The Abbeyfield (Monifieth) Society Limited
Housing Support Service

Tullis House
6-8 Maule Street
Monifieth
Dundee
DD5 4JN

Telephone: 01382 535 298

Type of inspection:
Unannounced

Completed on:
22 January 2025

Service provided by:
Abbeyfield (Monifieth) Society Limited

Service provider number:
SP2004005848

Service no:
CS2004061233

About the service

The Abbeyfield (Monifieth) Society housing support service is situated in Tullis House in the centre of Monifieth, with easy access to the local shops and services of the town. Tullis House is purpose-built and provides accommodation for 12 people in 10 single rooms and one double room.

All residents have their own room with private use of a shower and toilet. Residents share the use of three kitchens (for breakfast and snack preparation), a dining room, lounge, conservatory, laundry, and gardens. Main meals are prepared in the main kitchen by the housekeeper or the relief housekeeper assistant, and served in the dining room. Out with normal hours, emergency cover is provided by the local authority community alarm service.

At the time of the inspection there were 10 residents living at the service.

About the inspection

This was an unannounced follow up inspection which took place on 21 and 22 January 2025. The inspection was carried out by one inspector 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 eight people using the service and their families
- spoke with six staff and management
- observed practice and daily life
- reviewed documents.

Key messages

• People told us they were happy and enjoyed living at Tullis House.

• Management had identified lead roles to cover responsibilities in all key areas of the service.

• Support plans had improved, were detailed and accessible for tenants in their rooms.

• Quality assurance processes were in progress however, more time will be required for this to be fully embedded in the service.

• Staff felt happy and well supported at work.

• All staff had completed mandatory training and an annual training planner was in place.

• There were several opportunities for people to give feedback about the service and people told us they were listened to.

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 good is our leadership?	3 - Adequate

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

How good is our leadership? 3 - Adequate

During our follow up inspection there was a considerable improvement in the leadership of the service. We have therefore re evaluated Quality Indicator 2.2 - Quality assurance and improvement is led well. We evaluated this key question as adequate, where strengths only just outweighed weaknesses.

A clear management structure had been implemented, with each trustee having a key area of responsibility. As a result;

Management processes were in place to facilitate service development, however this will need time to be firmly embedded moving forward. We will follow this up at our next inspection.

Comprehensive training had been completed by all trustees and staff, and relevant guidance documentation implemented. This had increased awareness and knowledge around required responsibility and reporting, in order to keep people safe.

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

Requirements

Requirement 1

By 03 January 2025, the provider must ensure that service users experience a service which is managed in a manner which results in better outcomes for service users through a culture of continuous improvement, underpinned by robust and transparent quality assurance processes.

This must include but is not limited to:

a) ensuring appropriate and effective leadership of the service;

b) ensuring that service users' assessed support needs are monitored, managed and reviewed at six monthly intervals;

c) implement effective action planning to address areas of required improvement to include appropriate timescales for completion and review of actions to be undertaken, and ensuring staff are accountable for and carry out the required remedial actions.

d) ensure that a training needs analysis of all committee members and staff is carried out to ensure that staff have the skills necessary to keep people safe.

This is to comply with:

The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 3 - Principles & Regulation 4. 1 (a) Welfare of 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 requirement was made on 3 July 2024.

Action taken on previous requirement

It was evident that there had been development and progress with regards to leadership in the service, since our last inspection.

A management structure was now in place, and displayed in a diagram, for all to see within the service. This highlighted the staffing structure across all departments. Areas of responsibility for all trustees had been identified, and each trustee had been given specific responsibilities allocated for different key aspects of the service. This ensured that there was no confusion between roles and responsibilities, and ensured who was responsible for reporting in their allocated area. As a result, continuity and consistency had improved.

The recent changes had been a relatively new way of working for the trustees, with a lot of information for them to process. Although there had been positive improvements within the trustee team, strong and effective leadership will take time to develop and evolve, and embed within the service. The service will however, continue to be supported by an independent consultant with experience of Health and Social Care, moving forward. We will follow this up at our next inspection.

Tenant's support plans had significantly developed since our last inspection, and contained current, appropriate detail relating to people's needs. The house committee had responsibility for monitoring tenants' wellbeing, and updating support plans accordingly. All tenants had a six-monthly review, which people confirmed during our visit. One family also confirmed that her father had had a review since returning from hospital recently. The service were currently using the Abbeyfield support plan as a six-month review, but this will be developed further in March 2025 to better reflect people's views. The housekeeper also monitored tenants daily, and reported any significant changes. It was good to see tenants taking ownership of their support plans which were now kept in people's rooms.

