Ablecare (Philiphaugh) Ltd

Philiphaugh Manor

Inspection report

Station Road
St Columb
Cornwall
TR9 6BX

Tel: 01637880520

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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 caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service: Philiphaugh provides accommodation with personal care for up to 32 people. There were 29 people using the service at the time of our inspection.

People's experience of using the service:

Some people were not all able to fully express their views therefore they were not able to tell us verbally about their experience of living at Philiphaugh. Therefore, we observed the interactions between people and the staff supporting them.

The management team and staff knew people well and understood their likes and preferences and health needs. Staff were caring and chatted with people as they provided care and support. Relatives told us they were welcome at any time and any concerns were listened and responded to.

Staff showed a true fondness for the people they cared for and there was a warm, friendly and welcoming atmosphere.

Staff recruitment processes were not always robust. Induction provided was not always clearly recorded.

The environment was well maintained. Recent renovations and redecoration had taken place.

Not all staff had received necessary mandatory training and support to enable them to carry out their role safely. Staff did not have regular supervision or annual appraisals.
People did not always receive their medicines as prescribed. Medicines management was not robust.

The provider had not ensured adequate management oversight or governance arrangements to cover the recent consecutive annual leave of the registered manager and two team leaders.

The provider had moved the head of care to another service in the group for over a year. Their role had not been replaced. Their last audit at the service was February 2019. Actions identified in that audit had not been addressed by the registered manager at the time of this inspection.

Quality monitoring systems were in place but had not been carried out for the last few months. This had led to concerns identified at this inspection.

The environment lacked appropriate stimulation for people living with dementia. Activities provided were not always meaningful and relevant to people's backgrounds and interests. We have made a recommendation about this issue in the Responsive section of this report.

People were provided with the equipment they had been assessed as needing to meet their needs. For

example, pressure relieving mattresses. These correctly set at the time of this inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care plans were not always reviewed to take account of changes to people's needs. However, appropriate care was being provided by staff and handover sheets provided some direction for staff.

Risks were identified during this inspection that had not been identified prior to this inspection. For example, fire doors were seen propped open with furniture and other items, these would not close in the event of an emergency. Person Evacuation in an Emergency Plans (PEEPS)for people living at the service were not in place.

Monitoring records were not audited to ensure they were always completed appropriately. There were gaps in these records. Staff were recording care and support retrospectively.

Visiting healthcare professionals told us they had no concerns about the care provided at Philiphaugh.

Rating at last inspection: At the last inspection the service was rated as Good (report published 23/12/2016)

The rating for this service has changed to Requires Improvement. There were breaches of the regulations identified at this inspection.

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

Follow up: We will carry out a further inspection, in line with our inspection programme, to check improvements have been made to ensure the service is meeting the regulations. We will continue to monitor intelligence we receive about the service. If any concerning information is received, we may inspect sooner

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

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 caring? The service was caring Details are in our Caring findings below.	**Good**
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.	**Requires Improvement**

Philiphaugh Manor

Detailed findings

Background to this inspection

The 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.

Inspection team:
This inspection was carried out by one inspector, a member of the medicines team and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Philiphaugh 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. The service accommodates up to 32 people. At the time of our visit there were 29 people using the service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did:
Before the inspection, we reviewed:
• The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.
• Notifications of incidents we had received. These are events that happen in the service that the provider is required to tell us about.
• The last inspection report.
• Feedback and information, we had received about the service.

During the inspection we:
Spoke with eight people who used the service.
Spoke with seven staff members and the registered manager, the team leader and the head of care.
Reviewed the care records of seven people who used the service.
Reviewed the medicine records for 29 people.
Reviewed records of accidents, incidents, compliments and complaints.
Reviewed staff recruitment, training and support.
Reviewed audits and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

Safe –this means people were protected from abuse and avoidable harm

Requires Improvement: 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. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse.

- People were protected from potential abuse and avoidable harm by staff who were aware of how to report any concerns.
- People told us they felt safe, commenting, "I worry about nothing and I feel safe all the time" and "It's a very safe environment and I really appreciate that there are locked front and rear doors, so nobody is here who shouldn't be."

