Abbeyfield Extra Care House & Templeton House
Care Home Service

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Rutherglen
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Telephone: 01416478311

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Unannounced

Completed on:
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Service provided by:
Abbeyfield Rutherglen Society Ltd

Service provider number:
SP2004006270

Service no:
CS2003001376

About the service

The service is provided by Abbeyfield Rutherglen society and is registered as a care home for up to 30 older adults. The service consists of two purpose built buildings. Extra Care house is the larger of the two buildings and has 19 bedrooms. Templeton House, adjacent has 11 bedrooms and is attached to a sheltered housing complex. There are 30 single bedrooms and access to communal bathrooms, for people who do not have en-suite facilities in their rooms. Both buildings have a communal lounge/dining area and a conservatory. At the time of inspection there were 29 people being supported in the service.

The service is situated in a residential area of Rutherglen, South Lanarkshire. The service is accessible to public transport routes and within walking distance of local shops and community amenities.

Dedicated teams of staff work in each of the houses and a registered nurse provides support to both. Each house has its own team of catering and domestic staff.

The service benefits from extensive gardens, which provide an attractive and well used outdoor space, which can be enjoyed by the residents of the home and visitors.

About the inspection

This was an unannounced inspection which took place between 21 February and 26 February 2024 during the hours of 09:00 and 19:30. The inspection was carried out by two inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration and complaints information, the service action plan, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we spoke with:

- seven people using the service
- eight family members
- 13 staff and management
- five visiting professionals.

We also observed practice and daily life and reviewed documents.

Key messages

- People were treated with respect and dignity by staff who knew them well.
- Recruitment processes should improve to safeguard people using the service.
- People's health and wellbeing benefitted from their support.
- Medication practice needs to improve to ensure this is delivered safely.
- The service needs to do more to meet people's changing needs.
- People had choice and control in their lives and support was provided in a personalised manner.
- Staff training and competency should improve to keep people safe.
- Collaborative working is needed to ensure quality assurance is effective.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	3 - Adequate
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate
How good is our setting?	4 - Good
How well is our care and support planned?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 3 - Adequate

We evaluated this key question as adequate. While we recognised there were a number of strengths that had led to positive experiences for people using the service improvements are required to prevent people experiencing poor outcomes in relation to their health and wellbeing. We have made a requirement and two areas for improvement in this key question.

People using the service were having good experiences and were treated with compassion, dignity, and respect. Staff were engaging with people using the service in a meaningful, friendly and sensitive manner. People told us that care staff treat them well and they are kind and caring. Care staff we spoke with had good individual knowledge of people using the service. People's families told us that they had chosen Abbeyfield as their preferred care provider for their relatives due to being a smaller group living setting. Families spoke positively about their relatives move to the service. One family member told us "It was like having a warm hug." Some people had gained weight, were more engaged and alert since moving to the service. Families told us that their relatives health and wellbeing had improved. One family told us "Dad's mobility has really improved, he is getting the opportunity to move around which has also improved his circulation, he has a new lease of life." This demonstrated how responsive the service was to supporting people to improve their wellbeing.

Some people were not being supported well with key aspects of their support, such as support with hydration and managing diabetes support. We have made a requirement under key question 2.2 to ensure improvement is made in this area.

People should be involved about decisions around meaningful activities and engagement to ensure this meets their social and emotional needs. The service had a sufficient plan of regular group activities. Some people told us that the regular activities on offer were not stimulating and didn't meet their preferences. Residents meetings were carried out by the service. Minutes of meetings sampled did not demonstrate how well people were supported with decisions making. This meant that some people were at risk of becoming bored. **(See area for improvement 1).**

People were supported to develop relationships and maintain social and emotional connections. Regular activities were organised to bring people from both buildings together. This included a newly organised church service held on Sundays which recognised and promoted people's spiritual needs. People were encouraged to have visits from their families and choice was given where these took place, such as quieter areas of the service or individual bedrooms. This meant that people's wishes and choices were respected.