We saw that there were some action plans, which incorporated feedback from tenants and staff, following recent questionnaires and meetings. Outcomes were recorded following completion of actions. Trustees in the house committee had been identified as responsible for this key area of work. This has been identified by the service as an area that does require further development, and the trustees will focus on this as part of their quality assurance processes moving forward. We will follow this up at our next inspection.

A training analysis had been completed, and all staff and trustees had completed the identified training required. Staff confirmed training had been undertaken and discussion with trustees evidence their increased understanding of areas such as adult support and protection and first aid. An annual training planner had been put in place covering all required training. An induction pack had been implemented which was comprehensive for trustees and all new staff. Staff roles, duties and responsibilities had been reviewed and updated. This meant people were being supported by a team of staff who were knowledgeable and well trained, to be able to keep them safe.

This requirement has been met.

Met - within timescales

Requirement 2

By 31 July 2024, the provider must ensure that the Care Inspectorate is notified of accidents and incidents promptly, as per guidance 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations SSI 2011/210, regulation 4(1)(a). Health, welfare and safety of service users

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that,

'I benefit from different organisations working together and sharing information about me promptly where appropriate' (HSCS 4.18).

This requirement was made on 3 July 2024.

Action taken on previous requirement

The service had improved on reporting relevant events within the service, since our last inspection.

The service had two accident books in place to record all accidents and incidents. Notifications had in general, been made appropriately. A sample of recent accidents and incidents highlighted some issues around wording of accident reports, which could be confusing and open to interpretation. This meant there was confusion with whether these were reportable or not. We discussed the importance of effective and clear documentation in relation to all accident/incident reports and the importance of notifying us timeously where appropriate. The service took prompt action to implement a guide to reporting of events, with working examples included and this will be discussed with all staff at the forthcoming staff meeting.

We discussed the need for oversight of all accident/incident reports and to clearly document who has reviewed each form, what action was taken, what was the outcome and who was informed. We discussed this with management and a health and safety lead was identified who will review all reports moving forward to ensure compliance with current guidance. As a result, clear outcomes will be documented following each event to maintain people's overall wellbeing and safety.

This requirement has been met.

Met - outwith timescales

Requirement 3

By 03 January 2025 the provider must ensure that all staff training requirements are up to date.

This should include, but is not limited to:

a) Complete updates for all core and essential training such as food hygiene, Infection and prevention control training and first aid.

b) Ensure that relevant staff receive training regarding supporting dietary requirements of residents including diabetic diets.

This is to comply with:

The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 3 - Principles & Regulation 4. 1 (a) Welfare of Users.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that,

'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11)

This requirement was made on 3 July 2024.

Action taken on previous requirement

All updates for core and essential training for staff and committee members had been completed. Evidence of completion was noted on certificates which were displayed in the service. Staff also had a training record completed and a training planner was in place. Topics such as infection prevention and control, first aid, food hygiene, moving and handling, control of substances hazardous to health (COSHH), and adult support and protection had been completed.

All cleaning products were kept in a locked cupboard. COSHH data sheets were available for all chemicals used in the building. A first aid kit and eye wash kit were now in place, with appropriate safety equipment purchased for use with chemicals. As a result, staff practice had improved and risk of harm reduced.

The housekeeper had completed diabetes awareness training. A diabetic cookbook and information resource were now available in the kitchen. People told us they would like to see more diabetic options for desserts on the menus. We discussed with management that the addition of diabetic options on the six weekly menu, would be beneficial. This would ensure tenants with diabetes would have suitable choices and not feel like they were missing out.

This requirement has been met.

Met - within timescales

Requirement 4

By 31 July 2024, the provider must ensure that when it recruits staff, it follows the guidance in "Safer Recruitment Through Better Recruitment" (Scottish Government, 2016). This will help to ensure that all staff who are employed in the care home are fit to work with vulnerable people.

This is in order to comply with:

The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210) Regulation 4(1)(a), 9(1)(2) - fitness of employees

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that, 'I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected (HSCS 4.18)

This requirement was made on 3 July 2024.

Action taken on previous requirement

A sample of staff files evidenced that the service were recruiting staff in line with safer staffing guidance. Staff had two references obtained and a Protection of Vulnerable Groups check (PVG), in place. This meant people could be reassured that new staff were being recruited safely.

A comprehensive induction pack had been developed for new trustees, outlining all areas of responsibility. This had been a positive development and useful tool for new staff.

