Ranfurly Care Home
Care Home Service

69 Quarrelton Road
Johnstone
PA5 8NH

Telephone: 01505 328 811

Type of inspection:
Unannounced

Completed on:
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Service provided by:
SCCL Operations Limited

Service provider number:
SP2014012299

Service no:
CS2014326139

About the service

Ranfurly Care Home is registered to provide a care service to a maximum of 62 older people. The service may care for one named adult under the age of 65. The provider of the service is SCCL Operations Limited.

Ranfurly Care Home is a purpose-built home which is located in a residential area of Johnstone and is near local bus routes. The home is built over two levels and divided into four units named Culzean, Brodick, Lochranza and Kelburn. Each unit has a lounge area and a dining room. All of the 62 bedrooms have ensuite shower facilities and each unit has access to communal bathrooms and toilets. The home has a large secure garden area to the rear of the building which residents and visitors are able to access.

At the time of inspection 62 people were living in the home.

About the inspection

This was an unannounced inspection which took place on 22, 23 and 24 May 2024 between the hours of 09:00 and 21:00. 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 information, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service we spoke with:

- six people using the service and six of their family and friends
- 19 staff and management
- three visiting professionals.

We also took account of feedback from 39 completed Care Inspectorate surveys, observed practice and daily life and reviewed documents.

Key messages

- People were supported by a skilled and knowledgeable staff team.
- Improvement should be made to support people with their nutritional needs.
- People and their families were involved in decisions about their home.
- Staff had meaningful relationships with people supported.
- Improvement is needed to how people are supported with medication to be given 'as and when required'.
- People's views and wishes toward end-of-life care were known and respected.
- The service had seven outstanding requirements and two areas for improvement from previous inspections. Five requirements were met at this inspection.
- We have made a new requirement and a further four areas for improvement from this inspection.

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?	4 - Good
How good is our staff team?	4 - Good
How good is our setting?	4 - Good
How well is our care and support planned?	3 - Adequate

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 found some strengths that had led to some positive experiences for people using the service, improvements are needed to prevent people having poor outcomes in relation to their health and wellbeing.

People using the service were treated with compassion, dignity and respect. Families we spoke with told us "Staff are compassionate and understanding, they know my relative's needs and she is treated with respect" and "Mum has been thriving since she moved here, she was very ill before her admission". This means that people's health and wellbeing had benefitted from their care and support.

Where people do not have capacity to make decisions around their care and support, services should hold evidence of any legal decisions that are made by others. The service maintained a good overview of legal documentation including guardianship orders and medical incapacity certificates. These linked directly to people's care plan. This ensures staff are aware of their legal duties and responsibilities around decision making.

We observed staff supporting some people in a calm and reassuring manner which had a positive impact on people's emotional wellbeing. Not all care plans included approaches that were effective to support people who may show stress and distress. The service should strive to capture this information more clearly. This is to ensure all staff are aware of how to support people well with their emotional health and wellbeing. Some people were prescribed medication to be taken as and when required, known as PRN medication. This included medication to help reduce anxiety or distressed behaviours. Where people have PRN medications prescribed, clear protocols must be in place to give staff information on how and when medication should be given. PRN protocols sampled did not clearly set this out. We have discussed this further in the report under a previous requirement in the section 'what the service has done since the last inspection'.

People should be supported with their nutritional needs to maintain their health and wellbeing. The service carried out a range of support assessments including assessing people's risk of malnutrition. Where people are assessed as being at high risk of malnutrition, care plans were in place to monitor people's weight and provide support with specialised diets. Records of people's support with their nutritional needs were completed inconsistently. For example, information contained in some people's care plans did not match the information shared with kitchen staff detailing individual support requirements with specialised meals. This meant that some people may be at risk of not having their nutritional needs met. **(See area for improvement 1).**

The service had good links with external health teams to ensure care and support is responsive to people's needs. Health professionals we spoke with told us that the service proactively sought advice and support beyond their expertise. This included liaising with local GPs and pharmacies to arrange a review of medication that may no longer be effective or required. We saw good practice of a review taking place where a lower dose of pain medication was prescribed as a result. This meant the service was assessing the benefits of long term use of pain medication for people against the potential impact from the known side effects.

Practice observations are carried out to ensure staff were competent to perform specific tasks. We observed staff demonstrating good practice when supporting people with their medication. This meant that people received their medication safely to benefit their health and wellbeing.

A required improvement was made at the last inspection about medication management. This had not been met. For further details see "what the service has done since the last inspection".