People were supported well to make choices about how and where they wanted to spend their time. Some people told us they preferred to eat their meals in the conservatory as this was quieter and more relaxed. The service had considered and accommodates preferred seating request. This offered a better mealtime experience for people using the service. Some people required support with eating and drinking and did not always receive this support timeously. This meant that some people were having to wait longer for their meals. Leaders should carry out observations of people's mealtime experiences to ensure people are supported well with their nutritional needs.

Some people required modified diets or fortified (higher fat) meals. Clear guidance should be in place to ensure people can be supported safely and monitored for good nutritional intake.

Documentation from health professionals such as Speech and Language Team (SALT) on how to support people safely with modified diets were not in place. This meant that people were at risk of having poor nutritional intake as well as being at risk of choking and/or aspiration. **(See requirement 1).**

Care reviews are completed four weeks after admission to the service and at a minimum annually thereafter. Families told us they had been involved in post placement meetings alongside social workers, which meant they could contribute to care planning arrangements. The service told us that families were invited to attend review meetings, however reviews sampled did not always involve family. The service should increase the frequency of care reviews and ensure people and their families are included. **(See are for improvement 2).**

We observed staff providing support to people with their medication and found this was not always being carried out safely. Poor practice around the administration of medication was exposing people to a risk of harm. We have made a requirement under key question 2.2 to ensure improvement is made in this area.

Requirements

1. By 16 of June 2024, the provider must ensure that people who require modified diets are supported safely. This includes but is not limited to:

a)ensuring assessment reports from speech and language (SALT) and or Dieticians are available and retained
b)clearly and consistently detailing people's support with modified diets within care plans
c) providing up to date and clear guidance to staff, including kitchen staff on each person's level of support. This includes ensuring staff have received updates when people's needs change
d) ensure staff have knowledge of good practice guidance to support people living with dysphasia. Guidance must be in accordance with the International Dysphasia Diet Standardisation Initiative (IDDSI).

This is to comply with SSI 2011/210 Regulation 4(1)(a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure support is consistent with Health and Social Care Standards (HSCS) "I experience high quality care and support because people have the necessary information and resources". (HSCS 4.27) and "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.12).

Areas for improvement

1.
To ensure that people are included in decision making and meaningful engagement, the service should:

a) involve people to develop the service in a range of ways, such as through purposeful residents meetings or via surveys
b) ensure where appropriate feedback involves families
c) evidence how people's feedback has linked to service development
d) set out clear timescales for any improvement or actions identified.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I can maintain and develop my interests, activities and what matters to me in the way that I like" (HSCS 2.22) and "I am supported to give regular feedback on how I experience my care and support and the organisation uses learning from this to improve" (HSCS 4.8).

2.
To ensure that a collaborative and responsive approach is taken to meet people's changing needs. The service should:

a) evidence how people and/or their families have been invited to review meetings
b) work flexibly with people and their families to maximise opportunities to include them in review meetings
c) implement systems to plan for and carry out reviews a minimum of six monthly.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change' (HSCS 1.12).

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, where strengths were just outweighed by weaknesses. We have made a requirement in this key question.

Quality assurance across both Abbeyfield extra care and Templeton house was inconsistent. The management team were not working together cohesively to maintain good oversight across both buildings. This had significantly impacted on the management team's ability to identify areas for improvement and take responsive action.

Auditing of key areas such as health and wellbeing weren't always carried out effectively. Audits should be purposeful to help meet people's needs effectively and identify improvements. The management should have oversight of the electronic care plan system which flags an issue with support. We highlighted concern where the system had flagged some people had not been offered their target amount of fluid each day which could lead to dehydration. Protocols were not in place for some people with diabetes to give staff clear instruction. Improvement is needed to ensure the service is able to identify and support people's well with their health needs. **(See requirement 1)**.

