

Ablecare (Philphaugh) Ltd

Philphaugh Manor

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Philiphaugh Manor is a residential care home providing personal care to up to 32 people. The service provides residential care to older people who may have a physical disability. At the time of our inspection there were 23 people using the service.

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

We found repeated concerns from the last inspection. Risks were not always identified, assessed and recorded. Care plans were completed for each person and contained details of the person's needs and preferences. However, changes in people's needs were not always recorded. Reviews had not taken place monthly as stated by the provider in a recent Provider Information Return (PIR).

There were sufficient staff to support people at the time of this inspection. However, the service was not fully staffed and was struggling to recruit new staff to vacant posts. The service was not using any agency staff at the time of this inspection, but some staff were working over 60 hours a week to cover shifts. Recruitment procedures were robust.

We found repeated concerns with medicines management and administration, as at our last inspection. People did not always receive their medicines as prescribed. This was because some medicines were unavailable. Medicine records contained gaps. We were not assured people had prescribed creams applied as required. Risk assessments for medicines such as anticoagulants were not in place. Four out of five staff were overdue for medicines training.

As at the last inspection, auditing and monitoring processes were not robust at the time of this inspection. Monitoring records were not being reviewed. Some skin check records had inappropriately ceased several days before this inspection. The service had not implemented effective quality assurance systems to monitor the quality and safety of the care provided.

There were concerns with the premises. Water pressure and supply had been an issue due to a large mains leak under the building. This was being addressed but water pressure issues were causing difficulties for staff providing baths for people.

A recent fire survey had found some non-compliance with regulations. The provider was asked for written assurances about when recommended actions would be completed. This had not been received.

Carpets in the lounge were torn and badly stained and malodorous throughout the service. Some corridor carpets had been replaced. Some furniture was malodorous. The gas cooker was faulty during this inspection. The gas oven could not be turned off and needed to remain lit to prevent gas escaping. The provider and staff made arrangements for food provision for the next few days and notified relevant agencies to resolve the matter.

Accidents and incidents were recorded. However, these events were not currently being audited or reviewed. This meant the opportunity to reduce the risk of reoccurrence of accidents had been missed.

People's care and support needs were assessed before they started using the service. People received support to maintain good health and were supported to maintain a balanced diet. Some people were having their food and drink intake recorded; however, this was not recorded in their care plans or on the shift handover record. This meant new or temporary staff would not be aware of the need for this monitoring.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. There was no record of people, or their legal representative, having been asked for their consent to having their photographs displayed in their records.

Mental capacity assessments had been carried out where it was indicated. Deprivation of Liberty Safeguards (DoLS) authorisations had been applied for appropriately. We were told there was one authorisation, for a restrictive care plan, in place at the time of this inspection. However, the manager's records were not an accurate oversight of people's DoLS status and no authorisations were in place. This meant people may be being unlawfully restricted.

The transition to a new electronic care planning system was not managed well. The maintenance person was leading this task and had inappropriately advised staff to cease keeping some paper records before being taught how to use the electronic system. This meant there was a risk changes in people's need would be missed.

People told us they felt safe with staff. There were systems to help protect people from abuse. Posters displayed the contact details for the local authority safeguarding unit.

People were supported by staff who were knowledgeable and were skilled in their role. Some staff training updates were overdue, but we were assured there was a plan to address this.

Staff were tired but felt supported and were able to access the management team whenever they needed any assistance or guidance. Staff comments included, "(Manager's name) works with us regularly at the moment, they have found themselves in the deep end, it's really hard at the moment with not enough staff," "Things are tough, we have often got none or very few staff. The weekends and the nights are a struggle. The managers are doing nights, we are so short" and "The place is looking tatty to be fair, the carpet in the lounge is awful. Two new bathrooms, but they don't work that well. We have not been able to do baths as we don't have the staff the water is not running well. We had to boil pans a couple of months ago because of the water problem."

People told us they liked living at Philiphaugh and that the staff were caring and responded when they called. Comments included, "Yes, I am fine here they are kind to me." "I like the food good enough" and "I am ok here, I have visitors sometimes. I can do what I like." A relative told us, "(Person's name) is always clean, her room is clean and the staff are kind to her. Staff are always nearby."

People were asked for their views by the management team. A survey in February 2022 and a residents meeting had sought people's views on the service provided. However, the responses had not been audited or reported upon so any actions which may have been needed had not been addressed.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update:

The last rating for this service was requires improvement (published 21 June 2019) We found breaches of the regulations and also had made recommendations following the last inspection.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

We carried out this inspection to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 monitor the service and will take further action if needed.