Assessing risk, safety monitoring and management

- Risks to people were not always identified. Fire doors were propped open with furniture and other objects. Substances which could be hazardous to health (COSHH) were available to people and not stored securely.
- Weekly required fire checks of the service were not always being carried out in a timely manner. This had been highlighted in the last audit carried out in February 2019 but not addressed.
- 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 has been referred to the fire service for review.
- Staff told us they had repeatedly told the registered manager about a bath lift which they did not feel comfortable using. Staff told us they did not feel this piece of equipment was safe to use for some people who could not move their legs easily. This concern had not been actioned.
- Care plans provided staff with information to help them support people to reduce the risk of avoidable harm, such as falls and poor nutrition. However, many risk assessments had not been reviewed since March 2019, and changes had taken place in some people's needs which had not been recorded effectively. For example, one person had a catheter in place and this was not recorded in the main care plan. Other people had fallen and this had not led to a review of their falls risk.
- 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.

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

- Where people presented with behaviour that challenged staff and other people there was guidance and direction for staff on how to help reduce the risk of this behaviour.
- The environment was well maintained. Equipment and utilities were checked to ensure they were safe to

use. All equipment was in good working order, however staff felt one specific piece of equipment, although working correctly, was of concern to them as mentioned above.

Staffing and recruitment

● The registered manager used a dependency score to help ensure there were sufficient numbers of staff to meet people's needs. There were staff vacancies at the time of this inspection. Agency staff were not used as existing staff covered all annual leave and sickness absence.

● Staff told us they were tired. Staff worked 13 hour shifts and were regularly doing extra shifts to cover shortages. The registered manager was required to cover the kitchen porter role during this inspection due to annual leave.

● The provider stated in the Provider Information Return (PIR), "I have increased the staffing levels ensuring there is two managers on duty and a team leader as well at the care staff. This had not been the case in the past two months.

● Staff had not always been recruited safely. Not all pre-employment checks had been carried out before the person began working unsupervised service. The registered manager had not ensured all reference requests were returned to the service before the person began working. This had been highlighted in the February 2019 audit carried out during a brief return of the head of care, but not addressed. Disclosure and Barring Service (DBS) checks had been carried out.

● People told us staff responded quickly to them when they called. We observed people were responded to in a timely manner.

● People had access to call bells to summon assistance when needed.

Using medicines safely

● People did not always receive their medicines as prescribed, including external preparations and those prescribed to be taken when required. We saw that sometimes people ran out of medicines such as medicine to manage pain.

● There was no guidance or pain assessments for staff to use particularly for people with dementia. When we asked staff how they knew what dose to give people of medicines that had been prescribed for occasional use (PRN) they either said they just knew or followed the previous pattern. People who had been receiving the full dose of paracetamol were left without any for several days at the end of the month as stock had run out.

● The medicines policy had not been reviewed at the identified time (January 2019) and did not describe how staff should support people to receive their medicines safely and effectively.

● Medicines were not always stored securely. The trolley was left in the lounge between medicine rounds and could be moved easily by people without staff knowing.

● Staff did not always follow best practice when administering inhaled medicines. One person's inhaler was to be used when required for shortness of breath. This inhaler was administered regularly four times a day, even if not needed. Staff demonstrated poor inhaler technique when administering the inhalers.

● Medicine administration records (MAR) were not always an accurate record of the medicines a person was taking. Several people had medicines recorded on the MAR and held in stock that were not administered. The registered manager told us that these medicines had been stopped by the GP or had been for short term use only, but there was no record of this in the care plan or on the MAR.

The poor management of medicine practices left people at risks of inappropriate treatment.This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There had been medicine errors. No learning had taken place to ensure the risk of a re-occurrence was reduced.

● There was no robust auditing of medicines management.
● Staff received annual training and observations.
● There was no clear guidance for staff on using medicines that were required occasionally (PRN).
● The medicines trolley was not always stored securely between medicine rounds.

Preventing and controlling infection
● The premises were clean and free from malodours.
● Flooring and surfaces were intact and could be effectively cleaned.
● Staff had access to aprons and gloves to use when supporting people with personal care. This helped prevent the spread of infections.
● People told us, "I can't fault the cleanliness. It's always spotless" and "The cleanliness is amazing, and the people too. You never notice a bad smell or anyone smelling, and they always make sure people are nicely dressed."

Learning lessons when things go wrong
● Accidents and incidents were recorded. 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.
● The regular auditing of the service provided including care plans and medicines management had not taken place since March 2019. We had concerns, which the registered person had not picked up about care planning and the management of medicines.