People should have a range of activities to choose from that benefit their social, emotional and physical needs. Vacancies within the activities team meant that there was limited resource to ensure a programme of planned activities. People and their families told us that there was a lack of stimulation or meaningful activities in the service. Staff did not feel that they had time to support people with activities due to the demands of their role. Although the management team recognised improvement was needed, we were unable to see clear plans to progress in this area. This meant people were potentially at risk of physical and cognitive decline due to prolonged periods of inactivity or engagement. (**See requirement 1)**

Requirements

1. By 31 August 2024, the provider must ensure people experiencing care have access to a programme of stimulating and meaningful activities and engagement. This includes:

a) developing an activity programme to meet the needs, preferences and abilities of everyone within the service.
b) gathering and using feedback from people supported to develop the programme
c) ensuring there is sufficient time and resource available to support meaningful engagement
d) maintaining a record of all activities and participation levels.

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 to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that: "I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors." (HSCS 1.25)

Areas for improvement

1. People should be supported to ensure their nutritional needs are identified and delivered safely. To achieve this, the service should review the information shared with kitchen staff. This should clearly detail each person's support with specialised diets. Further training and guidance to enhance skills and knowledge should be explored.

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).

How good is our leadership? 4 - Good

We evaluated this key question as good, where several strengths had a positive outcome for people and clearly outweighed areas for improvement.

At the time of inspection the service was in the process of re-designing quality assurance systems to allow for more oversight and monitoring. The service's aim was to improve the effectiveness of how audits linked to areas of development. Audits sampled during the inspection included environmental audits, care planning, medication and infection control. Areas for improvement were identified on each audit sampled. However, it was not always clear where improvements linked to the service development plan. Further reference to this and our findings from an existing requirement are detailed under "what the service has done since the last inspection". **(See also area for improvement 1)**

When things go wrong in a service, this should provide an opportunity for identifying lessons learned to support improvement. The service monitored falls and had risk assessments in place. However, accidents and incident reports highlighted that reviews of risk assessments were not always effective to minimise further risks of falls. This means there is potential that some people's changing needs may not be met. Additionally, formal reporting of accidents and incidents to the Care Inspectorate and other relevant bodies were not always taking place. This meant that the service may be at risk of breaching statutory and regulatory obligations. **(See area for improvement 2)**

People and/or their families should be included in developing the service. This includes providing opportunity to share ideas and suggestions to improve the service. The service gathered feedback from people and their families through resident and family meetings. Recordings of meetings detailed good discussion taking place. People and their families were provided with details of plans for refurbishments. This meant people and their families felt listened to and their views and opinions mattered.

Staff told us they felt supported by the management team. We were assured that staff were confident about seeking support and guidance out with their knowledge. This demonstrated a whole team approach to helping people to have positive outcomes.

Areas for improvement

1. The service should ensure people benefit from robust quality assurance systems that drive continuous improvements. Actions identified from audits as well as feedback from people experiencing care and stakeholders should be clearly linked to the service improvement plan.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which states "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "I use a service and organisation that are well led and managed" (HSCS 4.23).

2. The service should ensure opportunities for learning are fully explored following any accidents or incidents. Further risk reduction measures to meet people's ongoing or changing needs should be identified. In addition, the service should ensure that they comply with their notification obligations as set out in the document entitled 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My personal plan is right for me because it sets out how my needs are to be met, as well as my wishes and choices" (HSCS 1.15) and "My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event" (HSCS 4.14).

How good is our staff team? 4 - Good

We made an evaluation of good in this key question, where strengths had a positive impact on the experiences of people using the service.

People were supported by a staff team who knew them well. People told us "Staff are great, they generally all know me" and "the staff can't do enough for you". Interactions between staff were warm and respectful. Consistent staff were working across all areas of the home. This meant that people were supported by staff who were familiar to them and understood their needs.

Staff engaged with people and their families in a respectful and caring manner. Families told us that staff were visible during visits to the service and they could receive updates easily about their relative's health and wellbeing. We observed meaningful relationships between staff and people using the service. It was clear that staff had taken the time to build relationships with people to benefit their emotional wellbeing.

People should be supported safely by the right number of people with the right knowledge and skills to meet their needs. The service carried out routine assessments of people's needs to ensure that changing needs were recognised and influence staffing arrangements. We suggested involving care staff who know people well in the ongoing assessment of people's needs. This would promote a person-centred approach to ensure people receive the support that is right for them. We saw staff moving across the service to provide support at busier periods in the day. This ensured people received the right support from the right number of people at the right time.