We have found repeated breaches in relation to risk management, management, governance and oversight. New breaches were found regarding consent and premises at this inspection.

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

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.

Enforcement

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We identified breaches in relation to the management of risk, premises, medicines, provider oversight and consent at this inspection. We issued warning notices requiring the provider to meet the requirements of the regulations by 26 August 2022. If they fail to do this we may take further action.

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective

Details are in our effective findings below

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well led

Details are in our well led findings below

Inadequate ●

Philiphaugh Manor

Detailed findings

Background to this inspection

Inspection team

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 Health and Social Care Act 2008.

Inspection team

The inspection was carried out by three inspectors.

Service and service type

Philiphaugh Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

Registered manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was no registered manager in post. A manager was about to commence the application process to become the registered manager.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Before the inspection, we reviewed information we held about the service and the provider which included any statutory notifications sent to the CQC. A notification is information about important events which the service is required to send us by law. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information

about their service, what they do well, and improvements they plan to make.

We used all of this information to plan our inspection.

During the inspection

We reviewed ten people's care plans and risk assessments. We reviewed 15 people's medicines records. We looked at three staff files in relation to recruitment. We reviewed staff training and supervision. We also reviewed other records relating to the management of the service, including complaints received. We met with the acting manager, the duty manager, the provider representative, four staff and two people.

We spoke on the phone with one relative and a visiting healthcare professional, about their experience of the care provided.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection this key question has remained requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection we found there was a lack of robust risk management around fire and environmental issues and a lack of up to date information around risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider remained in breach of this regulation.

- At our last inspection we found fire doors were propped open with furniture and other objects. At this inspection we found the manager's office and staff office both had fire doors held open with furniture. A weekly fire alarm test was carried out by the maintenance person during our inspection, both doors remained held open and would not have closed in the event of a fire. This alarm test was not robust.
- At our last inspection we found a recent fire risk survey had been carried out by the maintenance person at the service. Despite this we found concerns with the fire risk management. This was referred to the fire service for review. At this inspection we found the fire service had reviewed the service and issued a notice of non-compliance with the regulations, in November 2021, with actions to be taken. The provider had completed some of the required actions. However, an extra fire door was required on a first floor corridor. This had not been fitted. We sought written assurance from the provider that urgent action would be taken to meet the requirements of the regulatory reform (fire safety) order 2005. This was not received.
- At our last inspection staff told us about a bath lift which they did not feel comfortable using. This meant people were not being bathed as requested. At this inspection we found two bathrooms had been refurbished since the last inspection however, only one was usable, due to a broken bath lift in the second bathroom taking it out of use. Staff and management confirmed this had been broken for several months. Staff told us, "Two new bathrooms, but they don't work that well. We have not been able to do baths as we don't have the staff and the water is not running well. We had to boil pans a couple of months ago because of the water problem." The service had experienced a large water mains leak below the building which was being addressed. The impact of this leak was low water pressure.
- At our last inspection risk assessments had not been reviewed regularly and changes had taken place in some people's needs which had not been recorded effectively. At this inspection we found this concern continued. For example, one person was unable to stand independently, they required two staff and equipment to be moved, a wheelchair to move around the service and had a dressing which required the community nurses attention. Their care plan stated they were able to stand independently, walk with a

frame and use a bed lever when getting in and out of bed. There was no mention of a dressing. Staff and relatives confirmed this was not accurate. Comments included, "(Person's name) cannot walk, or get in or out of bed without staff assistance and equipment" and "(Person's name) needs help for most things."

- Another person who had been a resident since February 2022 did not appear on the weekly/monthly service users weight records list. This meant they had not been regularly weighed since admission and any concern would not have been identified as required.
- We were shown the book in which staff recorded when people had been weighed. However, this information was not transferred to their paper care plans or on the electronic system. This meant there was a risk staff would not be aware of any concerns with a person's weight.
- At our last inspection we found some people required specific equipment to protect their skin from pressure damage. Pressure relieving mattresses were in place for people who had been assessed as needing them. Some of these mattresses were not set correctly for the person using them. At this inspection we found two mattresses were in use, one was set incorrectly. There was no process in place to monitor these mattresses, to ensure they were set correctly. This meant that people were at risk of sustaining pressure damage.
- The gas oven was faulty during our inspection and could not be turned off and required to remain lit to prevent gas escaping. The provider and catering staff made arrangements for food provision for the next few days and notified relevant agencies to resolve the matter. We were provided with assurances following the inspection that the gas had been isolated from the cooker and a part was on order.