The service had a proactive approach to support people with continence management. The service regularly monitors support with continence care and makes referrals to continence teams responsibly. This ensured that people were treated with dignity and respect as well as enabling independence to maintain their personal hygiene.

We identified significant concern with medication management. Care staff and clinical staff did not always carry out medication administration safely. Medication support was not undertaken in accordance with Guidance on 'Managing medicines in care homes, National Institute for Health and Care Excellence' (2014). This meant that people were at risk of receiving their medication incorrectly which could have significant adverse effects on their health and wellbeing. **(See requirement 2).**

The service had taken some steps to involve people using the service and their families in the development of the service. Minutes of resident's meetings sampled showed evidence of family members sharing suggestions for improvements. We suggested ways in which the service can improve on how they involve people using the service and their families, such as utilising surveys. The service should clearly identify when learning is taken from feedback to continuously drive quality improvement as well as learning from significant events. There was no clear overview of how learning had led to actions or development areas. **(See area for improvement 1).**

Requirements

1. By 16 June 2024, the provider must ensure that guidance and daily recording that relate to peoples health and wellbeing are monitored and improved. This includes but should not be limited to:

a) regular monitoring of key areas of support such as where applicable; skin integrity, nutrition, and systems of measurement in relation to MUST (MaInutrition Screening Tool), food and fluids, and blood sugar testing
b) ensuring auditing is purposeful and effective to highlight changing need
c) identifying when trigger points have been met to seek input from health professionals
d) ensuring protocols are in place to give clear instruction on how to support people with diabetes.

This is to comply with SSI 2011/210 Regulation 4(1)(a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that the quality of care and support provided is consistent with the Health and Social Care Standards (HSCS) which states that: "My future care and support needs are anticipated as part of my assessment". (HSCS 1.14) and "I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm. (HSCS 3.21)

2. By 16 June 2024, the provider must ensure that support with the administration of medication is safe. This must be in accordance with Guidance on 'Managing medicines in care homes, National Institute for Health and Care Excellence' (2014). To do this the provider must:

a) ensure staff have received the appropriate level of medication training for their roles
b) carry out medication competency assessments. These should be completed at a minimum annually and where issues with practice arise.
c) Identify where practice needs to improve and set clear actions and timescales for achievement
d) ensure there is provision in place to regularly assess competency and practice of clinical staff in accordance with the Nursing and Midwifery Council's standard of practice.

This is to comply with SSI 2011/210 Regulation 4(1)(a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that my care and support is in line with Health and Social Care Standards (HSCS) 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes (HSCS 3.14) and 'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24)

Areas for improvement

1. The service should create a service development plan to capture where improvements to the service have been identified, actions agreed and outcomes achieved. This should include but not be limited to:

a) evidencing where feedback from people using the service, their families and staff have linked to service development areas
b) ensuring the plan is a live document, continually reviewed and updated
c) ensuring actions set out in the plan are Specific Measurable Achievable Realistic and Time-bound (SMART).

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership" (HSCS 4.7) and "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate. While we recognised strengths were having a positive impact on outcomes for people, improvement is required to safeguard people using the service. We made two requirements and an area for improvement in this key question.

There was a steady and reliable staff team working in the service and a positive culture of career development. Staff stability meant that people had support from staff familiar to them. Some staff told us they were supported to undertake qualifications that had enabled them to progress into senior roles. Staff were registered with the Scottish Social Services Council (SSSC) in line with their role functions. We suggested the service maintain oversight of staff professional registrations, when these are due for renewal and monitoring staff registered subject to obtaining a qualification. This is to ensure that staff can lawfully continue to work in accordance with SSSC registration requirements.