There was a good programme of mandatory training for staff which included adult support and protection, moving and handling and infection prevention control. Additional training in areas such as dementia awareness and stress and distress training was used to enhance staff's understanding of people living with dementia. The service had a good system in place to monitor and ensure staff remained up to date with essential training and those that required refreshing. This ensured staff were knowledgeable and competent to support people to meet their needs. The management team were supporting staff with their understanding on how to support people toward the end of their life. We have discussed this further in the report in section "what the service has done since the last inspection".

How good is our setting? 4 - Good

We have evaluated this key question as good, as strengths taken together outweighed any areas for improvement.

The home was clean and fresh during our visit. Cleaning schedules were in accordance with the National Infection Prevention and Control Manual for care homes. Some areas of the home were tired and worn and needed refreshment, including painting of walls, doors and door frames. A cycle of refurbishment had commenced to progress some of these works. Plans were in place for the day-to-day upkeep of the building as well as longer term improvements to the environment. The service had recently involved people and their families in decisions for refurbishments, including choosing wall colours for communal areas. This ensured that people were involved in decisions about their home.

The service had a good level of maintenance to ensure health and safety standards were adhered to. This meant people benefitted from an environment that was safe and well maintained.

Equipment and facilities in the service should be used to promote people's choice and maximise and maintain their independence. Bedrooms had ensuite facilities to provide people with immediate access to toilet and shower facilities. The service has communal bathrooms, however many of these were not in use at the time of inspection. We suggested ways in which the service could maximise the use of bathing facilities in the home. This is to ensure people are given choice of how they wished to be supported with their personal care. We were told about plans to develop one of the communal bathrooms to make this more accessible. This would provide more suitable bathing for people with advanced mobility issues.

The service had a large well maintained and secure garden area. People had recently been supported to attend a local garden centre and were involved in selecting and planting flowers in the garden. This promoted choice, inclusion and participation. We saw some people and their families making use of the garden area during the inspection. The garden provided a private and relaxing space for people to spend time with their visitors. Some people told us they enjoyed being in garden but were unable to access this independently. **(See area for improvement 1)**

Areas for improvement

1. The service should explore ways to maximise people's independence and freedom of movement to enhance people's outcomes and experiences. This includes establishing ways in which people can have readily and regular access to the garden area.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: if I live in a care home, I can use a private garden. (HSCS 5.23)

How well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate. While we recognised strengths, these were just outweighed by weaknesses.

People who experience life limiting conditions, should have comfort measures in place as well as active care and plans for end-of-life care known as future care planning. The service had been working alongside people and their families to develop future care plans. Further reference to this and our findings from an existing requirement are detailed under "what the service had done since the last inspection." **(See also area for improvement 1)**

A regular assessment of people's care and support should be carried out to ensure this is responsive to changing need. Care plan reviews were taking place monthly to ensure that these reflected people's current needs. A schedule of six-monthly formal reviews of people's care and support where routinely occurring. Some people and their families told us they had attended reviews. This meant they were able to contribute to the development of care plans. We shared some feedback on how records of discussion from review meetings could be developed. This is to ensure the service captures how people's views and wishes had influenced their planned care.

People's personal plans should reflect their rights, choices and preferences. Care plans provided staff with information on how to support people safely. Staff we spoke with appeared to know people well and recognised their likes and dislikes. However, information in personal plans did not always capture this. It is important that this is recorded to ensure a consistent approach to guide all staff, especially in the event of agency staff who may not know people so well. This ensures that all staff are aware of people's preferences and needs.

The service held meetings with staff teams over the day to promote communication. We observed a good level of engagement during these meetings with essential information sharing. This included the outcomes of visits from external health professionals. Good practice around sharing of information ensured staff were kept up to date. This meant that people continued to have their needs met. Some staff told us that they didn't always read care plans to be aware of people's support changing. The service should consider ways in which to signpost staff to read key areas of care plans when changes are made. This is to ensure that staff continue to support people safely.

Daily recordings should demonstrate how people's needs were met in relation to their health and well being as well as give a picture of people's day. Recordings sampled focused more on clinical aspects of care. Recordings didn't always give a picture of people's overall wellbeing or how they had spent their day. Training had taken place on how to record people's outcomes in a meaningful way with senior staff and nursing staff. We suggested the manager extends this training to all care staff. This will ensure a more personalised approach is taken to record people's outcomes and experiences.