The failure of the provider to ensure robust risk management around fire and environmental issues and a lack of up to date information around risks to people is a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At our last inspection emergency escape plans (in the event of an emergency) were not in place. This meant the fire service did not have access to necessary information on how to support people safely to evacuate the building in the event of an emergency. At this inspection we found these were now in place in people's care plans and in the fire book by the door of the service, for use in an emergency.

Using medicines safely

At the last inspection we saw that medicines were not managed safely, and improvement was needed.

At this inspection we saw that not enough improvement had been made and people were still at risk of not receiving their medicines as prescribed. This contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Management and team leaders were trained to administer medicines. Updated training was overdue for four out of five staff. There were no internal medicines audit process in place and staff had not identified the errors that we found on inspection. The medicines policy did not reflect best practice as described in NICE guidance or HSCA 2008 (RA) regulations 2010.
- Care staff applied external medicines, such as creams, during personal care. Care staff did not receive any training and were not checked to make sure they were competent to safely apply medicated creams. There was no guidance for care staff to follow about how or where to apply creams and there was no record kept of their application. Medicine administration records (MARs) indicated that application of creams would be recorded in people's daily notes. But when we checked, this was not happening.
- Some people were prescribed medicines to be taken when required, for example for pain relief. There was not always guidance or pain assessments for staff to use to make consistent decisions about whether a

medicine might be needed. At the last inspection staff told us they just knew how to administer these medicines or followed the previous pattern. We saw, and were told, that this practice continues. Some medicines need a minimum gap between doses. Staff did not record the time of administration, so could not be certain that enough time had passed before giving the next dose. This put people at risk of taking too much or too little medicine.

- We found that MARs were not always signed, or a non-administration code used. This meant it was not possible to tell if people always received their medicines as prescribed.
- At the last inspection we saw that people sometimes ran out of medicines. We found this was also the case at this inspection. A regular medicine for one person had been unavailable for 12 days, which put them at risk of harm. The service told us this had been chased up repeatedly but there was no recorded evidence of this.

Poor management of medicines left people at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Storage of medicines had improved since the last inspection, with the medicines trolley being secured when taken outside of the treatment room. Temperatures of medicines storage areas were checked regularly and were within range.

Learning lessons when things go wrong

At our last inspection there was a failure of the provider to ensure there were robust systems to monitor and improve records and the lack of robust process to monitor services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found the provider had not taken action and the service remained in breach of this regulation.

- At our last inspection accidents and incidents were recorded however, the registered manager did not formally record an audit of such events. This meant there was not an overview to help ensure any trends were identified. Actions taken to help reduce re-occurrence were not clearly recorded. At this inspection we found accidents and incidents had been recorded but there was no recent audit of such events and opportunities to reduce reoccurrence had been missed.
- At our last inspection the regular auditing of the service, including care plans and medicines management had not taken place regularly. We found concerns which had not been identified by the provider prior to our inspection. At this inspection we found the manager was not completing any audits due to staffing pressures. Four out of five staff who administered medicines were overdue for training, yet they were the people signing off others as competent. Care plans were not always accurate and staff had completely ceased monitoring people's skin condition several days prior to the inspection. The provider and manager were unaware of this concern.

The failure of the provider to ensure there were robust systems to monitor and improve records and the lack of robust process to monitor services was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations 2014.

Systems and processes to safeguard people from the risk from abuse

- There were safeguarding processes in place and the service had made appropriate referrals to the local authority where required. However, the lack of effective monitoring of risk meant people were at risk from

harm.

- People told us they felt safe with the staff that supported them.
- Staff knew how to recognise abuse and protect people from it. Staff had received training in how to keep people safe.

Staffing and recruitment

- The staff rota showed the covering of shifts was very tight, especially at weekends. The service had sufficient numbers of staff to meet people's needs, on the day of this inspection. However, some staff were working over 60 hours a week to cover vacancies, which the provider was finding difficult to recruit to. There was no risk assessment in place regarding the risk to staff and to people being at risk of unsafe care. The ex-registered manager had returned to cover some night shifts and the current manager was also working many shifts providing care in order to meet peoples' needs.
- Recruitment practices were robust. Staff files showed the relevant checks had been completed including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

The service was supporting visits from families and friends. Systems were in place using current COVID-19 guidance to support these visits, including testing and use of PPE.

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.

