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

Summary of findings

Overall summary

We inspected this service in June 2016 and rated the home as 'Good' overall. When we inspected the service on 8 November 2018 we rated the service as Inadequate overall. This is the first time Vaughan House has been rated as Inadequate overall. This inspection was not announced.

Vaughan House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Vaughan House provides personal care and accommodation for people who have a range of learning disabilities. Vaughan House can provide care for up to ten adults. At the time of the inspection ten people were living at the home. Vaughan House comprises of accommodation over two floors.

This service has not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. These principles were not being promoted and actively introduced into the home.

There was a registered manager in place when we inspected the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was poor oversight and leadership of the service. Provider and internal audits were not effective. They had not identified the issues which we found at this inspection. They had identified in the summer that the service was not delivering good care to people. However, they had not taken timely action to correct this. The day to day management of the home was also not always effective.

Plans to keep people safe were not always being followed by staff. A combination of ineffective staff practice and risk assessments meant people's safety was not routinely promoted at the home. People's medication was not always stored and managed in a safe way. Specialist advice and guidance was not sought to keep people safe.

There was a poor culture at the home. Staff did not always treat people in a kind way. Staff sometimes did not respect that this was people's own home.

Staff knowledge and ability to perform well in their work varied. Despite this being known by the management and provider action had not been taken to address and resolve this issue. The management team had not created strong systems to monitor staff abilities. Staff training was not always effective.

People were not involved on an individual basis with what they could eat and drink. The meal experience was not a social one. Independence with food preparation and healthy eating and life styles were not promoted at the home.

Staff did not spend real time with people chatting and engaging with them. There was a lack of social events taking place. People's interests, dreams and ambitions were not developed and promoted at the home. Real plans to support people to achieve what was important to them were not made and reviewed.

Some of these issues constituted breaches in the legal requirements of the law. There were five breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

People's safety was not always checked and promoted resulting in unnecessary risks to their safety and welfare.

The provider and management did not ensure they stored oxygen cylinders in a safe manner.

The provider did not ensure staff followed people's risk assessments.

The provider did not ensure that people's medicines were stored or administered safely.

There were hygiene and infection control risks

Is the service effective?

Requires Improvement

The service was not always effective.

There was poor direction of the staff team to ensure people's needs were met and people received good support.

Staff were not knowledgeable about people's needs and how to keep them safe.

Specialist professional guidance was not sought and followed to meet some people's needs and keep them safe.

People were not fully involved with what they ate and drank.

Heathy food was not promoted at the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were unkind at times and controlling towards the people at the home.

Staff did not always respect people's personal spaces.

The provider did not value people's home environment.

Is the service responsive?

Inadequate

The service was not responsive.

The service did not provide person centred care to people.

People's interests and ambitions were not promoted at the home to ensure people had good lives and had opportunities to explore their interests.

People did not have end of life plans in place.

There was a complaints process, but complaints were not always well evidenced.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of consistent and robust leadership and oversight of the service.

There was a poor culture at the home, people were not always valued at the home.

Internal and provider audits were not effective or of a good quality.

Vaughan House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection site visit took place on 7 November 2018. The inspection was unannounced. The inspection team consisted of one inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is someone who has experience of this type of service.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service and we took these into account when we inspected the service. We looked at the notifications that the registered manager and previous managers had sent us over the last two years. Notifications are about important events that the provider must tell us about.

During the inspection we spoke with five people who lived at the home. We spoke with four people's relatives and four members of the care staff, and the registered manager. We looked at the care records of four people, the medicines records of two people and the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and safety records completed at the home.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually 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 the report.

Inadequate

Is the service safe?

Our findings

We inspected Vaughan House in June 2016 and found the service was safe, at this inspection in November 2018 we found the service was not safe.

A person used oxygen to support their breathing at night. In their room there was a water tank for the building which could reach high temperatures. On 5 November 2018 the temperature reading for this water tank was 50 degrees Celsius. The management of the home knew that this person's room must not reach 50 degrees as this could cause the oxygen cylinders to combust. A plan was in place to monitor this. However, the management team including the provider had not risk assessed this additional heat source which the cylinders sat next to. They had not sought a specialist assessment of this situation or spoken to the manufacture of the oxygen cylinders to explore and respond to this unique risk. The management team had not followed current guidance with the safe storage of oxygen cylinders as they were sited too close to the heat source. The management team and provider had not identified this risk which could cause a fire.

