Parkcare Homes (No.2) Limited

Vaughan House

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
Vaughan House is a residential care home providing accommodation and personal care for up to 10 people living with a range of learning disabilities and autism. There were eight people living at the home when we inspected it.

We expect health and social care providers to guarantee autistic people and people with a learning disability, the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture. Care provided was not person centred, it did not put people first, to keep them safe, meet their mental health needs, promote their interests and hopes for the future. As a result of this people were being put at risk of harm and were not experiencing a good quality of life. The provider has started to act about these failures, but it is early days, and more improvements are needed.

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

A relative told us, "Vaughan House should be Priory's [name of provider] flagship home, with all the inspections, visits from the local authority, and managers over the years, but it's not. I blame Priory."

We still found there was a poor closed culture. Staff had not formed positive and personal working relationships with the people they were there to support and care for. Activities were very limited and there were missed opportunities during lock down and after this time to promote people's interests. Creative solutions to help people to explore their interests, develop new interests and have fun had not been considered. Some staff treated the environment as their own space and were not putting people first.

The environment was poor, and the provider had not identified this issue and taken action or made plans to do so, until this was pointed out to them by the local authority. We also found additional concerns with the environment and with the equipment used when we inspected. Safe processes and practices to manage infection control and COVID-19 were not routinely taking place at the home.

Improvements had been made with elements of how people's medicines were being managed, but we still found problems with this area of people's care. Some people's risk assessments were not complete. When issues had been identified in terms of emergency evacuations, timely actions were not completed to check these issues had been fixed.

Despite a change in management, and COVID-19, the provider did not effectively continue to monitor the service and test the quality of the care provided, to check the previous concerns had not returned. Audits

and senior management oversight which did take place, failed to identify these issues and concerns.

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

Rating at last inspection (and update)
The last rating was Requires Improvement (published on18 July 2019). Improvements at this inspection had not been sustained. There were continued breaches of the regulations at the most recent inspection.

Why we inspected
The inspection was prompted due to concerns received about institutionalised abuse, people receiving poor care and support, concerns relating to medicines, and staffing recruitment checks and support. We were told by the provider they were taking action, we wanted to check this and see how effective this had been so far. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
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 providing safe care, responding to safeguarding concerns, poor nutrition and hydration, a lack of person-centred care and support, poor maintenance of the building and equipment, ineffective leadership and provider oversight at this service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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.

Vaughan House

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
This inspection was carried out by two inspectors.

Service and service type
Vaughan House 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. 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
We announced the inspection 20 minutes before we entered the building to establish the provider's policy regarding COVID-19 infection control procedures for visitors.

What we did before the inspection
We sought feedback with the local authority and their safeguarding team. We spoke with the provider to understand what they were doing in relation to the recent concerns, this included speaking with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used all this information to plan our inspection.

During the inspection
We spoke with four people who lived at Vaughan house, the acting manager and the operations manager.

We looked at people's risk assessments, care plans, personal behavioural support plans, 'activity' charts and food menus. We also looked at staff recruitment checks, medication administration records, and we completed many observations of staff interactions with each other and the people at the home.

After the inspection
We spoke with the operations director, five care staff, three relatives and the managing director. We reviewed incident reports, evacuation plans, safety records, maintenance records and recent audits by the provider.

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 requires improvement. At this inspection this key question has now deteriorated 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

- We had received a serious concern from a member of the public about staff undertaking restrictive and abusive practices at the home. The local authority's safeguarding team were also alerted by the service and undertook an enquiry into these allegations. They identified concerns with the culture of the staff team and abusive bullying practices by some staff towards people at the home. Some staff were aware of these practices, but they did not speak up about this.
- After these concerns were raised and some actions were taken by the provider, we were told a member of staff was seen laughing at a person, but no action was taken by the managers to respond to this emotional abuse and poor staff practice. This member of staff was accidently left in charge of the home for a whole weekend as the senior who was requested to work had been suspended, and the managers had not realised the rota had not been updated. This member of staff was not a senior. The managers and provider had not taken strong action to assure themselves people were safe and well cared for. We observed a member of staff being terse with the person they had previously laughed at. We identified gaps with how the provider was managing this situation.
- We raised a safeguarding referral to the local authority during the inspection. A person was washing staff cars, there was no risk assessment or plan to protect this person from exploitation. They were not getting paid and they were using their own benefits to buy the cleaning products. This person told us they enjoyed this work. But they were vulnerable to exploitation which no one at the service had oversight of.
- Safeguarding competency checks we reviewed were not complete in showing how the assessor had assessed staff competency. Some staff were signed off as competent, even when their competency assessments showed they had gaps in their knowledge and were partially competent.

All these issues had placed people at risk of abuse. Poor staff practice and poor effective provider oversight had placed people at risk of harm. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received refresher training on good safeguarding practices. When we spoke with staff, they had a good understanding of what abuse looked like including institutionalised abuse, and how they must report their concerns. Staff said they felt intimidated by some members of staff who now no longer worked at the home, which was why they had not shared their concerns.