At our last inspection we rated this key question requires improvement. We found a breach of the regulations regarding staff support. We also made recommendations regarding consent and signage to support people living with dementia.

At this inspection this key question has remained requires improvement.

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 MCA 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 when this is in their best interests and legally authorised under the MCA. 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection we found there were no formal record of people being asked to sign in consent to care and treatment and for photographs to be displayed of them, in their care plans. A recommendation was made.

At this inspection we found the provider had taken no action and this concern remained.

- Care plans and medicine records, did not contain any record of consent to photographs being displayed of people. Where people were unable to consent, due to their health care issues, no legally empowered person was sought to consent on their behalf.
- The manager had applied for DoLS on behalf of people who had restrictions in place, and kept records of which were awaiting authorisation. We were told one authorisation was in place at this time. This information was inaccurate, there were no authorisations in place and the information held by the manager was not robust. This meant that people could be being restricted unlawfully.

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

- Most staff had received training in the Mental Capacity Act 2005.
- The manager held a list of people who had appointed lasting powers of attorney to make decisions on their behalf when they could not do this.
- Mental capacity assessments had been carried out for decisions other than the use of photographs. Details of best interests meetings were recorded where appropriate.

Adapting service, design, decoration to meet people's needs

At our last inspection we made a recommendation that the service take advice and guidance from a reputable source regarding the management and design of the premises to support people living with dementia safely.

At this inspection we found although some improvements had been made there were still concerns in relation to the environment.

- At our last inspection we reported on the confusing room numbering system in place throughout the service, and this anomaly had not been addressed. The building was divided in to three areas, the same room numbers were repeated in each area. This meant there were three sets of rooms numbered 1 - 6 which was very confusing for people, visitors and new staff trying to find a room. This could also be a risk when reference is made to a room number without identifying in which part of the service the room is situated, especially with visiting emergency personnel.
- People's sensory needs were not always taken into account. At our last inspection the bathroom, where people were supported by staff to bathe was bare, spartan and clinical in appearance. The room was white with no pictures or furnishings to help provide a relaxing and enjoyable environment in which to enjoy a bath. The staff told us they were keen to re-decorate this room as some people found using the bath stressful. We were told this had been raised with the provider during their regular premises reviews, but no action was taken. At this inspection, we found two bathrooms had been refurbished. However, they remained entirely white and clinical, with no furnishings or pictures to help provide an environment which people with dementia would find calming.
- The provider told us there was a programme of re carpeting in progress. Some corridor carpets had been replaced. However, carpets in the lounge were torn and badly stained and malodorous throughout the service. Some furniture used by people was malodorous. The gas cooker was faulty during this inspection.
- The managers office was full of boxes, equipment, and general clutter. The management team struggled to locate information in the piles of files and paperwork. This did not provide a positive impression for visitors as this was the first room one came to once inside the front door.
- As visitors entered the drive up to Philiphaugh Manor, there was an open wooden structure referred to as the 'smoking shed' by staff. This structure was erected on the right side of the drive and contained old take away containers, many discarded face masks and cigarette butts. This was not attractive neither did it provide a positive image of the standards of cleanliness at the service or the way staff conducted themselves. It indicated a lack of respect for people's home. We discussed this with the manager and the provider who did not appear to be aware of this issue.

The failure of the provider to ensure the premises are suitable for the purpose for which they are being used is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's care plans showed they saw visiting healthcare professionals when needed.
- Philiphaugh Manor worked with a range of agencies when taking in new people to live at the service. The service was not taking in any new people, at the time of this inspection, due to staffing challenges.
- Staff ensured people's health care needs were being met and if they had any concerns regarding a person's health then this was communicated with the relevant professional.
- Relatives were assured the care staff that supported their family members were quick to identify changes in the person's health, report their concerns and request the required assistance.
- People were supported with their dietary needs where this was part of their plan of care.
- We spoke with a visiting healthcare professional. Comments included, "We have no concerns."
- Some people living at the service were living with dementia and were independently mobile with aids, such as walking sticks and frames. Since the last inspection the service had added some additional pictorial signage to help people to orientate around the service. For example, pictorial signs for bathrooms and toilets. A few people's bedroom doors contained a small identifying sign or their name to help them with orientation around the service.

Staff support, training, skills and experience

At our last inspection we found a lack of supervision, appraisals and appropriate training, which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not provided with regular supervision and appraisal, and regular training updates.

At this inspection we found improvements in staff supervision, appraisal and training. The provider was no longer in breach of this regulation.

