# East Ayrshire Health and Social Care Partnership Care at Home and Housing Support Service (North Locality) Housing Support Service

The Johnnie Walker Bond
15 Strand Street
Kilmarnock
KA1 1HU

Telephone: 01563 554 200

**Type of inspection:**
Unannounced

**Completed on:**
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**Service provided by:**
East Ayrshire Council

**Service provider number:**
SP2003000142

**Service no:**
CS2011282263

## About the service

East Ayrshire Health and Social Care Partnership (North Locality) is registered to provide a combined Care at Home and Housing Support service to adults and older people living in their own homes.

The north locality covers Kilmarnock and surrounding towns and rural communities in the north of the locality.

The support is provided by seven staff teams. The registered manager was supported by five area leads and seven care co-ordinators. At the time of inspection the service was supporting 512 people.

## About the inspection

This was an unannounced inspection which took place on 24, 25, 26, 27 and 30 September 2024 and 1 and 2 October 2024 between the hours of 08:30 and 19:30. The inspection was carried out by two inspectors from the Care Inspectorate and one inspection volunteer.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration and complaints information, information submitted by the service and intelligence gathered since the last inspection.

To inform our evaluation we:

- spoke with 28 people using the service and six of their families
- spoke with 15 staff and management
- reviewed email feedback from eight staff
- reviewed 48 questionnaires from people using the service and their families
- observed practice and daily life
- reviewed documents
- received feedback from three other professionals.

## Key messages

- Staff were observed to be kind and respectful.
- Staffing shortages were having a significant impact on the continuity of support.
- Personal plans did not reflect the support offered.
- Staff were struggling to meet the demands placed upon them.
- A new team manager had recently been appointed.

## 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? | 2 - Weak |
| 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, where strengths only just outweighed weaknesses.

Staff were observed to be kind and respectful when offering support. However, the lack of consistency with staffing and the continual need to support extra people due to staff shortages meant that people's outcomes were impacted. People were happy with their care staff who they said would "go above and beyond for them" but that they wanted more continuity. People told us "I'm happy with the carers, it's good when it's the usual faces."

People's wellbeing was compromised because rigorous processes were not in place to support effective communication about changes to people's visits. There were frequent changes to support which was not reliably communicated to people supported or their families. The repeated extra visits diluted the quality of support as visit times were cut to accommodate them. People reported that the staff were so busy and that they didn't know who is coming to support them "I don't know who is coming I never do" and "I have a lot of different people as they are short staffed and need more staff." This resulted in anxiety and worry for people supported.

Due to the lack of continuity of carers it meant that opportunities to support people to access other healthcare professionals to maintain their well being and physical health could be missed. This resulted in staff being less likely to recognise changes in peoples needs quickly and seek appropriate support. Whilst we saw contact with external professionals we couldn't be confident that this was consistent for all people supported.

We could not be confident that people received the right medication or treatment at the right time. This was as a result of a lack of oversight of medication by the management team. This partly was due to the absence of spot checks or audits taking place. In addition there was no way to accurately assess how much medication had been given as no counts were recorded. This had the potential to affect people's physical and emotional wellbeing. The prescription of 'as required' medication was reported not to be in use. However, due to the numbers of people supported this is unlikely and we would advise a review to ensure compliance in line with good practice guidance. The required gaps between medication doses was observed to be inconsistent due to staffing issues and time constraints of all staff finishing support at the same time. (See requirement 1).

Staff working in the service lacked understanding about supporting people's physical conditions, so opportunities to prevent a deterioration in people's health could be missed. Staffs' inability to be able to escalate concerns consistently to office staff added to this. This meant that information on someone's changing health needs would not be shared quickly with the right people.

Staff did their utmost to ensure that people had enough to eat and drink within the time constraints. We saw that people were provided with extra fluids which staff made sure were within reach before leaving. Food charts were completed as directed but the reason for their completion was not consistently recorded in the support plans. This resulted in staff not being fully informed of people's needs.

### Requirements

1. By 6th January 2025, the provider must ensure that all medication processes are followed, and good practice guidance adhered to.

To do this the provider must, at a minimum ensure:

a) Where people require support with their medication at level 3, that the service has an oversight of that medication. It is important that an accurate count is made when medication is checked in to enable balance checks as required.

b)That clear records are kept when medication is not administered as prescribed and that the reason for non-administration is recorded.

c) Spot checks are done regularly to ensure staff responsible for supporting people with medication understand the process of and importance of recording and administering medication.

d) Medication audits are done regularly to identify gaps and actions required to improve recording and practice in line with current organisational policy and good practice guidance.