The person who used these oxygen cylinders was at risk of falling. Their cylinders were not attached to the wall. The person's room was small and they had little room to freely walk about it. Therefore there was a risk that these cylinders could be knocked over. This placed this person and others at an increased risk of harm.

We spoke with the provider about this issue. They made plans to assess this risk. We were later told by the registered manager what plans had been made to respond to this potential risk. Such as connecting the cylinders to the walls and moving them further away from the heat source. They also told us that a specialist fire safety assessor was visiting the home to assess this risk.

People's medicines were not always stored safely. People had lockable medicine cabinets in their rooms. We found that one person's medicine cabinet was not locked. We showed the registered manager who then locked it. The cabinet contained scissors which we were told could be a risk to this person or others. In this person's risk assessment, it stated that it was not safe for them to administer their own medicines. There were other people living at the home where it was considered to be a risk if they had access to medicines. When we went into this person's bedroom their door was unlocked which meant that other people could have accessed this person's medicines. As a result of these actions by staff people could have been harmed in some way.

This person also had two prescribed items in their room, both were open without a lid. Another person had a prescribed cream in their room opened and nearly used without an open date on it. Staff should have used a system to know if these items should not be used after a period of opening them, as they had done with other items in the home. This meant that staff did not know if these items were still effective to treat these people's health needs.

Some people's prescribed creams and toothpastes were not being recorded on the Medication Administration Record (MAR) as being given to people. This meant that the service had no way of monitoring that these prescribed items had been administered to people.

The service did not have a safe system for signing out people's medicines when people went out and medicines were required. The member of staff signed the MAR to say the person had had their medicines when in fact they had just taken them out of the home with them. There was no further check when this person had returned to the home, that they had received their medicine and at what time.

The medication audit completed at the service did not complete a count of what medicines had been given to people and what medicines remained. This would be a good check to see if people had received their medicines. Over the last six months there had been some medication errors. Despite this the management and the provider had not ensured that there were strong systems to check that everyone had received their medicines.

A person was at risk of falling and was unsteady when walking. The person's only means of accessing their room, the lounge, and the shower room was via a staircase. There were parts of the staircase where the person could not hold onto both sides to support their balance. The plan in place for this person when using the stairs was not being followed by staff. Staff were not walking with this person when they were using the stairs. We observed this person struggling to use two steps in the kitchen. The management team had not sought professional advice about the plan in place for this person or whether the stairs were safe for them to use. We spoke with the registered manager about this. They then made a referral for a specialist professional to visit to assess these issues as a result of our conversation. This issue had also not been identified by the provider.

One person was at risk of choking. There was a plan in place from a specialist professional advising staff what to do to prevent this person from choking. However, at some point it had been decided by some members of staff that staff did not need to follow this plan. No contact was made with the appropriate professional to check it was safe to do this. No conversation had been had with the registered manager about this. We identified that staff had given this person food which would be difficult to swallow. Staff had also not monitored this person eating this dry food for lunch. We spoke with the registered manager about this. They spoke with staff straight away to correct this. They then made a new referral to this specialist team to seek their advice.

During this inspection we found infection control issues. Two people's shower rooms had mould in them, sinks and taps were not clean. People had dusty extractor fans in their rooms, and pull cords for toilet lights were stained brown. One person had two sponges on their sink, these were discoloured and did not look clean. One person had a mouth piece for their inhaler, it was not clean. Toilet brushes sat in water. These are all infection control issues and could make people unwell. The management team and the provider were unaware of these issues.

We observed staff preparing people their lunch. One member of staff wore gloves but they did not wear an apron. We saw another member of staff slap a knife in their hands repeatedly and then use the same knife to butter bread, they were not wearing gloves. One person had multiple used gloves in their bin in their bathroom. We showed this to the registered manager, they agreed that this is not a safe way to dispose of these items.