The lack of robust systems to monitor and improve records and the lack of robust process to monitor services is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

- People were assessed prior to moving in to the service. This helped ensure the service could meet people's needs.
- Care plans showed people's needs had been assessed and planned for. Guidance and direction was provided for staff on how to meet those needs. However, only four care plans had been reviewed and updated to take account of changes in people's needs since March 2019. This meant that staff were not always effectively provided with accurate information on how to support people. Further detail on this concern can be found in the Responsive section of this report.

Staff skills, knowledge and experience

- The PIR stated staff were provided with regular training and supervision. We found this was not always the case.
- Staff were not always given regular opportunities to discuss their individual work and development needs. Several staff had not received an appraisal in 2018/19 or any supervision in 2019.
- People were supported by staff who had training.
- Not all staff had completed mandatory training. People and staff were placed at risk of cross contamination. The cook on duty on the day of this inspection and four other kitchen staff had out of date food hygiene training. Two cleaners had out of date infection control training. This had been highlighted in the last audit carried out by the temporarily returning head of care in February 2019 but not addressed. This audit had not been repeated since then.
- Staff induction was provided. However, this was not clearly recorded.
- Training records did not show that two new staff had completed all necessary mandatory training in a timely manner.

The lack of supervision, appraisals and appropriate training is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- Staff monitored some people's food and drink intake where concerns about their intake had been identified. However, some people were at risk of dehydration because these records were not totalled or audited daily to ensure people had sufficient intake and action taken if needed.

The lack of robust monitoring of people's intake when they have been identified as a risk of poor nutrition is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The service had been inspected by the Food Standards Agency and given a five-star rating.
● People were offered a choice of food and drink. Their preferences were well recorded in care plans. Vegetarian meals were available.
● People told us they enjoyed the food provided. Comments included, "The food is very good. My family eat with me too, sometimes" and "I like the meals all of the cooks make, and I can ask for a drink anytime day or night."

● People had their weight regularly recorded. Action was taken to address any weight loss.
● Some people required adapted equipment to be able to eat independently. This was provided.

Staff working with other agencies to provide consistent, effective, timely care
●People were supported to maintain good health and were referred to appropriate health professionals as required.
● Regular GP visits ensured that changes to people's needs were managed effectively.
● Systems were in place to ensure that referrals were made promptly to external professionals and people's care plans were updated as required. People told us, "Access to the optician or dentist is easy because they come to see us here" and "I saw the dentist when he last visited and I am considering whether to have some work done. He explained everything to me."

Adapting service, design, decoration to meet people's needs
● Concerns were raised by staff and people about intermittent hot water provision in some areas of the service. We were told this is reported and resolved temporarily but re-occurs. One person told us, "They know my shower still hasn't been fixed, but I like to have a bath anyway."
● Some people living at the service were living with dementia and were independently mobile with aids, such as walking sticks and frames. The service was not specifically adapted for people with dementia. There was no additional pictorial signage to help people to orientate around the service. Bedrooms contained only a number in most cases. The building was divided in to three areas, the same room numbers were used in each area which could be confusing for people trying to find their room.
● 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 the providers had had this raised to them during their regular premises reviews, but this had not yet taken place.

We recommend 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.

● The service had recently been renovated. People's bedrooms and communal areas were in good condition.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal

authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Mental capacity assessments had been carried out. However, many were not dated and so it was difficult to establish when they were completed.
● The registered manager had applied for DoLS on behalf of people and kept records of which were awaiting authorisation and when they needed renewing. One authorisation was in place at this time. There were no conditions attached to this authorisation.
● Not all staff had received specific training in the MCA which had led to some staff not having an understanding of the requirements of the Mental Capacity Act 2005.
● The registered 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. These documents were held in people's care files.
● People told us staff always asked for their consent before commencing any care tasks. We saw this took place during the inspection.
● There was no formal record of people being asked to sign in consent to care and treatment and for photographs to be displayed of them, in the care plans we reviewed. Some family members and staff, who did not hold an appropriate lasting power of attorney, had signed care plans on behalf of people who were unable to do this themselves. People can only consent on behalf of another person if they hold a valid lasting power of attorney.

We recommend that the service take advice and guidance from the Mental Capacity Act 2005 Code of Practice.

Good

Is the service caring?