There were gaps identified in right to work checks. This means that staff recruitment practice did not follow guidance on 'Safer recruitment, through better recruitment' or Abbeyfield's own recruitment policy. This exposed people using the service to risk. **(See requirement 1).**

There was significant improvement to staff training required to ensure safe support is provided. The service did not keep an updated record of external training that had been facilitated. Staff training records for mandatory training had significantly lapsed in key areas such as adult protection, medication and moving and assistance. Staff did not have sufficient training or assessed competency to support people using the service in key areas such as Dementia and Dysphasia. This meant that people were at risk of potential harm. **(See requirement 2).**

Staff team meetings occurred routinely; however, records of attendees were not consistently recorded therefore we could not be sure that all staff had an opportunity to give feedback, gain knowledge and learning. Some staff we spoke with told us they had received good one-to-one supervision and felt able to seek support from management readily. Records of appraisals sampled did not demonstrate an individualised approach to carrying out performance reviews. This meant that staff were not always supported with their individual and professional development. **(See area for improvement 1).**

Requirements

1. By 16 June 2024, the provider must improve staff recruitment processes to safeguard people using the service, specifically in relation to government home office right to work checks and competency interviews. Recruitment checks carried out must follow 'safer recruitment through better recruitment guidance' (2016). This includes:

a) ensuring that staff suitability has been fully assessed at interviews and well documented
b) ensuring the organisational recruitment policy is adhered to, including the use of a recruitment checklist
c) maintaining signed and verified copies of right to work documentation, to evidence original documents have been seen
d) carry out government home office checks for any overseas workers and maintain copies of these checks.

This is to comply with Regulation 15(a) (staffing) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure care and support is in line with Health and Social Care Standards (HSCS) which states "I am confident that people who support and care for me have been appropriately and safely recruited." (HSCS 4.24).

2. By 16 June 2024, the provider must have a clear plan to ensure mandatory and service specific training is up to date and regularly reviewed. To achieve this the provider must:

a) carry out a training audit of all essential training, including refresher training. This should include, as a minimum, moving and assisting, adult protection, fire safety, health and safety and infection prevention and control (IPC).
b) Put a training plan in place, prioritising training for new staff and core training which has lapsed for existing staff
c) Ensure that staff training includes supporting people who have dysphasia and dementia
d) Dementia training should be at the appropriate level appropriate to staff roles and responsibilities in accordance to Scottish Governments 'Dementia- Health and Social Services staff framework: Promoting Excellence (2021)
e) monitor the training plan to ensure it is kept up to date and any remedial action required is taken.

This is to comply with Regulation 4 (1) (a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is also to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes." (HSCS 3.14).

Areas for improvement

1. The service should improve how they support staff with their personal and professional development in accordance with the Scottish Social Services Council (SSSC). To do this the service should:

a) use a tracking system to plan and carry out staff supervisions and appraisals
b) ensure the frequency of supervisions and appraisals follows organisational policy
c) maintain clear records of supervision, including any agreed actions, timescales for completion and delegated responsibility for each action.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes" (HSCS 3.14).

How good is our setting? 4 - Good

We made an evaluation of good in this key question, where several important strengths taken together, clearly outweighed weaknesses.

There had been several positive areas of improvement to the building and the environment of the service since the last inspection. Bright and fresh conservatories had been added to both buildings. These had provided an additional communal area and a space for families to spend time with their relatives. Both conservatories gave direct access to a large well-maintained garden. The larger conservatory at the extra care building is utilised for planned activities which enabled people supported in both buildings to come together for socialisation. These new additions to the service had provided people with choice on where they wanted to spend their time and where they wanted to have their meals.

Templeton house had provision for a larger laundry area with a sluice and extra care had extended their laundry to allow for more space. This meant that the service was able to comply with infection control guidance within the National Care Home Infection Control Manual (NICPM) and the safe management of linen. These adaptations to the service helped to safeguarded people from the spread of infection.