One person's radiator cover had completely come off their bedroom wall. This radiator cover was long and heavy and could hurt a person. There was a separate piece of wood against the wall which belonged to the radiator cover which had sharp edges to it. The person who lived in this room could sometimes express aggressive behaviour towards others at the home. The registered manager was unaware of this matter and told us that they would get this item fixed.

In both bathrooms in the mornings the floors were wet and slippery. This was a potential risk to people, because they could slip and hurt themselves. This risk had not been identified with a plan in place to manage this risk.

People had household cleaning products in their rooms. There was no risk assessment about the storage of these items which meant that the management team and the provider did not know if people were safe having access to these products.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were plans in place if people left the home alone when they were not safe to do so. However, these plans lacked some information such as where they might go to. This could be important information to pass onto the police or for staff to try and find these people.

Staff had a clear understanding what abuse could look like. They knew that they were to report any concerns to the registered manager. However, two out of the three members of staff we spoke with were not aware they could also report their concerns to the local authority. Staff knew what discrimination looked like, but they did not know what they could do about this.

The management team had a system to manage accidents and incidents. We looked at one of these and found that appropriate action had been taken to manage the incident to ensure the person was safe. However, on one person's plan who had epilepsy it stated that they had weekly seizures. Their seizure chart was not being completed. This is important, so that the information can be analysed to promote this person's safety.

One person told us that they felt safe. They said, "The staff keep me safe."

There were various safety checks completed to ensure the building was safe. These included fire safety checks, fire drills and checks on fire related equipment. The service checked the water was free of the virus legionella, which can cause people to become unwell.

There were sufficient members of staff on duty and who worked at weekends and evenings. However, there was a lack of consistent oversight on how the shift was working and the practice of staff, to ensure people were receiving good support and they were safe.

We looked at the recruitment checks completed on staff. We found that staff had full employment checks in place. Staff also had references, and Disclosure and Barring Service checks in place (DBS).

Requires Improvement

Is the service effective?

Our findings

When we inspected Vaughan House in June 2016 we found that the service was effective. However, when we inspected the service in November 2018 we found areas where people did not receive effective care.

Staff competency was not being routinely checked to see if they were competent in their work, even when errors had occurred. For example, one person had recently experienced a medication error and a blocked catheter which had resulted in them being admitted into hospital. Still staff competency in these areas were not being checked. The registered manager showed us a competency assessment to be used to monitor staff competency, however, this had not been implemented nor was it clear what action they would take if staff were not competent.

New staff did not receive a robust or meaningful competency check before they started working independently. We identified at this inspection that a new member of staff was working independently at times. However, the management team had no assurances that they safe to do so. No process had been followed and evidenced to form this decision.

Some members of staff spoke positively about the face to face training they received. They told us that they found this a better way of learning as they could ask questions during the training. These members of staff found the on-line training was not effective. They told us if they needed to repeat the test they knew how to manipulate it so they passed it, without knowing the answer. Staff had not been asked by the provider about their views of the training. The management team had not considered other ways to check that staff had a good knowledge in certain areas of their work or if the training was effective.

Risk assessments and plans relating to the people at the home were detailed. These plans gave staff information about how to meet people's needs and keep them safe. However, staff were not looking at these plans. The management team had not created a system to enable staff to look at these assessments and plans. The management team had not assurances that staff were following these plans.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Healthy food options were not being promoted or suggested by the staff team at the home. We observed breakfast, lunch and the evening meal. At no point were healthy additional or alternative foods suggested. At breakfast there was a large pan of congealed porridge. We asked a member of staff who this was for. They told us it was for staff, but later we saw them serving it to two people at the home. Staff did not suggest fruit or anything else with this plain porridge. At lunch time people were served fried eggs or bacon sandwiches with crisps. Again, no healthy additional or alternative food was explored with people.

People were not asked if they wanted something else to eat. Everyone ate the same food; no choices were offered. One member of staff told a person, "Its bacon sandwiches for lunch." We also questioned if this was enough to eat at lunch time. People were not offered snacks during the day.