Preventing and controlling infection

- We identified poor infection control and COVID-19 processes in place. We were asked by staff after we had our temperature checked to wash our hands in a basin in the kitchen. There was no hot water and no disposable tissues to dry our hands. Once we had been given disposable tissues, we were asked to discard

the tissue paper in the bin, but the electric bin lid did not open. We needed to open the bin lid which looked greasy and dirty. We saw staff did not prompt people to wash their hands as a routine during the day. We saw staff wearing masks and washing their hands routinely during the inspection.

● We had asked for an additional manager who had visited the home, because the inspection was taking place, to have a remote meeting with us instead. This was to minimise the risks of infection being brought into the home and because spaces for meetings in the home were not big enough to socially distance. But they decided to stay.

● The home was not clean in parts, there was ingrained dirt. Paint work was chipped and marked. Furniture and flooring were damaged. Given the poor condition of the environment it appeared the condition had been poor before COVID-19. We looked at two people's mattresses and these were stained.

● There were dead insects behind people's blinds in their Velux windows. A Velux window in the food store room was left open, which is a pest risk.

Assessing risk, safety monitoring and management

● Risk assessments were not complete in relation to promoting people's safety. For example, people who had razors in their bedrooms and wet shaved, there were no risk assessments for these. People's self-harm assessments were not updated to reflect changes in their needs.

● The staff and the managers had not been managing people's needs well in terms of their mental health needs. A person had a period of significant crisis, but staff had not spotted the triggers and acted to respond to this need. Staff had a poor understanding about this aspect of people's care.

● One person's evacuation plan was not up-dated and another person's plan said they should have sugary food and drinks available on evacuation, but these were not present in the evacuation grab bag.

● The provider's fire assessment report for the home identified the cooker hood was dirty which posed a fire risk. We found it was very dirty with a full covering of yellow grease to it. No action had been taken here to address this safety issue. When the last fire drill had highlighted new staff needed to have further fire training, there was no additional fire drill to see if these members of staff were now competent in this area.

● We found the backdoor was blocked by two equipment charging devices. As this was a main fire exit this blocked a potential escape route in the event of a fire. Cords to this equipment lay on the floor causing a potential trip hazard. Staff had not identified this as an issue. The deputy manager immediately moved the equipment when asked.

Using medicines safely

● When the local authority safeguarding team investigated the concerns at the home, they found staff were not signing for when they had administered people their medicines, which included mood controlling prescribed drugs. We found that staff were now signing when they had given people their medicines.

● After our inspection visit, we called staff to speak with them. One member of staff answered their personal phone saying they were at work and giving people their medicines. This lack of focus could cause a medicine error.

● A person was running low on a medicine and there was no new prescription for this medicine. Late action was taken to try and resolve this issue, which meant they missed one dose. A member of staff who had tried to resolve this had not told a manager or a senior colleague about this situation to assist them in resolving this problem. This was not a safe way to manage this situation.

● A member of staff had identified a person was in pain, they thought it was a hip pain. We saw this person's legs were also shaking as this conversation took place. Instead of fetching their Paracetamol, this member of staff asked twice for this person to come with them to their bedroom to collect the medicine. This would have involved climbing a series of stairs. We needed to intervene in this situation to ensure this person was safe as they could have fallen when climbing the stairs.

All these issues had placed people at risk of harm. Poor staff practice and a lack of effective oversight about the quality of the care provided had placed people at risk of harm. This was a repeat breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● When the local authority visited the home following the safeguarding concerns, they found a series of shortfalls in the manager's safe recruitment checks. When we inspected, we found these checks had now been completed retrospectively. However, the managers and providers had not identified these previous shortfalls themselves.

Learning lessons when things go wrong

● There was a closed culture at the home in the staff team and leadership of the service. There was not a culture which identified issues and learnt from them.

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 requires improvement. At this inspection this key question has now 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Two people told us they did not like living at the home. One person said they did. These people could not tell us why.
- There was a closed culture at the home. Staff lacked the skills, training, and support to meet people's needs. Staff had returned to treating the home as their own personal space. This was evident in some of the safeguarding concerns raised. When we inspected, staff handbags were left in the lounge despite a staff room with lockers being available upstairs. A member of staff was seen sitting in the kitchen diner with their head phones on looking at their phone. Two members of staff were seen watching TV and not engaging with people.
- Staff were not engaging with people and promoting their interests to give them a quality life and a sense of purpose and fun in their daily life. Activities which staff could have supported with or replicated during lock down and after were simply not taking place. For example, some people enjoyed going to the gym and visiting allotments, despite two empty ground floor rooms and a large garden, creative alternatives were not considered or realised to replicate these interests.
- The staff we spoke with did not know how to respond to people's needs when their mental health was changing. Records showed staff did not treat people as adults during these times, referring to them as, "Mis-behaving."
- In the safeguarding allegations and from what staff told us, it was reported that people were often disciplined by some staff and in restrictive ways, such as denying desserts due to perceived 'poor behaviour'. We saw staff observing people a few feet away from them, holding a folder, there was no conversation. When a person wanted to show us their bedroom a member of staff insisted on following us and standing between us in their bedroom. There was no need for this to happen, this was confirmed by the manager. We observed that staff only spoke with people when they were asking them what they had done that day, so staff could fill out their daily notes rather than initiate any meaningful conversation to promote peoples well-being.
- There were institutionalised practices of cupboards in the lounge having pad locks. A knife cupboard in the kitchen with notice saying "Not to leave unlocked" was placed in an obvious place. Non slip yellow signs were left in dining area stacked together. Industrial bins were located at the front of the home for the public to see, which depicted the home as a care home, rather than give the appearance of a domestic dwelling.