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 state that: '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 leadership? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses.

There were some systems in place to monitor aspects of the service. However, due to time constraints staff had been unable to perform the necessary spot checks and audits which meant that no evaluation could be made to lead to any improvement. The new team manager had recently introduced a system of protected time to complete the checks but it was too soon to see a result from this change. This resulted in changes that were reactive due to responding to crisis rather than through effective quality assurance and self-evaluation. This was impacting on outcomes for people as no effective improvements had been implemented since the previous inspection. (See requirement 1).

There had been little effective evaluation of people's experiences to ensure that they were supported to meet their outcomes. The annual survey has not yet been distributed for 2024, the survey results from October 2023 were shared.

Accidents and incidents were reported and tracked with lessons learned and changes required identified. However, this information was not always reflected in the support plan which meant that all staff would not be aware of changes in a persons support.

The new team manager had identified the need for change and potential solutions. However, due to the short time that they had been in post no significant impact had yet been made.

### Requirements

1. By 6th April 2025 ,the provider must demonstrate that service users experience consistently good outcomes, and that quality assurance and improvement is well led.

To do this the provider must, at a minimum ensure:

a) That they continue to develop quality assurance systems that continually evaluate and monitor service provision to inform improvement and development of the service.

b) That there are action plans to address issues identified with the manager having a clear overview of the outcome of audits undertaken.

c) That actions taken are reviewed to ensure that they effectively improve outcomes for people supported.

This is to comply with Regulation 4 (1) (a) and (b) (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 state that: '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? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

Staffing arrangements were inadequate. The calculation of service capacity did not fully consider vacancies and absence leading to permanent shortage and crisis management. This had deteriorated since the last inspection and the impact on peoples outcomes had increased. Staff were working really hard to mitigate the shortages however this was not sustainable. (See requirement 1).

Staff reported that they were exhausted and felt unheard. They told us "There are constant changes. Its taking all the care out of the job," and that "Not much has changed for the better in fact it has got worse."

Staff reported that their area leads were a good source of support but were spread too thin to do more than offer occasional help and advice. Staff told us "My manager is great she will always help and get back to you if you leave a message. She cares and has helped me with stuff I was going through." No one had received regular supervision which was only taking place when an issue was identified. Area leads had responsibility for the supervision of too many staff and as such it was unachievable. Team meetings were taking place but staff did not feel they impacted on the outcome of anything with the same subjects raised consistently with no change. This resulted in staff becoming disillusioned and not attending the meetings.

There was an over-reliance on the splitting up of runs which had no cover. This led to people experiencing a lack of consistency and stability in how their care and support was provided and limited their ability to build a trusting relationship with staff members.

The numbers of staff were insufficient to meet outcomes for people using the service.

Staff worked under pressure every day and some aspects of care and support were skipped or missed affecting outcomes for people. If staff are rushed they become task orientated and could miss changes in someone's condition.

Staff were consistently caring for people with conditions for which they have not yet had adequate training such as dementia, stress and distress and diabetes. There is now a plan in place to address this however, the skills of staff need to be considered as part of the allocation process. The staff reported that training they had attended has been useful and increased both their knowledge and skills. This ensures people are supported by appropriately skilled staff. (See requirement 2).

Communication and team working had suffered due to a lack of time and staff told us this had affected staff motivation and morale. Staff told us that they tried to help each other. However, they told us that the schedules are so overloaded due to additional visits there is very little opportunity for this. Important information was not shared or passed on accurately, leading to a negative impact on people. Some staff told us that poor communication in or with the office base meant that information sometimes gets lost or was not shared appropriately or at the right time. Staff told us "There is no back up for us the coordinators do not answer the phone or get back to you if you leave a voicemail. You feel really isolated and alone."

### Requirements

1. By 6th January 2025, the provider must review the staffing assessment to ensure that there are sufficient staff at all times to support people.

To do this, the provider must, at a minimum:

a) Consider the assessed needs of people supported.

b) Take into account any vacancies and other planned absence including long term sickness when assessing capacity.

c) Consider the impact of travel between visits.

d) Include feedback from all stakeholders.

This is in order to comply with section 7 of The Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care standards (HSCS) which state that: “My needs are met by the right number of people”(HSCS 3.15).