There were food menus in place. We were told that these were decided at weekly meetings. However, on the day we inspected the home staff were unclear what was for dinner. One member of staff said, "Minced beef with pasta." However, we noted everyone had chicken curry. When we looked at the historical menus there were no alternatives on these. At lunch time people were given juice but they were not asked what they wanted to drink or what flavour of juice they wanted. The service had no menus for the last two weeks, eventually it was identified that these menu meetings had not taken place. The menus were also not written in a way which people could all understand. We concluded that we could not be confident that people were being involved in a meaningful way, with what they were being offered to eat and drink.

The meal times lacked a social atmosphere. People sat together for dinner with staff who also ate. However, staff did not try to have a conversation with people. One member of staff got up to get a drink, they did not ask if anyone else wanted one. The registered manager told us that they assessed the meal experience daily. There was no record of this.

One person who had lived at the home a long time told us about their views of the food at the home. "My favourite would be a nice steak and chips, but I have never had that here."

One person was at risk of being an unhealthy weight. We saw how this was being monitored by staff on a regular basis. We saw that this person's weight had increased and stabilised. However, there was no plan in place of a weight goal, with a guide or prompt for staff to follow if this person lost further weight for staff to easily follow.

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).

The staff we spoke with told us how they promoted choice with people at the home in terms of their daily needs. However, when there were opportunities where staff could do this when we were at the home, these were not explored. For example, people were not offered choice of what to eat or drink.

People had capacity assessments for particular decisions. However, it was not always clear what the outcome was. The assessor at the home also only had these conversations once. Good practice would have been to return at different times to check these people had capacity regarding particular decisions. One person had an assessment about whether they could manage their money. It was unclear if this person wanted to have this conversation about their money at this time. Which questioned how effective this assessment was and the conclusion reached about this important issue of whether this person could manage their own money.

We could see that DoLS were in place for some people. Staff were adhering to these conditions. However, when we spoke with staff they knew what a DoLS was but not who had a DoLS in place and what were the reasons for this. Staff could not tell us how these people's movements were being restricted. We concluded that further work was needed to ensure the service was compliant with the MCA and DoLS.

The design and layout of the home had not been considered for all those living at the home. Two people had real difficulties in walking. The staircase had not been considered to ensure it was safe for a person to use, or if they could use the stairs safely independently. Another person only had access from their room to the kitchen. There was a long drop from the back door to the garden. We were told a portable ramp was placed there in the summer for this person with rails either side. However, this was not in use when we visited. There were steps leading to the lounge and the kitchen which this person could not use. Options had not been explored by the provider and the management team to maximise people's access to their home.

We saw recorded that people were supported to attend health appointments when required.

Requires Improvement

Is the service caring?

Our findings

When we inspected Vaughan House in June 2016 we found that the service was caring. When we inspected the home in November 2018 we found at times it was not caring.

During the inspection we saw two members of staff speaking in a stern way to a person living at the home. One member of staff was pointing at them and saying in a loud voice, "No you will not do that." Both members of staff looked angry. Their body language looked assertive and animated. Another example was where a person was sitting down waiting to have a shower. They asked a member of staff for assistance to have a shower. The member of staff said, "You can wait till I am ready or you can come and have a strip wash downstairs." We observed another member of staff speak in an abrupt way to a person when offering them crisps at lunch time. On two of these occasions when staff noticed we were present they changed their behaviour and were kind to these people. Helping, smiling, and lightening their tone of voice. This told us that these members of staff knew how to be kind and respectful to people, but were choosing not to.

We spoke with the registered manager about these unkind and disrespectful situations we had seen. They contacted the local authority and raised two safeguarding referrals. They made plans to ensure the staff members involved did not work with people independently. An investigation was planned by the local authority.

One person was not feeling well on this day and wanted to remain in their bedroom. We observed one member of staff knock on their door say who they were, and then enter. They did this each time they checked on this person. However, we saw another member of staff check on this person on three occasions. They did not knock, they just entered the person's room demonstrating a lack of respect for people's private space. We were told by two members of staff that this person was anxious. This person's relative told us that they were anxious about another person who also lived at the home. This member of staff was also not considering that this person may be apprehensive if someone just came into their room, when they did not know who it was.