Our findings

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- One person told us, "We all get on very well with the staff and they are more like friends to me."
- A relative told us, "[My friend] misses her home but they have accepted this is where they live now. The staff are very attentive and they are so lovely; even affectionate to her I could say."
- People were provided with choice and their wishes and preferences were recorded.
- Staff told us, "There is a good atmosphere here" and "There is a lot of love here."
- Not all staff had been provided with training on equality and diversity. However, staff were able to tell us how people's rights were protected at the service.
- We found many unnamed toiletries in the communal bathroom. During the morning we advised the registered manager that sharing toiletries did not respect people's dignity and could be an infection risk. Some were removed, and some remained until the inspector removed them later in the day.

Supporting people to express their views and be involved in making decisions about their care.
- People told us they felt able to speak with staff and the registered manager about anything they wished to discuss.
- Care plans indicated that some people had been involved in their own care plan reviews. The registered manager provided care and support to people at the service on a daily basis and spoke with people regularly to discuss any changes they wished to make to their care and support.

Respecting and promoting people's privacy, dignity and independence
- Throughout the inspection visit we saw many positive interactions between people and the staff and management.
- People told us they felt respected. We observed care staff lowered their voice when asking people if they wished to use the bathroom.
- Staff ensured people's privacy was respected by closing doors and curtains during personal care.
- People were given the opportunity to lock their bedroom door if they wished. This respected people's right to privacy.

Requires Improvement

Is the service responsive?

Our findings

Responsive –this means that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preference, interests and give them choice and control

- The provider stated in the PIR, "Care plans are reviewed monthly." This was found to have lapsed since March 2019 in many cases.
- Care plans described peoples individual needs, preferences and routines. However, care plans were not always reviewed regularly to help ensure they reflected people's needs at all times.
- Life history was seen in most files, detailing their past lives and interests. One relative told us, "They helped my friend record her history and her likes and abilities in her care plan and this really benefitted their ability to meet her personal needs."
- Care plans did not always provide accurate and up to date information for staff on how to meet people's needs. One person required to be re-positioned every two hours, another person required to be stood up every two hours. This direction was recorded on the shift handover record but not in either care plans. One person had a catheter. This was not recorded on the handover or in the 'elimination' section of the care plan.
- Staff did not always record care in accordance with direction provided in the handover records. For example, re-positioning and standing a person regularly. There were gaps in these records and some were completed by staff retrospectively during this inspection.
- Monitoring records such as food and fluid charts, re-positioning records and skin checks were not audited daily to ensure care and support was being provided as directed. There were gaps in these records.
- People's life history was seen in most files, detailing their past lives and interests. One relative told us, "They helped my friend record her history and her likes and abilities in her care plan and this really benefitted their ability to meet her personal needs."

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

- The community nurses confirmed there was no pressure area damage requiring dressings at the service at the time of this inspection.
- There was information in place to enable the provider to meet the requirements of the Accessible Information Standard (AIS). This is a legal requirement to ensure people with a disability or sensory loss can access and understand information they are given. Each person's care plans included a section about their individual communication needs. For example, about any visual problems or hearing loss and instruction for staff about how to help people communicate effectively.
- Some people had been assessed as requiring pressure relieving mattresses. These were provided and set correctly for the person using them.
- There was an activities co-ordinator who provided activities for people. Comments from people included, "We can do as much or as little as we want, and it's not forced on you. They encourage but never insist" and

"The staff are very imaginative, and they get us doing art and singing. Some people are a bit shy. Nobody insists you join in but they can encourage people."

We recommend 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.

Improving care quality in response to complaints or concerns

● The service held an appropriate complaints policy and procedure. This was accessible to people living at the service. One person told us, "I complained to the manager and when [staff name] didn't improve they must have taken action because they were gone soon after."

● Two people reported asking staff for specific assistance and they felt this was not always forthcoming. One commented, "I can't go for a walk or to the pub without someone with me, and I can't understand my finances. They just say, 'it's nothing for you to worry about' which is not helpful." Another person who felt depressed was told to 'cheer up'. The registered manager assured us this concern would be addressed.

● The registered manager held a record of any formal concerns raised, the action taken and the resolution. The registered manager told us there had been no recent formal complaints

End of life care and support

● The staff were supported by the community nursing team to provide good quality end of life care to people.

● Medicines were ordered and held to be used if needed at the end of a person's life. This helped ensure people were pain free and comfortable.

● Care plans showed information had been recorded on people's views and wishes about how they wished to be cared for at the end of their lives.

Requires Improvement

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.