The service is in a good state of repair, decorated well and clean and tidy throughout. Maintenance records were up to date and repairs completed timeously. Servicing arrangements were in place for equipment such as hoists and profile beds. This ensured that equipment was safe for use to support people with mobility issues. The management team carries out environmental audits to check the cleanliness of the building and to highlight where any replacement of furnishings is required. We suggested ways in which the service could capture when building and maintenance requests are made, timescales for completion and when work is finished. This would ensure the service was being proactive to ensure any risks to health and safety were being addressed effectively.

People and their families told us the smaller group living environment worked better for them and their relatives. Families told us that their relatives were engaged and stimulated, and chose to spend their time in communal areas. We observed several positive interactions between people supported and staff in communal areas. This meant that people were less likely to become isolated and withdrawn.

Kitchen areas within the service were of a good standard of cleanliness. We observed kitchen staff wearing gloves where this was not necessary. We suggested the service organise further learning for kitchen staff to promote good practice on hand hygiene.

Templeton house had a secure room where medication was stored safely. This provided sufficient space to carry out essential audits of medication.

However, the recent extension of the laundry area in extra care meant the service had lost space previously used to store medication appropriately. The medication trolley was secured in a room used to store extra wheelchairs which offered limited space. We suggested the service repurpose this area to enable this to be better utilised for safe medication storage.

How well is our care and support planned? 4 - Good

We made an evaluation of good in this key question as we recognised several strengths within the service outweighed the weaknesses.

The service had a strength-based approach to personal planning, which included the involvement of people and their families as well as relevant professionals. Families told us that they had met with management and were asked about their family members preferences and life history. Care plans recognised people's preferences, likes and dislikes and routines. Examples viewed stated people's choices in relation to how they wanted to dress, what time they wanted to get up and go to bed. People told us "Staff do their best to accommodate you, they listen." This evidences good practice around person-centred planning.

The service had good values and a focus on enablement. People's families told us that their relatives care had improved from previous care homes where they had lived. Where people's independence, choice and control were restricted, the service managed this in a person-centred way considering risk and outcomes. Risk assessments were completed for people identified as a falls risks. Where risk reduction measures included restrictive practice, people and/or their families were involved and relevant consents were in place. This meant the service promoted positive risk taking and supporting people to maintain their skills where possible.

There was a multi-disciplinary approach to personal planning. Care plans sampled included evidence of support from health professionals such as district nursing, GP's, dieticians, and SALT. This demonstrated the service was sourcing support from external professionals appropriately out with their expertise to improve health outcomes for people.

The service was not actively supporting discussion with people and their families about future health and support needs, including plans toward end-of-life care. Care plans included a section where end of life care can be recorded, however those sampled were incomplete. **(See area for improvement 1).**

Areas for improvement

1. The service should take proactive steps to carry out anticipatory care planning. This should include having sensitive discussion with people using the service and their families. This is to ensure that people's wishes toward the end of their life are known.

This is also to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that "I am supported to discuss significant changes in my life, including death or dying, and this is handled sensitively" (HSCS 1.7) and "I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty"(HSCS 3.18).

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

People experiencing care were not being supported by a management system that informed a current overview of care and support provision and how that meets current healthcare needs. Due to the severity of the concern you, the provider, must take the following action immediately and to be completed by 20 October 2020.

You must ensure that you set out how systems of audit will be introduced to focus on healthcare needs, including but not limited to:

- skin care
- stress and distress
- prevention and management of falls
- epilepsy.

This is to ensure care and support is consistent with the Health and Social Care Standards which state: "I experience high quality care and support based on relevant evidence, guidance and best practice". (HSCS 4.11) "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes." (HSCS 4.19)

This is to comply with Regulation 4(1)(a) and (d) (welfare of users and procedures for the prevention and control of infection) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This requirement was made on 13 October 2020.