When we visited people's rooms we saw that people had boxes of gloves for staff to use during personal care, on clear display in their rooms. This is not respecting people's bedrooms as their own spaces.

The home environment looked tired in most rooms apart from the lounge. For example, there were marks and chips in the paintwork, furniture looked neglected, one person's curtains had fallen off the curtain rod and had been placed on top of their wardrobe. The registered manager told us about plans to re-decorate the communal spaces but indicated they were not aware that people's rooms needed attention. We were later told by the provider that people's bedrooms would be included in this redecoration programme, however no real plans had been made. No one had spoken with the people who lived in the home about this.

The above issues constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they supported people to be independent. However, we saw missed opportunities during the inspection. For example, at lunch time people were not asked to help prepare the food, or contribute in some way towards this. The same happened when the evening meal was prepared. A member of staff needed to collect some people's medicines and did not ask if anyone wished to assist with this task. Staff talked among themselves in terms of allocating certain tasks out. People were not involved in this.

When we spoke with people's relatives, some told us that they felt comfortable and welcomed into the home when they visited their relative. Most relatives told us that they did not enter the home, when they came to see their relatives. Relatives said they often waited outside for their relatives.

Inadequate

Is the service responsive?

Our findings

We visited Vaughan House in June 2016 and found the service was responsive to people's needs. During this inspection in November 2018 we found that this was not the case.

People's care records reflected some people's physical needs. However, these were not always accurate or completed in full. We found examples of when staff were not actually meeting these needs or raising with the management of the home issues or concerns about some people. The leadership and the staff of the home were not routinely looking at people's needs to check if in fact people's needs were being met, or if the service could do better in this area of people's lives.

People's ambitions and dreams were touched upon in these records but they were not dealt with any real detail. We looked at one persons one to one meetings in August 2018, they had said that they wanted to be healthier and more active. In September 2018 at the next meeting there was no information about how they were achieving that goal. Instead there was a statement that this would be looked at again when the weather improved. There was no evidence or plans in place to look at ways to promote this. This goal had been put on hold for some months, this did not prompt the member of staff who was writing it to consider if this was necessary or what other plans they could support this person to make to try and realise this goal. People were not being fully involved in the planning of their care.

People had activity plans in place. This charted what activities they had completed and if it fulfilled their wishes. However, these were largely domestic and routine activities. One person chose to smoke. On one of their activity plans it stated they had spent a day smoking. This is not an 'activity' for this person, this is part of their day to day life.

Some people went out shopping and about in the local area with the support of staff. We saw this take place during our inspection. People told us what they liked to do when they went out and this was reflected in people's plans. However, there were no planned events or occasions in or out of the home. Staff did not try and promote what people liked to do. Staff did not explore people's interests and make real plans with them.

When opportunities arose to develop people's social needs at the home this was not taken advantage of. A member of staff told us about the ideas they had to do this. They told us that they had spoken with the registered manager about this, but no plans or action had been taken. With one exception, we did not see staff spending real time with people as part of their work, chatting and engaging with people. Most people had lived at the home for a long time, but staff did not seem to really know people. The service had not supported people to make and sustain friendships inside and outside of the home. We observed time when staff were not thoughtful or considerate to the people who lived at the home. When staff treated people in a disrespectful way.

The condition of the environment of the home had not been considered for some time. Purposeful plans

were not in place to improve the quality of people's day to day life at the home. The provider was not valuing people by ensuring there were robust systems to ensure the service promoted and met people's needs and wishes.

Some people's needs were not being met or considered at the home. There was no robust system to check if people received person centred care. For example, one person lived with breathing difficulties. Their room was hot, the management team had not considered if this could have had a detrimental impact on this person. A plan had been made to start to address this issue, but no action had yet been taken. This person had lived at the home for a long time but this issue had not been identified before.

The above issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Technology was not being used at the home to support people to meet their needs and explore their interests. By for example looking on the internet to look at ways to explore their likes and interests. Or for making plans for the future about how they were going to be supported to fulfil these interests.