Some people's personal plans detailed support required to maintain their hydration levels. However, daily recordings of people's fluid intake did not always demonstrate that this support was met. Further discussion on this is detailed in a previous requirements in "what the service has done since the last inspection" section of the report.

Areas for improvement

1. People should be supported with dignity and respect toward the end of their life by compassionate and knowledgeable staff. The service should provide training and practice guidance on how to support people with end-of-life care. Staff should have access to end-of-life care plans that sets out people's future wishes clearly to ensure these are known and understood.

This is to ensure that people's needs are met in line with the Health and Social Care Standards (HSCS) which states 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)

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

Requirements

Requirement 1

To ensure people's end of life care is managed well, the provider must develop a detailed personal plan in consultation with people's family/representatives which identifies their individual support needs and wishes and how these will be met. To be completed by 14 November 2022.

This is to ensure care and support is consistent with Health and Social Care Standard 3.18: 'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty'.

This is in order to comply with: Regulation 5(2)(b)(ii) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This requirement was made on 21 July 2022.

Action taken on previous requirement

The service has worked hard to develop end-of-life care planning, ensuring that people supported and their families were at the forefront of decision making. The service had gathered feedback from external health professionals to establish how well they supported people with end-of-life care. This had enabled the service to reflect on feedback to highlight areas for development. People and their families told us that the service had led sensitive discussion with them to establish people's future needs and wishes. We saw evidence of discussions taking place with people and their families at resident and family meetings. This included providing people and their families with information on end-of-life care planning. We saw that there was a good response from people's families from a questionnaire that was sent to them by the service. This was designed to capture information from families about their relative's future wishes to ensure these were personal to them.

The manager had begun a programme of updating end-of-life care planning in a more person-centred manner. We saw good examples of people's choice and wishes being clearly documented. This included details of who people wanted to have with them toward the end of their life, how they wished to be remembered and any requests they had such as preferences of music played. This promoted people's dignity and respect.

We saw the roll out of new end-of-life care plans being carried out in a phased manner that offered the opportunity to measure their effectiveness, as well as supporting staff to understand these. Development work ongoing in this area assured us that the service had strong values around promoting and preserving people's rights and wishes toward the end of their life.

Met - outwith timescales

Requirement 2

To ensure people experiencing care are supported by staff who have the appropriate training and skills, the provider must:

a) revise and distribute the service policy and procedure on end of life care to care staff

b) provide training on palliative/end of life care

c) support staff to access best practice guidance on end of life care.

To be completed by: 14 November 2022.

This is to ensure care and support is consistent with Health and Social Care Standard 3.14: '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'.

This is in order to comply with: 4 of 5 Regulation 15(b)(i) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This requirement was made on 21 July 2022.

Action taken on previous requirement

We sampled the service's Death in Service policy and found this had been updated in line with national guidance. Staff we spoke with were aware of their ethical and moral duties when supporting people with end-of-life care. Senior staff were aware of the steps to take following a death in service which aligned with organisational policy and procedures. This included notifying families, local authorities, police and the Care Inspectorate within set timescales. End-of-life care plans detailed the contact arrangements to be made with families. This ensured families were contacted timeously in line with the details set out in end-of-life care plans. Families shared positive feedback with the service about their relatives end-of-life care.

Senior staff and clinical staff had completed training to support people with their end-of-life care. Staff we spoke with had good knowledge around how to support people with dignity and compassion at end of their life. We were told about plans for in-house training with all care staff to enhance their knowledge and understanding of the process of end-of-life. We were satisfied that the service has made good improvement in this area, however, to ensure plans for staff training continue we have developed an area for improvement to ensure this is achieved. **See area for improvement 1 in How well is our care and support planned.**

Met - outwith timescales

Requirement 3

By 10 February 2023 the provider must ensure people receive medications safely to maintain their health and wellbeing. To do this, the provider must, at a minimum ensure:

a) medication administration and practice is in line with 'Guidance about medication personal plans, review, monitoring and record keeping in residential care services (Care Inspectorate, 2012)' and 'Professional guidance on the safe and secure handling of medicines (Royal Pharmaceutical Society, December 2018)'

b) all 'as required' medications have a clear protocol in place

c) health monitoring information, including but not limited to skin integrity, weights and positional charts are completed timeously, accurately and inform the care plan

d) medication audits adequately audit all elements of the medication system

e) actions from medication audits are followed up, documented and communicated clearly with all staff who administer medication.

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 to ensure care and support is consistent with the Health and Social Care Standards which state that: 'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24). and '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)

This requirement was made on 18 November 2022.