Action taken on previous requirement

The service has improved on systems to maintain oversight of people's health needs. A new electronic care planning system is being used by the service which has enabled the service to have a clear overview of people's support. Staff record key areas of support provided such as skin and wound care, behavioural support, falls and accident/incidents. The reporting function within the new system can be used to assist managers with carrying out audits. Reporting gives a collective overview of people's health recordings across the service as well as looking at individual health records. Reports produced have provided the service with oversight of people's support with their health and wellbeing. We sampled monthly reports to the executive committee which provided updates from managers audits completed. Those sampled highlighted where managers were able to identify changing needs and seek responsive support from health professionals to meet people's needs effectively. We were satisfied that improvements made by the service had led to better health outcomes for people. There is still some improvement required around the consistency of quality audits which has been captured in key question 2.2.

This area for improvement has been met.

Met - outwith timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The service must ensure that all staff wear PPE as stated in Health Protection Scotland guidance entitled "COVID-19 Information and Guidance for Care Home Settings".

This is to ensure care and support is consistent with the Health and Social care Standards which state that: I experience high quality care and support because people have the necessary information and resources (HSCS 4.27)

This area for improvement was made on 24 November 2020.

Action taken since then

Care staff were observed to be wearing personal protective equipment (PPE) appropriately when providing support with a range of tasks. This included wearing aprons and gloves when support was required with eating and drinking, preparing to support with personal and intimate care and when providing physical support with moving and assisting where there may be risk of cross contamination.

There service had provision for sufficient access to PPE via the stations throughout both homes in hallways, communal areas and in residents' bedrooms where necessary. This included gloves, aprons, disposable bags, hand sanitiser and waste disposal bins. This meant that people using the service were protected safeguarding and protected.

This area for improvement has been met.

Previous area for improvement 2

Management should review the content of current environmental and cleaning audits to ensure that they are more robust.

This is to ensure care and support is consistent with the Health and Social care Standards which state that: I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment (HSCS 5.22)

This area for improvement was made on 24 November 2020.

Action taken since then

Senior staff carry out weekly Environmental cleanliness audits. This includes spot checks of communal areas, kitchen, laundry, bathrooms and bedrooms. Mattress audits are completed monthly by senior staff who select three/four residents' rooms per audit. We sampled three months of each audit and viewed these to be robust and sufficient in their content to assure us that cleanliness of the building was regularly being maintained. The service was in general clean and tidy and waste disposal systems were effective. We identified an issue with a mattress that required replacing. This was addressed at time of inspection and mattress changed.

This area for improvement has been met.

Previous area for improvement 3

The service should assess against current Building better care homes guidance to identify gaps and make a risk based long term refurbishment plan to address any issues highlighted. In meantime management should risk assess activities in these areas and put controls in place to reduce the risks of cross contamination, and any health and safety risks.

This is to ensure care and support is consistent with the Health and Social care Standards which state that: 'I experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment' (HSCS 5.22).

This area for improvement was made on 24 November 2020.

Action taken since then

Both services have undertaken planned improvements since the last inspection. This includes a large conservatory being added to the extra care building which was bright and welcoming. We saw this being used by visiting families which offered an additional space to allow for privacy during visits. Extra care service had a newly refurbished laundry room with new laundry equipment in place. Templeton house had a refurbishment and extension of their laundry area to include a sluice area to reduce risk of cross contamination in relation to the safe management of linen. Both houses also have new lifts installed. There were plans in place for a new kitchen to be fitted in extra care in the coming weeks. We sampled monthly reports to the executive committee with requests for replacement of furnishings that were actioned timeously.

This area for improvement has been met.

Previous area for improvement 4

4. Management need to ensure that all staff complete COVID 19 training including Infection Control, Donning and Doffing of PPE and handwashing within a set timeframe.

This is to ensure effective and consistent practice is carried out within the service to reduce the possible spread of infection. This is to ensure care and support is consistent with the Health and Social care Standards which state that: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organised codes' (HSCS 3.14).

This area for improvement was made on 24 November 2020.