2. By 6th April 2025, the provider must develop and implement an effective staff and training and supervision programme.

To do this the provider must, at a minimum ensure:

a) That all staff complete mandatory training requirements and update and refresh this when necessary, relevant to their roles and responsibilities.

b)That all staff receive supervision as per the organisations policy.

c)That training is provided to support staff to meet the specific needs of people using the service.

This is to comply with Regulation 4 (1) (a) and (b) (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 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 well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses.

Support plans were basic and were not routinely used to inform staff practice or approaches to care and support. The standard of the support plans had deteriorated and were not as fully completed as at the previous inspection. They were not consistently updated with changes or audited.

The support plans did not reflect the current care and support needs of people who use the service and were not sufficiently detailed to direct staff. People supported told us "I get fed up having to repeat things when new staff come in."

Support plans focused on tasks to be carried out and weren't reflective of a strength based approach. There was little information on what level of support was required or what the person supported was able to do for themselves. This can result in people losing life skills.

The standard of care and support planning was inconsistent. The new team manager was aware of the need for development of the support plans and intended to arrange training sessions for staff. The team manager had a strong knowledge of the requirements of a person centred support plan and the importance of the same.

People had limited involvement in their care and support planning and the review process. This meant that people did not consistently experience care and support in line with their wishes and preferences. It is acknowledged that staffing constraints had a significant impact on the staffs ability to complete and update plans. People could not be confident that the support would be delivered in accordance with their outcomes wishes and changing needs. (See requirement 1.)

Risk assessments were not present within the care documentation. Where risks were identified there was no evidence of assessment or the actions to be taken to keep people safe.

### Requirements

1. By 6th April 2025 ,the provider must ensure support plans and risk assessments contain accurate, up to date, detailed information about the support being provided or required.

To do this the provider must, at a minimum ensure:

a) That all staff receive training and support in support planning.

b) That the audit process is developed to ensure that support plans reflect peoples outcomes and wishes and are sufficiently detailed to direct staff.

c) That people supported are encouraged to be involved in the process.

This is to comply with Regulation 4 (1) (a) and (b) (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 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).

## 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 provider should improve the consistency of support for people. Where there are changes to support, this should be communicated to ensure the safety and wellbeing of people and to improve the quality of the service.

To do this the service should ensure:

a) People are provided a schedule of support times and the names of staff who will attend in advance of visits.

b) Changes to support times are kept to a minimum and provided as close to preferred support time as possible. Changes of times or staff should be communicated to people (or their families if appropriate) and a record kept of the discussion.

c) People are made aware if there will be a staff member they have yet to be introduced to visiting.

d) Staff providing cover visits, should be made aware of information required to support people safely.

e) Robust and regular oversight of the service by the organisation.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that: "I experience stability in my care and support from people who know my needs, choices and wishes, even if there are changes in the service or organisation." (HSCS 4.15).

**This area for improvement was made on 20 February 2024.**

### Action taken since then

Staffing challenges had significantly impacted on the service's ability to provide a consistent allocation of staff and peoples experience. People reported that they were not always informed of any changes and were often unsure who would be coming to provide support. The support plans did not contain sufficient information to allow staff to offer consistent levels of support.

This area for improvement has not been met and will be continued.

## Previous area for improvement 2

The provider should, at a minimum, ensure that all medication processes are followed, and good practice guidance adhered to.

To do this the service should ensure:

a) Where people require support with their medication at level 3, it is important that the service has an oversight of that medication. It is important that an accurate count is done to ensure that the person is administered the appropriate medication required.

b) Detailed as required protocols are in place for each medication that has been prescribed "as and when required". They should include information on when to be given, desired effect and when follow up actions should be taken. Clear records should be kept of when as required medication has been given, detailing the outcome for the person.

c) Spot checks are done regularly to ensure staff responsible for supporting people with medication understand the process of and importance of recording and administering medication.

d) Medication audits are regular and effective; identifying gaps and actions required to improve recording and practice in line with current organisational policy and good practice guidance.

This is to ensure that care and support is consistent 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).

**This area for improvement was made on 20 February 2024.**

### Action taken since then

Spot checks and audits were not being applied in a consistent way . A new system had recently been introduced to address this. However the lack of a stock check count meant that it was not possible to accurately assess the amount of medication that had been administered.

The service reported that there were no as required medications and that a sheet was being introduced to record where medication was not given as prescribed.

This area for improvement has not been met and will now be the subject of a requirement (See Key Question 1 Requirement 2).