Action taken on previous requirement

During the inspection we saw medication practice being delivered safely to people supported. Records of medication administered were effectively completed and clearly documented. This assured us that people were receiving the right medication at the right time.

The service used tools such as Malnutrition Universal Screening Tool (MUST) to monitor and assess people who require support with their nutritional needs. We saw reviews of MUST assessments occurring routinely, this included carrying out weekly weight monitoring. Where required, the service had liaised with dietitians to help support people's nutritional needs. Where people were at risk of pressure sores we were satisfied that monitoring was in place to safeguard people, this included re-positioning charts where people were supported for longer periods in bed.

We sampled 'as and when required' protocols (PRN protocols) and found that these did not clearly detail people's support needs. For example where medication was to be given to reduce anxiety or distressed behaviours, there were no details of the signs and symptoms to be aware of or interventions to be attempted prior to administering medication. It was unclear how the service was measuring the benefits of PRN medication or review of how effective this was to support people's wellbeing. This meant that some people may be at risk of being over medicated.

A system was in place to monitor stock levels of medication. However, we noted errors in stock levels as well as discrepancies that had not been identified during any audits carried out by the service. This meant that the system to monitor stock levels was ineffective to identify any areas for development or to take remedial action.

Although some development has been made, we were not satisfied that significant improvement has been made to meet this requirement.

Not met

Requirement 4

By 10 February 2023 the manager must ensure that staff's infection prevention and control practices in the home comply with best practice guidance. To do this the manager must, at a minimum:

a) ensure that all staff receive training/education on the Care Home National Infection Prevention and Control Manual appropriate to their role

b) produce a schedule of planned observations of staff practice to ensure that staff are putting the above training/education into practice.

This is to comply with Regulation 4 (a) and (d) (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 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)

This requirement was made on 18 November 2022.

Action taken on previous requirement

We reviewed the service's training schedule and were satisfied that all staff had completed Infection Prevention and Control (IPC) training as well as refresher training. Observation of practice took place throughout the year of hand washing and donning and doffing of PPE (personal protective equipment). This ensured that staff were competent and knowledgeable about their roles and responsibilities to ensure safe and effective IPC practice to keep people safe. The service had a plan in place to ensure all staff had a minimum annual competency assessment carried out and we could see this plan was up to date.

Met - outwith timescales

Requirement 5

By 10 February 2023, the provider must ensure that the quality assurance processes improve people's outcomes. To do this, the provider must ensure:

a) actions identified by audits have a clear action plan for each area identified, the plan is reviewed regularly, progress documented, completed and the impact of the action on improving the service is clearly recorded

b) actions are prioritised with realistic and sufficient timeframes for completion

c) residents and family members are supported with opportunities to contribute to the development of the service plan.

This is to comply with SSI 2011/210 Regulation 4 (1) (a) - a requirement to make proper provision for the health and welfare of service users.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19) 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)

This requirement was made on 18 November 2022.

Action taken on previous requirement

We sampled weekly and monthly audits carried out by the service which included audits of the environment, medication, care plans, infection control and health and safety. Where any areas for improvement were highlighted, we saw that actions had been made. However, it was difficult to establish how these had led to improvements in some areas. The service was in a process of transition of their quality assurance systems. Audits were being migrated onto a new system called RADAR. We saw how this would be used more effectively to give the service a greater oversight and link any actions required from audits to the service development plan.

We were satisfied that efforts had been made by the service to gather feedback from people using the service and their families. Sampling of residents' and family meetings offered a good detail of discussion, which included updating families on plans for refurbishments and seeking input around decoration of the home. We saw that this feedback had linked to the service development plan which had timescales set out for planned works.

We were given a demonstration on how RADAR could be used to produce reports to look at patterns and trends around falls, accident/incidents and complaints. This offers a function to give an overview of how well these have been managed by the service and any actions taken. We were satisfied that improvements had been made to safeguard people using the service; therefore this requirement has been met. The service is aware that there is time needed to embed the new system used for auditing to measure its effectiveness, as well ensuring all staff are confident on its use. We have made a new area for improvement under key question 2.

Met - outwith timescales

Requirement 6

By 13 January 2023 the provider must ensure that the setting is equipped to meet people's needs and that they are protected from the risk of cross infection: To do this the provider must:

a) provide a plan, that demonstrates how the designated domestic services and sluice rooms will be laid out and equipped in line with relevant guidance, including but not limited to, the Care Home Infection Prevention and Control Manual

b) the plan must include how the ensuing works will be managed to incur least disruption to the lives of residents affected by the works, including assessments of risks and how these will be managed and a timetable for the completion of the works.