We were told about one person who moved to the home sometime after we last inspected the service. We were told that this person was placed by a previous manager without the consideration of the other people who lived at the home. We were told how this has had a detrimental effect on one person's wellbeing. Action had been taken by the current registered manager to resolve this issue. However, a member of staff and a person's relative was anxious this would happen again.

People did not have end of life plans in place. No consideration had been given to address or plan for this part of people's lives.

There was a complaints process in place. From looking at the complaints records we saw that a complaint had been raised, but there was no information to say how this complaint had been dealt with and processed. During our visit a person wanted to make a complaint. The area director talked through with the person the complaints process using an easy read format.

A person's relative said, "I think [name] is the best they have been for a long time. I am happy with the care given [name]."

Inadequate

Is the service well-led?

Our findings

When we inspected Vaughan House in June 2016 we found that the home was well led. However, when we inspected this time in November 2018 we found that the home was not well led.

The provider had not taken action to ensure the home had effective management. The day to day leadership of the home was not effective. We identified several issues with staff practice which led us to the conclusion that there was a lack of robust oversight, presence and direction of the staff team. Issues of staff practice had previously not been identified and resolved by the provider or the management team of the home.

There was a poor staff culture at the home. We saw three examples of different staff exercising control over people. Staff did not consistently promote the home as people's own home and space. The provider and registered manager acted when we identified these issues. However, we were not confident had we not been at the home and seen these issues relating to staff culture, that they would have been identified and therefore dealt with.

The provider and registered manager's audits were not effective and had not identified the issues which we found during the inspection. The provider had completed a health and safety audit this year but they had not identified the potential risk of a person's oxygen cylinders combusting or how this person's breathing could be being adversely affected due to the temperature of their room.

Staff performance had been identified by the registered manager and the provider some time ago. However, there was no active plan in place to address this and make positive changes by the management team and the provider.

The provider had not ensured that people's care plans were followed which placed them at risk of harm. The provider had not ensured the environment was assessed to check it was safe for some people to use. Nor had consideration been given to see if people's safety and independence would be promoted at the home. Internal audits also had not sought to check this.

The management and provider had not checked to ensure that people's interests were being promoted at the home in a meaningful way. People were not being involved in the development of the home.

The registered manager and provider also managed another service close to Vaughan House. We had inspected this service some months before and found the same or similar issues. It is a concern that the management team and provider had not learnt from lessons and issues identified at the earlier inspection. The local authority had been very involved with Vaughan House this year. Still the service was not providing good care to people. The management and provider had not created systems to identify areas of improvement and checked these had taken place.

Some plans to improve the quality of care given had been partially made, but these were not being

implemented. Or the plans were not complete to ensure they would meaningfully make a difference to people's lives. For example, the environment of the home was in part in a poor condition and registered manager had not identified this as an issue. There were no meaningful plans in place to address this. This issue had not been identified during the provider and registered manager's audits.

The service was not implementing the recommendations of registering the right support. This is CQC guidance about ensuring that people with a learning disability are fully supported to live as meaningful and independent lives as possible. The provider was not implementing the principles of this guidance in terms of supporting people to live as independently as possible and fulfilling people's goals.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were multiple breaches of the Health and Social Care Act 2008 as a result of this inspection. We sought assurances that the provider was correcting the issues we found and making real plans to improve the service.

There were no attempts to try and involve the community or external organisations with the home.

There was a registered manager in place. The registered manager was aware of the important events that they must notify us about. We saw that they notified us about these events and gave clear information about what the issues were and how they were managing the risk. Relatives spoke positively about the registered manager.

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 Regulation 9 HSCA 2008 (RA) Regulations 2014: Person centred care The provider had not ensured that people's social needs and preferences are met. Regulation 9 (1) (a) (b) (c). (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and Respect The provider had not ensured that people are always treated with dignity and respect. Regulation 10 (1) and (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b) (d) (e) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider had failed to have effective systems and processes in place to monitor and improve the safety and the quality of the service. Regulation 17 (1) and (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The provider had not ensured that there are always suitably qualified competent staff at the service. Regulation 18 (1) and (2) (a).