- Staff received supervision and appraisals from the management team.
- Staff completed training in a range of different subjects to ensure they had the right skills, knowledge and experience to deliver effective care. Whilst some updates were a little out of date the manager had a plan for this to be addressed.
- New staff received an induction which included training and a period of working alongside a more experienced staff member before they started working on their own.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before people moved in to Philiphaugh Manor, to ensure their needs could be met by the service.
- The assessment also considered people's protected characteristics as part of the Equalities Act 2010, including any disabilities.
- Outside secure enclosed areas had been upgraded for use by people living at the service. The manager told us planters had been created for people to be supported to do some gardening. However, all the planting areas were overgrown with weeds at the time of this inspection.
- Philiphaugh Manor is an old, previously residential, building which had been adapted for use as a care home many years ago. The layout of parts of the service were not suitable for people with mobility issues or cognitive impairment, so the manager told us they were considering using these unoccupied rooms for storage of the clutter from the manager's office, laundry and bedding.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported with their dietary needs where this was part of their plan of care. We saw staff sitting and supporting people with their meals where required.

- People's preferences, likes, dislikes, and dietary requirements were recorded in their care plan. Experienced staff knew people's needs well.
- Kitchen staff were aware of all people's dietary needs and preferences.
- Staff recorded if people were at risk of poor nutrition and involved healthcare professionals where required.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we found the lack of accurate records in respect of people placed them at risk of inappropriate care. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found concerns remained and the requirements of this regulation had not been met.

- Care plans described people's individual needs, preferences and routines. However, care plans were not always reviewed regularly to help ensure they reflected people's needs at all times. All care plan review records stopped in April 2022. We were told this was due to staffing challenges due to COVID-19 infections.
- Care plans did not always provide guidance and up to date information for staff on how to meet people's needs. One person was living with a long-term condition. This person's care plan did not contain a specific care plan for this condition or any specific care guidance for staff.
- Monitoring records such as food and fluid charts, were in place for six people living at the service. This monitoring was not recorded in their care plans or on the shift handover record. This meant new or agency staff would not be aware of the need for this monitoring. It was not clear why some of these people were having their intake recorded when their weight records showed no cause for concern. We asked a manager about this who could not offer an explanation.

The failure of the provider to ensure robust and appropriate recording systems were in place is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's life history was seen in most files, detailing their past lives and interests.
- People had electronic personalised care plans which identified people's care and support needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our previous inspection we made a recommendation that the service take advice and guidance from a reputable source about the provision of suitable activities, and social engagement opportunities, both inside and outside the service, for people living with dementia.

At this inspection we found improvements had been made.

- Two activity co-ordinators were providing varied activities to people. People were seen enjoying quizzes and games during this inspection.
- As well as in house activities, external entertainers visited the service regularly.
- Staff were aware of people's interests and were able to offer activities which were meaningful to them.
- People had been supported to keep in touch with friends and relatives throughout the COVID-19 pandemic. Visitors were now able to visit people in person in the service.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's care plans included their communication needs and how best to achieve effective communication.

Improving care quality in response to complaints or concerns

- People and their relatives were aware of how to complain if they needed to. Information on how to make a complaint was included in the service user handbook that was given to people and their relatives.
- Complaints and concerns were investigated by the manager and used as an opportunity to learn and improve. There were no outstanding concerns at the time of this inspection.

End of life care and support

- No one was being cared for at the end of their lives at the time of the inspection.
- Staff were offered training in end of life care. Some staff had been recorded as completing this.

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 our last inspection we rated this key question requires improvement. At this inspection we have rated this key question inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection we found a lack of robust and effective quality assurance systems and processes meant areas that required improvement had not been identified or actioned. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found this concern remained and the service was still in breach of this regulation.

- Since the last inspection the registered manager had left Philiphaugh. The deputy manager was acting up into the manager role at the time of this inspection. They were supported by two duty managers. There had been a recent outbreak of COVID-19 in the staff team leading to absences and shortages on shift. This had meant the managers had to provide care rather than carry out management tasks. The acting manager told us they had not been provided with an induction or any formal supervision by the provider since they commenced the role upon the former registered manager's retirement in May 2022. They were not aware of any audit timetable.
- Systems for overseeing and assessing the service were not effective. There was no clear system of allocating roles and responsibilities to the two duty managers and the acting manager. This meant some tasks had not been completed and monitoring of the service provided was not robust. For example, the auditing of monitoring records, some of which had ceased several days prior to this inspection without the knowledge of the management team.
- The manager did not have a staffing assessment tool in use to monitor the dependency of people living at the service and how many staff were required to meet their needs. This meant there was not a robust process in place to ensure there were always sufficient staff deployed to meet people's needs. The manager told us, "It's just in my head, I would like more staff than we have on duty, but they seem to manage one way or another."
- At the last inspection we reported that the provider visited the service regularly and carried out their own audits and checks. The concerns that had arisen with the governance, records and management oversight of the service had not been identified by the provider. At this inspection this concern remained. The provider had not identified the concerns found at this inspection.
- At the last inspection we reported that quality assurance audits of all aspects of the service had lapsed.