Action taken since then

We were told by the service that public health teams had regularly been sourced to facilitate learning sessions on the safe use of PPE and infection control with staff. While it is good practice to use external sources to provide training, there was no evidence of when these sessions took place and identifying staff attendance. Staff records failed to evidence that training had been completed for individual staff in the last two years. The home was not carrying out observations of practice in line with infection control policies. This means that there were no assurances that care staff had the necessary skills, knowledge and competence to comply with infection control standards.

This area for improvement is no longer in place and has been incorporated into a new requirement under key question 3.1.

Previous area for improvement 5

The service should continue to review and improve personal planning to ensure that it reflects people's needs and wishes and how these are to be met.

This is to ensure care and support is consistent with the Health and Social Care Standards which state that "My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices " (HSCS 1.15).

This area for improvement was made on 24 November 2020.

Action taken since then

We sampled care plans on the electronic care planning system and found the general quality to be good. Care plans included likes and dislikes section and these were personalised to each resident. People's families told us they had been asked about their family members likes and dislikes by the home and these were captured within care plans. Personal preferences recorded included food and drink, routines such as what time people wanted to get up in the morning and when they liked to go to bed. People told us that their individual routines and choices were met by the home, which demonstrates the home was taking a person-centred approach to care planning.

This area for improvement has been met.

Previous area for improvement 6

The provider should implement a dependency tool to ensure that staffing levels remain adequate to meet the needs of residents. This should include:

(a) continuing to update dependency tools within care plans regularly to ascertain the needs of residents
(b) ensure that the services dependency took is updated regularly or whenever there are changes in residents' needs
(c) the dependency levels should determine the staffing levels and qualifications of staff required, to meet the needs of service users.

This area for improvement was made on 30 October 2020.

Action taken since then

Dependency assessments are regularly completed by the management team. The service is staffed at an appropriate level to meet the current needs of people using the service. We viewed staff deployment levels and found this was in line with assessed dependency levels.

We advised the service that further improvements could be made by involving staff when carrying out dependency assessments, particularly to identify any changing need.

This area for improvement has been met.

Previous area for improvement 7

The provider must ensure that all facilities in the home are in good working order, where there is a delay in repair this must be fully risk assessed and interim arrangements put in place to ensure safety and minimise confusion and distress.

This is to ensure care and support is consistent with Health and Social Care Standard 5.22: 'I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment.'

This area for improvement was made on 4 February 2022.

Action taken since then

Maintenance records sampled and repairs were completed timeously. Building audits are carried out monthly by senior staff which highlights when any repairs are needed or have been made. We saw evidence of monthly reports the management team send to the committee. Samples viewed included budget requests for replacement of furnishings. This evidenced the home was being proactive to ensure repairs and maintenance requests were actioned effectively.

This area for improvement has been met.

Previous area for improvement 8

When there is an unexpected death in the home staff must fully follow the Procurator Fiscal advice in regards to managing an unexpected/sudden death. When discussing the death with other relevant services staff must ensure that these services are furnished with full details and circumstances of that death.

This is to ensure care and support is consistent with Health and Social Care Standard 4.11: 'I experience high quality care and support based on relevant evidence, guidance and best practice'.

This area for improvement was made on 4 February 2022.

Action taken since then

We sampled the death in service policy. and found this to be robust. This clearly sets out the steps to take when there has been a sudden and unexplained death in the home. This includes contacting the police to carry out investigation. The management team has reflected on their response to a previous death in service where the correct procedure was not followed and has taken learning from this experience. We were assured through discussion with the management team that they were aware of organisational policy and were clear on their responsibilities on how to respond to any sudden deaths in service.

This area for improvement has been met.

Previous area for improvement 9

The provider should carry out a full audit of the home, taking note of repairs, minor and major. This audit should inform plans to refresh and replace tired, stained and damaged furnishings, this plan should have timescales for work to be completed. All rooms such as the laundry and sluice rooms should be decluttered. The provider should continue with plans to redesign areas of the home. The back of the communal lounge should not be used for file storage or as an office or break area for staff.