People were not receiving person centred care and treated as individuals. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff, managers, and the provider were not promoting healthy eating at the home. Meaningful plans were not being made to encourage and support people to make some healthier choices with their food and drinks. No consideration had been given to people experiencing poor mental health and eating a lot of processed and sugary foods and drinks. When the local authority visited, they needed to direct staff to this issue. When we inspected staff did not offer alternatives to unhealthy foods or discuss healthy eating options with people.
● People were now having weekly meetings to make a menu for the week. But alternative menu suggestions were not planned for. The meal which had been agreed for the day we visited, did not happen, as the ingredients were not available.
● When we asked staff how they promoted healthy foods, they did not know how to do this. Staff who recorded what people had eaten and drank did not know why they did this. The local authority needed to direct the provider about resources available to support people to make healthy food decisions.

People's nutrition was not being considered or promoted at the home. This was a breach of regulation 14 (Meeting nutrition and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● We and the local authority identified concerns with the maintenance and upkeep of the building. There was no hot water in the kitchen when we inspected. This had been raised by the local authority on their visit two weeks prior. When we looked at the maintenance records it showed there has been an ongoing issue with hot water in the kitchen since 15 April 2020 with some actions being taken to address this issue. There had been water leaks in the home. The kitchen ceiling collapsed in July, this was fixed that day with a new plastered and painted ceiling, but no consideration was given to decorating the whole kitchen which was in a tired state.
● A double-glazed window in a person's room had blown, this was reported in July 2020 and had not been fixed. This person said, "I keep cleaning [the window] but I can't clean the mark off." New flooring had been requested but no action has been taken about this.
● A decoration plan was issued but only after this was raised by the local authority. This only included painting. No action was considered about tired and damaged furniture in the home. Curtains and people's bedding looked tired.

The building and equipment used was in a poor condition. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not taken appropriate steps to effectively monitor the service, considering the historic concerns of a poor staff culture and poor leadership at the home. The registered manager had left, and a manager was put in charge who did not have previous experience as a registered manager. Also, these changes had taken place during a national pandemic. This did not prompt the provider to robustly monitor and support the service. When the provider had been made aware of this poor culture, there was no adequate management cover during the weekends to support and direct staff.
● The provider was reactive to the concerns identified by the local authority and the safeguarding team, rather than being proactive in identifying the problems themselves.
● Provider audits were taking place, but these had been ineffective at identifying the problems with the service. These audit reports did not show detailed assessments had taken place.
● Staff were not receiving regular supervisions, regular and effective competency checks, or having team meetings. Staff did not feel the training was as effective as it could be. The local authority identified key gaps

where the provider was not providing staff with training. For example, in Autism, prompting nutrition, knowing how to manage times when people's mental well-being changed and triggers to people entering crisis.

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

- People were not involved in the developments with the service or supported to lead the service. People were asked to complete questionnaires but when issues were identified these were not followed up in a robust way, even when people indicated they had issues with some members of staff, managers did not act on this.
- When a member of staff raised issues about a person being racist and targeting them, no action was taken to address this.
- There was no culture of learning and improving.

We found the leadership at the home at management and provider level was not effective in bringing about positive change at this home. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- The provider did write to the relatives explaining the recent safeguarding concerns. Relatives told us the managers have been calling them on a regular basis to support them and offer information during this time.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not being treated as individuals. Their interests and hopes for the future were not being explored and promoted. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of experiencing harm as risks assessments and safety checks about the home and including COVID-19 were not complete. There were infection control risks which were unidentified by the service. Regulation 12 (1) (a) (b) (d) (f) (g) (h)

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 People were at risk of experiencing abuse as there had been a poor understanding by staff and the managers about what abuse looked like. Staff had not felt they could speak up. Regulation 13 (1) (2) (3) (4) (C)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not supported to have a balanced diet, be active, and manage their mental well-being in relation to nutrition. Regulation 14 (1) (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and environment were not being properly maintained to ensure it was clean and safe for people. Regulation 15 (1) (a) (d) (e)