This meant that opportunities to continuously improve the service had been missed. Many care plans were overdue for review and not entirely accurate, accidents and incidents were not audited, no recent medicines audit had been carried out and there were concerns with medicines management. At this inspection we found exactly the same concerns which had not been actioned by the provider and remained an issue.

- At our last inspection the filing cabinets where the care plans were stored were not locked. This did not protect people's confidential personal information. At this inspection the care plans remained in unlocked filing cabinets in a room where the door was propped open and unattended throughout the inspection. Piles of confidential records were also present in the open managers office, which was often unattended throughout the whole inspection visit.

The failure of the provider to ensure robust and effective quality assurance systems and processes meant areas that required improvement had not been identified or actioned, and confidential records were not stored securely is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service sent in notifications of events which took place in the service in line with their legal responsibilities.

Continuous learning and improving care

At our last inspection we found a lack of robust and effective quality assurance systems and processes meant areas that required improvement had not been identified or actioned. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found concerns remained.

- The provider had not learnt from previous concerns and care had not improved. People were still at risk of not having their needs met. The service was in the process of transitioning from paper care records to an electronic system. There was not a clear process in place for this change. The task was being overseen largely by the part time maintenance person. Staff had not been provided with adequate training to use the electronic system fully. Some paper records had ceased being used but electronic records were blank. This meant there were gaps and omissions in care records.

- Our last report states the provider had made statements in their Provider Information Return (PIR) which were found to not be accurate. At this inspection we found these concerns remained. The provider had completed a new PIR since the last inspection. It stated, "We review clients care needs every month or immediately if changes were needed", as reported in the safe section of this report that was not found to be the case. The PIR also stated, "We ask all to sign consent forms prior to displaying personal photos," as reported in the effective section of this report, we found this not to be the case.

- At our last inspection we found opportunities to improve the service had been missed. At this inspection we found the same concerns remained. Breaches of the regulations found at the last inspection had not been acted upon.

The failure of the provider to ensure robust and effective quality assurance systems and processes meant areas that required improvement had not been identified or actioned. This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- People, relatives and visiting healthcare professionals were complimentary about the service provided at Philiphaugh Manor.

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 manager understood the duty of candour requirements and ensured information was shared with the relevant people when concerns were identified.

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

- People had been asked for their views on the service in a survey in February 2022. People's feedback had not been audited or reported on. This meant any concerns or actions needed would not have been identified.
- The manager had held a residents meeting when she first took up post several weeks ago. People were asked for their views about various aspects of the running of the service.
- Staff told us that they felt supported by the management team. They told us they all worked well together but were very tired due to the shortages of staff. Staff comments included, "(Manager's name) works with us regularly at the moment, they have found themselves in the deep end, it's really hard at the moment with not enough staff," "Things are tough, we have often got none or very few staff. The weekends and the nights are a struggle. The managers are doing nights, we are so short" and "The place is looking tatty to be fair, the carpet in the lounge is awful. Two new bathrooms, but they don't work that well. We have not been able to do baths as we don't have the staff the water is not running well. We had to boil pans a couple of months ago because of the water problem."
- Relatives told us, "(Person's name) is always clean, her room is clean and the staff are kind to her" and "Staff are always nearby."
- People told us, "Yes, I am fine here they are kind to me," "I like the food good enough" and "I am ok here, I have visitors sometimes. I can do what I like."

Working in partnership with others

- The service had established good working relationships with professionals including health and social care professionals to help ensure people's needs were met.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider had failed to ensure that staff who obtain consent of people who use the service are familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005, and are able to apply those when appropriate, for any people they are caring for.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>The provider had failed to ensure the premises are suitable for the purpose for which they are being used.</p>

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure robust risk management around fire and environmental issues, medicines management and a lack of up to date information around risks to people.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust and effective quality assurance systems and processes were in place to assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

Warning notice