This is to ensure care and support is consistent with Health and Social Care Standard 5.22: I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment.'

This area for improvement was made on 4 February 2022.

Action taken since then

Conservatories have been built in both buildings which gave residents additional space to sit, eat and drink and enjoy visits with families. The large conservatory at extra care was being used for activities when the home had planned entertainment arranged. This enabled residents from both buildings to attend and meant that people had opportunities to meet and socialise. The back area of communal lounge is no longer being used by staff and this was free from clutter.

The management team were carrying out building and environmental audits monthly. These are used to highlight any repairs or maintenance required as well as replacement of furnishing. We saw evidence of repairs taking place by viewing the monthly reports sent to the committee. This means the home is being proactive to ensure repairs and maintenance are taking place timeously. We asked the home to maintain an overview of repairs and maintenance requests with timescales for completion. This will help to clearly evidence the responsiveness of the service around repairs and maintenance requirements.

This area for improvement has been met.

Previous area for improvement 10

The provider should continue with the current plans to build a new laundry to ensure that there is an efficient and well organised laundry facility in the home.

This is to ensure care and support is consistent with Health and Social Care Standard 5.16: 'The premises have been adapted, equipped and furnished to meet my needs and wishes.'

This area for improvement was made on 4 February 2022.

Action taken since then

A new laundry area has been built in extra care housing. A new laundry and sluice area has been created in Templeton house. The sluice area is not regularly used as laundry is separated into colour coded laundry bins when this is being collected from people's rooms, all of which have en-suites. This reduces the risk of cross contamination when dirty laundry is being transferred to the laundry area for washing. Each resident has a designated storage box for clean clothing to be taken back to bedrooms. We were satisfied that the systems in place to manage linen and waste are in line with the National Infection Prevention Control Manual (NICPM) for care homes.

This area for improvement has been met.

Previous area for improvement 11

When there is an identified risk to a person experiencing care in the home, in this case placing hazardous items in their drawer. There must be a practical risk assessment carried out and a suitable plan of care included in their care plan with, where appropriate, checklists to ensure all staff are aware of the strategies in place to minimise risk for that person.

This is to ensure care and support is consistent with Health and Social Care Standard 1.15: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices'.

This area for improvement was made on 4 February 2022.

Action taken since then

This area for improvement was made following an upheld complaint in August 2022 in relation to one person using the service. From discussion with the management team and the sampling of care plans, we were satisfied that there were no risks in relation to the storage of hazardous items. We have made a requirement for staff to complete dementia training. This will increase staff knowledge of signs of stress and distress to give wider awareness of how to ensure people with a dementia diagnosis remain safe.

This area for improvement has been met.

Previous area for improvement 12

The provider should ensure that staff follow the most up to date and best practice guidance in relation to the risk assessment and management of falls. Care plans should reflect learning from falls.

This is to ensure care and support is consistent with Health and Social Care Standard 1.14: 'My future care and support needs are anticipated as part of my assessment'.

This area for improvement was made on 4 February 2022.

Action taken since then

We were satisfied that the service had improved in this area. The management team produces monthly reports from the electronic care planning which enables them to analyse falls. This highlights where updates to risk assessments were required or where support from health care professionals has been sought. We sampled risk assessments for people who were identified as high falls risks and were satisfied that these were being reviewed timeously. Where risk reduction measures included the use of restrictive practice such as the use of bedrails, consents were in place for people using the service and/or their families. We suggested ways in which the service could make further improvements by using technology enabled care to further reduce falls risks.

This area for improvement has been met.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.1 People experience compassion, dignity and respect	4 - Good
1.2 People get the most out of life	4 - Good
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our staff team?	3 - Adequate
3.1 Staff have been recruited well	3 - Adequate

How good is our setting?	4 - Good
4.1 People experience high quality facilities	4 - Good

How well is our care and support planned?	4 - Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	4 - Good

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