All staff had attended supervision sessions recently and told us they felt supported. Appraisals were also planned for all staff in the near future. As a result, staff were happier at work and told us their wellbeing was enhanced.

Training had been completed in line with staffs' roles. A planner was in place to ensure training is maintained and staff have opportunities to learn and develop their existing skills and knowledge.

Staff were now undertaking an Scottish Vocational Qualification (SVQ), where appropriate, in line with registration requirements. This meant staff had the right qualifications for the job.

This requirement has been met.

Met - within 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

In order to ensure that people have opportunities to feedback about the service and be involved in supporting improvement, it is recommended that the service carry out a service user satisfaction survey to obtain the views of people using the service, and consider a variety of ways in which consultation and involvement of people using the service could be encouraged and supported.

This is to ensure care and support is consistent with 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) 'I am supported to give regular feedback on how I experience my care and support and the organizations uses learning from this to improve' (HSCS 4.8)

This area for improvement was made on 3 July 2024.

Action taken since then

Support plans were held in tenants' rooms. It was clear to see that people were taking ownership of their support plans and were protective of their information. This meant people were fully involved in the ongoing review of their support plans. This gave people a voice and made them feel central to their plans.

A tenants participation statement had been developed, and a participation lead was driving this within the service. A tenant representative attended meetings, and offered information from all tenants in the service regarding any changes required.

People told us about the 'You said, we did board' in the lounge and how they added suggestions to this, which were actioned. An annual tenant satisfaction survey had been completed by all tenants and an action plan compiled. A suggestion box in the foyer gave an additional opportunity for people to feedback about the service.

Meetings for tenants had increased in frequency in order for more engagement. Tenants all had a copy of the latest inspection report. There was information in people's support plans advising of who to contact if they had a complaint or concern.

A staff survey had also been completed and all actions identified had been completed. A quality assurance survey had been successful in gaining tenants opinions.

It was good to see that the service had taken significant steps forward, in relation to engagement with people. This was evident in the variety of ways in which the service had sought feedback. Processes will be embedded in time and we will follow this up at our next inspection.

Management advised that they still had developments planned such as further development of participation, a review of the service policies and procedures and evaluations following all training.

This area for improvement has been met.

Previous area for improvement 2

In order to support staff, and in accordance to the service own policies, it is recommended that the provider carries out supervision of staff at intervals stated in the service's own policies and procedures.

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 codes.' (HSCS 3.14).

This area for improvement was made on 3 July 2024.

Action taken since then

All staff had all attended a supervision meeting recently.

Supervision will be held once per year, as per policy, and staff meetings are now being held three times per year. There was a new supervision format in place, covering all aspects of each person's job role. This encouraged input from the staff member, in order to reflect their views.

Staff contributed to the agenda of their supervisions, and therefore supervision had become more staff led. This meant staff took ownership of their own development and identified key areas to discuss.

Staff told us, 'I like my job more now, as I'm more supported'.

There was a more positive atmosphere in the service at the time of the inspection, and staff and management were working well together in a relaxed, friendly atmosphere.

This area for improvement has been met.

Previous area for improvement 3

In order to ensure that people are are fully represented, the service should ensure that records are updated to include information about people's legal representatives. These should include;

a) the legal powers that they hold;

b) when these powers should be enacted;

c) ensure that relevant people are invited to reviews and updates relating to the powers that they hold.

This to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that, 'If I am unable to make my own decisions at any time. the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account' (HSCS 2.12).

This area for improvement was made on 3 July 2024.

Action taken since then

Support plans we viewed, documented where tenants had legal powers in place and who to contact when necessary. People also had copies of power of attorney documents in place. This meant that staff were aware who was responsible for tenants who lacked capacity, to ensure they were protected, and their rights upheld appropriately.

An information session is to be planned for trustees and staff regarding legal powers, to aid understanding.

The House committee had access to the Care Inspectorate, best practice guidance for support planning and also the Health and Social Care Standards.

This area for improvement has been met.

Previous area for improvement 4

In order to ensure that people's health and wellbeing are managed and staff have the right information at the right time; the manager should ensure that support plans are updated when health needs change, and that DNACPR documentation is available to emergency services at the point of need.

This to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that,

'My care and support is provided in a planned and safe way, including if there is an emergency or unplanned event.' (HSCS 4.14).

This area for improvement was made on 3 July 2024.

Action taken since then

Do not attempt cardio pulmonary resuscitation (DNACPR) documents were evident in people's support plans, in their bedrooms. This meant that they were easily accessed by medical professionals, as and when required in an emergency situation.

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

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Contact us

Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

0345 600 9527

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