This is to comply with Regulation 14 (b)(Facilities in care homes) of the The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'The premises have been adapted, equipped and furnished to meet my needs and wishes.' (HSCS 5.16)

This requirement was made on 18 November 2022.

Action taken on previous requirement

During the inspection we viewed how laundry and linen were managed by the service. We found that sluice rooms were fully in use for unwashed laundry, this meant that infection prevention and control was managed in line with the National Infection Prevention and Control Manual for care homes. Domestic staff were confident and knowledgeable about cleaning systems and their responsibilities around prevention of cross contamination. Domestic Service Rooms (DSRs) were in use and included both a hand washing sink and separate sink for disinfecting cleaning equipment. Cleaning equipment was stored in locked DSRs to ensure this was stored securely in line with Control of Substances Hazardous to Health (COSHH).

There were no building or re-decoration works taking place in the service at the time of inspection to assess the impact on residents. We discussed plans for re-decoration of communal areas and how this would be managed to ensure this had minimal disruption to residents. We were satisfied that the service had a good knowledge of the risk assessment required.

Met - outwith timescales

Requirement 7

By 10 February 2023 the manager must ensure that people's care plans and the information contained in the plans is current, accurate and up to date. To do this, the manager must, at a minimum ensure that:

a) care plans are reviewed and updated to reflect people's current care needs

b) health monitoring information, including but not limited to food/fluid charts, skin integrity, and weights clearly inform people's care plans

c) people who come into the home must have a written plan which sets out how the service user's health, welfare and safety needs are to be met ,within 28 days of the date on which the service user first received the service.

This is to comply with Regulation 5 (Personal Plans) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011
(SSI 2011/210)

This is to ensure that support is consistent with the Health and Social Care Standards which state '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 requirement was made on 18 November 2022.

Action taken on previous requirement
The service carried out monthly audits of care plans using their 'resident of the day' system. This involved assigning residents for each day of the month to carry out a full audit of their support. Resident of the day audits carried out detailed where any updates were needed. However, we were unable to establish how identified actions had led to changes in care plans and how these were communicated to staff. Care plans sampled offered detail on how to meet people's basic support needs. Detail and quality of information set out in care plans varied. Some people's care plans had a good level of detail about their likes and dislikes, while others required further development. We discussed this during the inspection and the service told us about plans to review the content of care plans to ensure these were more person-centred.

Some people required support with their fluid intake to ensure they remained hydrated. Where fluid monitoring was recorded, this was not being carried out consistently. There was a lack of oversight to monitor people's support with their fluid intake to ensure this was responsive to meet people's needs. This meant that some people may be at risk of dehydration. The service should carry out a review of people who are at risk of dehydration including, where required, setting a target amount of fluids to be offered each day. This to ensure all staff are clear on how to support people to meet their needs.

During the inspection we gave feedback about a lack of planning taking place for some people who required support with visual and hearing impairments. We were unable to see clear evidence of the involvement of audiology or ophthalmology for some people. This meant that some people were not receiving support that met their needs.

Not met

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

To ensure that people benefit from staff who have the right knowledge and competence to support them the manager should:

a) ensure that existing staff who have outstanding training or induction courses have completed these

b) direct staff on which courses to prioritise during the induction

c) have a process to check that agency staff have the right knowledge and competence to meet the needs of the resident group.

This is to ensure that support is consistent with the Health and Social Care Standards which state '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)

This area for improvement was made on 18 November 2022.

Action taken since then

The service was in the process of trialling a new induction process. There has been no further progress in this area. **This area for improvement has not been met.**

Previous area for improvement 2

To ensure people and their families/representatives can have confidence, the provider should agree and record the expectations around when, and in what circumstances, relatives would want to be contacted.

This is to ensure care and support is consistent with Health and Social Care Standard 3.13: 'I am treated as an individual by people who respect my needs, choices and wishes, and anyone making a decision about my future care and support knows me'..

This area for improvement was made on 21 July 2022.

Action taken since then

The service communicated with families to gather information about how they wished to be contacted to share information about their relatives. We saw details of contact arrangements set out in those care plans sampled. People's families told us they received regular updates about their families when they visited the service and by phone. People's families were satisfied about the information they received about their families and had confidence in the support provided. **This area for improvement has been met.**

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement is led well	4 - Good

How good is our staff team?	4 - Good
3.3 Staffing arrangements are right and staff work well together	4 - Good

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

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

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