfully by staff. We observed staff carrying out their role and supporting people without communicating with them.
- The atmosphere was not calm and relaxed; we saw people looking distressed and anxious in the environment and this was rarely addressed by staff.
- The provider was not open or transparent. Information had not been given to people or relatives about the home being in special measures following the last inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last two inspections, in July 2017 and September 2018, quality assurance processes were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection we found the quality assurance processes continued to be ineffective and did not identify or address the issues we identified at the inspection. This included concerns about recruitment, training, supervision, record keeping, care planning, risk management, the environment, infection control, and a lack of person centred care.
- This was the third inspection in a row where the provider had failed to make sufficient improvement to meet all regulatory requirements and achieve a rating of Good.
- Numerous concerns were identified with records. These included incomplete, inaccurate and conflicting care plans; risk assessments that were not detailed; inaccurate PEEPs; poorly documented daily notes and a lack of monitoring charts for people. The lack of robust recording about people's care needs and support provided meant there was a significant risk of a negative impact to people's health, safety and well-being.
- The service had failed to implement effective systems and processes to monitor and mitigate risks to people.

This was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• There was very limited evidence that people or their relatives had been involved in decisions about their care or the running of the service. Surveys to gain feedback about the service were due to be sent out in February 2019.

• Staff surveys had been given out and the manager said that some had been returned but not all. We were advised the manager was waiting for the rest to be returned before looking at them.

Continuous learning and improving care. Working in partnership with others

• Quality audits were in place but these were ineffective and failed to record actions or drive forward any improvements needed.

• Despite the service being in special measures, there was no up to date improvement plan in place. The provider and manager acknowledged that improvements in the service had been slow and they were waiting for support from other agencies to make the improvements needed.

• We saw advice from social care professionals about how to make improvements at the service. However, we found that this advice had not always been followed.

• At this inspection we found the same breaches of regulations as at the last two inspections, which demonstrates learning and improvement had not taken place.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not provide a service that ensured appropriate care and treatment that met people's needs. People's care and treatment needs and preferences were not assessed by people with the required levels of skills and knowledge. Assessments were not reviewed regularly and where needed throughout the person's care and treatment. People's did not received person centred care.

The enforcement action we took:

Notice of decision to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times. Peoples privacy was not always maintained and independence was not promoted.

The enforcement action we took:

Notice of decision to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not adhere with the principles and codes of conduct associated with the Mental

	Capacity Act 2005, and did not apply these when appropriate, for the people they were caring for.

The enforcement action we took:

Notice of decision to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans and risk assessments relating to the health, safety and welfare of people using services were not always reviewed or kept up to date. The provider failed do all that is reasonably practicable to mitigate risks to people. The provider failed to ensure the safety of their premises and the equipment within it.

The enforcement action we took:

Notice of decision to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment was not kept clean and cleaning was not completed in line with current legislation and guidance. The premises was visibly unclean and had odours that were offensive and unpleasant.

The enforcement action we took:

Notice of decision to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to assess and monitor the service. The provider failed to monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay.

The enforcement action we took:

Notice of decision to cancel registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

the provider failed to asses staff correctly to ensure they were of good character to work with vulnerable adults.

Robust recruitment processes were not in place to ensure the suitability of staff working at the service.

The enforcement action we took:

Notice of decision to cancel registration