## Previous area for improvement 3

The provider should demonstrate that service users experience consistently good outcomes, and that quality assurance and improvement is well led. The provider should ensure the following:

a) Continue to develop quality assurance systems that continually evaluate and monitor service provision to inform improvement and development of the service

b) That action plans to address issues identified are fully developed following audits, with the manager having a clear overview of the outcome of audits undertaken

c) Ensure that actions taken are reviewed to ensure that they effectively improve outcomes for 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).

**This area for improvement was made on 20 February 2024.**

### Action taken since then

There had not been any consistent quality improvement activity since the last inspection. Samples captured were too small to effectively evaluate the quality of the service provision. Care coordinators now had dedicated time to complete the required tasks which should increase the data available.

The availability of accurate and up to date feedback is central to identifying service improvements and therefore had impacted on peoples outcomes.

This area for improvement has not been met and will now be the subject of a requirement (See Key Question 2 Requirement 1).

## Previous area for improvement 4

The service provider should continue to develop the content and quality of the care and support plans to ensure consistency. This should reflect the good examples of care and support plans we were presented with during this inspection.

This is to ensure that care and 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 area for improvement was made on 7 October 2022.**

### Action taken since then

Information contained within the personal plans was not sufficient to guide care. There had been no effective auditing of support plans.

This area for improvement has not been met a and will now be the subject of a requirement (see Key Question 5 requirement 1).

## Previous area for improvement 5

The service should continue to develop and implement their staff training and supervision programme to ensure that all staff complete mandatory training requirements and update and refresh when necessarily relevant to their roles and responsibilities. We saw good examples such as the new induction programme and commitment to supporting the staff team to deliver high standards of care and support to people in the community.

This is to ensure that care and support is consistent 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).

**This area for improvement was made on 20 February 2022.**

### Action taken since then

The majority of staff had not received any supervision with their line manager. The ratio of supervisors to staff being supervised required to be revisited to allow effective supervision to take place.

The supervision of staff is key to gaining feedback, allowing reflection of practice and identifying training requirements.

This area for improvement has not been met and will now be the subject of a requirement (see Key Question 3 requirement 2).

## Previous area for improvement 6

To ensure individuals have confidence in the care provided to them, the provider should ensure all staff receive training specific to the needs of individuals experiencing care.

**This area for improvement was made on 26 February 2024.**

### Action taken since then

Diabetes awareness had been added to the induction process but only a few staff had received this training. Dementia Skilled training is ongoing but the majority of staff had not yet completed this.

This area for improvement has not been met and will now be the subject of a requirement (see Key Question 3 requirement 2).

## Previous area for improvement 7

To ensure people experience high quality care and support that is right for them, the provider should ensure care plans and person-centred risk assessments contain accurate, up to date, detailed information about the support a person requires.

**This area for improvement was made on 26 February 2024.**

### Action taken since then

Information contained within the personal plans was not sufficient to guide support. There had been no effective auditing of support plans. Risk assessments were not present within the care documentation. Where risks were identified there was no evidence of assessment or the actions to be taken to keep people safe.

This area for improvement has not been met and will now be the subject of a requirement (see Key Question 5 requirement 1).

## Previous area for improvement 8

People should experience high quality care and support that is right for them this includes quality mealtime experiences. In order to achieve this, the care provider should ensure food is prepared in accordance with the instructions to reduce any risks to people supported.

**This area for improvement was made on 26 February 2024.**

### Action taken since then
Meals were observed to be prepared in accordance with manufacturers instructions and staff offered choices. Staff offered both a drink with the meal and other drinks to ensure fluids available until next visit.

This area for improvement has been met.

### Previous area for improvement 9

To ensure people experiencing care feel safe and secure in their homes, service management should ensure care plan documentation clearly states where house keys are stored and the process to be followed when securing individual's properties.

**This area for improvement was made on 26 February 2024.**

### Action taken since then
The information on the electronic system contained information on key safe locations and codes. The care plan documentation contained information on actions required before and on leaving the house.

This area for improvement has been met.

### Previous area for improvement 10

To ensure individuals and their families have confidence in the complaints process, the care provider should ensure all complaints and concerns are accurately logged and investigated in accordance with their own complaints policy and procedure.

**This area for improvement was made on 26 February 2024.**

### Action taken since then
Evaluation of action taken

A review of complaints and concerns received demonstrated adherence to the complaints policy and procedure. They had been logged appropriately.

This area for improvement is 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 |
|---|---|
| 1.3 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? | 2 - Weak |
|---|---|
| 3.3 Staffing arrangements are right and staff work well together | 2 - Weak |

| 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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Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

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