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; understanding and acting on their duty of candour responsibility

● Everyone at the service and their relatives told us the registered manager was open and very approachable. Comments included, "They [staff] all get on very well with each other, including the cleaning staff and the managers" and "The place is well run and there are plenty of staff except when it gets really busy."

● Staff told us, "[registered manager] is very approachable and we can always speak with her if needed" and "the door is always open." Some staff stated there was not always action taken as a result of their comments. Comments included, "We have repeatedly asked about a specific issue and nothing seems to have happened," "We are very tired, we have been covering leave and sickness endlessly. Some cover is not arranged and so you come in and find you are not doing what you thought you were, you are covering someone else" and "[registered manager] has been working in the kitchen as no cover was arranged. It is a bit chaotic sometimes."

●The registered manager was open and transparent. They agreed at feedback that the concerns identified were a fair judgement of the service. They admitted staffing pressures had been a key reason for the issues identified.

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

● Since 2018 the head of care had been taken from Philiphaugh, by the provider, to support another service in the group. The provider had not made arrangements to ensure that the work previously carried out by the head of care was allocated to another member of staff, this had led to the concerns identified at this inspection. We were told the head of care was returning to the service in June this year.

● The provider visited the service regularly and carried out their own audits and checks. However, the concerns that had arisen over the past few months with the governance and management oversight of the service had not been identified by the provider.

● Quality assurance audits of all aspects of the service had lapsed. There had been no audits completed since February 2019. This meant that opportunities to continuously improve the service had been missed. Many care plans were overdue for review and no longer entirely accurate. Accidents and incidents were not audited and any action taken was not recorded. Some regular premises checks were not being carried out as directed. There had not been a recent medicines audit carried out and concerns with medicines management had not been identified prior to this inspection.

● During the tour of the service, we noted the door to the office, containing people's care plans, was

propped open with a chair. The filing cabinets where the care plans were stored were not locked. This did not protect people's confidential personal information.

The 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.

● The registered manager had appropriately notified CQC of abuse concerns or events that stopped the service, including the reporting of any deaths and any DoLS authorisations.
● The ratings and report from our previous inspection were displayed in the entrance hall.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager had not held a resident's meeting since June 2018. This had been highlighted in the last audit carried out at the service in February 2019. There had been no formal opportunity to discuss activities, meal choices and how people viewed the service provided to them. One person specifically asked how he could express his views on the service, to one of the team during this inspection.
● The registered manager spent time in the service during the week, speaking to people and felt they were available to people. There was an open-door policy at the service.
● We were told a survey of all people and their families had recently been sent out. No responses had yet been received.
● Staff meetings were held regularly. The registered manager had been made aware of the need to extend the breakfast service till 9.30 am, to allow for more people to eat at a time of their choice. This had been done.

Continuous learning and improving care
● The service was using paper records. The files used to hold care plans were unsuitable for purpose with many loose pages, which fell out. This meant it was difficult to find current information. The registered manager and team leader accepted that this had been an issue for some time but that new files had not been provided by the provider.
● Opportunities to improve the service had been missed. Care plan reviews, staff supervision, appraisal and training, audits, residents' meetings and management oversight of the service had lapsed in recent months. This was due to a failure of the provider to arrange robust management cover for the absence of the head of care, and the annual leave of the registered manager and two team leaders over recent months.
● The registered manager was not learning from audits. The last audit carried out by the head of care in February 2019 stated only one reference had been received for a new member of staff. This had not been addressed and remained outstanding at this inspection. The audit also highlighted supervision was overdue for one specific member of staff. This remained outstanding at this inspection

The 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.

Working in partnership with others
● Care records held details of external healthcare professionals visiting people living at the service as needed, for example, opticians and community nurses.

● Care records showed when people had sight tests and seen the chiropodist.
● The community nurses visited people at the service regularly to support any nursing needs.
● Three external healthcare professionals, who visited the service regularly, had no concerns about the care and support provided to people at Philiphaugh. Comments included, "This is a good home, we have no concerns" and "I visit many places, and this is one of the best ones."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. The registered person did not have robust processes for the safe management of medicines and for the assessment of risk to the health and safety of service users receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure compliance with the requirements of this regulation. Systems and processes did not allow the registered person to maintain securely an accurate, complete and contemporaneous record in respect of each service user. The registered person did not seek and act on feedback from the relevant persons on the services provided, or evaluated and improve their practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed. Staff did not always receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties