# Muirshiel Resource Centre
# Support Service

Block 8
Industrial Estate
Muirshiel Road
Port Glasgow
PA14 5XS

Telephone: 01475745115

**Type of inspection:**
Unannounced

**Completed on:**
6 February 2025

**Service provided by:**
Muirshiel Resource Centre

**Service provider number:**
SP2021000203

**Service no:**
CS2021000323

## About the service

Muirshiel Resource Centre is a support service (day-care) registered for up to 30 adults (within the building base) who are older, have a diagnosis of dementia, have a learning disability, mental health problem and/or physical disability. The service is provided by Muirshiel Resource Centre within premises located in an industrial estate in Port Glasgow, Inverclyde. A minibus provides transport to and from the service.

The resource centre has a range of large and smaller rooms which are used for group events and activities. The upper floor of the service was closed temporarily until a ramp was installed for emergency use. Accessible toilets are available and there is a dining room where people can eat and drink together. A kitchen area is available for preparing hot drinks and snacks. People attending the resource centre can bring packed lunches to the service or are provided with a lunch. At the time of inspection, the service was supporting 43 people who attended the resource centre at varied pre-arranged days and times throughout the week. The registered manager of the service was supported by an assistant manager, a senior support worker, and a team of support workers.

## About the inspection

This was an unannounced follow up inspection which took place on 5 February 2025 between 09:45 and 16:30 hours. We were following up on two requirements and five areas for improvement made at a previous inspection, inspection report dated 20 September 2024.

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 five people using the service and seven of their family/friends
- spoke with nine staff and management
- observed practice and daily life
- reviewed documents
- spoke with one visiting professional.

## Key messages

- The service had met two requirements and four areas for improvement.
- The staff and management had worked hard to improve outcomes for people attending the service.
- Staff demonstrated warmth, kindness and respect to people.
- Relatives fed back positively about the care and support their loved one received.
- Quality assurance processes had improved to ensure people's safety and drive forward improvements in the service.
- Maintenance checks had improved and actions prioritised.

## 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 setting? | 3 - Adequate |

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

## How good is our setting? 3 - Adequate

The service has been regraded to adequate, following meeting two requirements pertaining to 'How good is our setting?'

Please see what the service has done to meet any requirements made at a previous inspection.

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

### Requirements

**Requirement 1**

By 30 November 2024, the provider must ensure that sufficient fire safety arrangements are in place in the service which meet the requirements of the fire (Scotland) Act 2005: Part 3 The Fire Safety (Scotland) Regulation 2006. To do this the provider must at a minimum:

a) undertake a Fire Safety Risk Assessment;

b) produce an action plan to address the risks identified in the Fire Safety Risk Assessment. This action plan should include timescales for the completion of required actions;

c) produce a schedule for reviewing the Fire Safety Risk assessment in line with organisational policy;

d) ensure a clearly defined Fire Safety Policy is available for the service;

e) ensure all staff are given information, instruction and training on the action to be taken in the case of fire and the measures to be taken or observed on the premises including taking part in fire drills.

This is to comply with Regulation 10(1) and 10(2)(b) (Fitness of Premises) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My environment is secure and safe' (HSCS 5.19).

**This requirement was made on 20 September 2024.**

Action taken on previous requirement

The provider had worked hard to address the requirements working closely with Scottish Fire and Rescue (Scotland) and other partners.

The upper floor has been closed off to people using the service as a safety precaution until the egress route

and ramp is established.

A fire risk assessment (FRA) had been completed. This ensured people were safe.

Action plans have been produced and updated regularly including dates for anticipated actions and completed actions improving oversight of safety.

A schedule is in place for reviewing the FRA. The Fire policy has been updated to include when Fire Risk Assessment has been reviewed or modified. The policy clarifies when this has to happen.

People using the service, their relatives, and visitors were able to view the Fire Safety Policy to encourage transparency.

A staff meeting was carried out around the evacuation procedure and actions to be taken in the event of a fire. This gave people assurance that staff knew what to do and that staff were competent.

A fire drill was carried out with staff and service users. A record of this was kept within paperwork stored in the Fire Folder. There was also a further unplanned drill.

Fire Warden e-learning training was purchased and carried out by all staff. This improved staff knowledge of fire safety. This included staff being trained as fire wardens. Staff confirmed that they had taken part in a few drills and felt confident supporting people in the event of a fire.

All staff have signed that they have read and understood the fire policy.

**Met - within timescales**

**Requirement 2**

By 30 November 2024, the provider must ensure that there is effective oversight of maintenance and safety of the premises. This should include, but not be limited to,

a) ensuring there is a clear maintenance policy detailing who is responsible for all audits;

b) produce a schedule of when these audits should be completed;

c) ensure any actions are completed and signed off by a responsible person.

This is to comply with Regulation 10(1) and 10(2)(b) (Fitness of Premises) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

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

'My environment is secure and safe.' (HSCS 5.19).

**This requirement was made on 20 September 2024.**

### Action taken on previous requirement

There is a clear maintenance policy detailing who is responsible for all audits, this gave assurance that safety was being prioritised.

A building maintenance schedule was clear for when these audits should be completed.

The Building Maintenance Policy highlights appointed persons and responsibilities and any actions are completed and signed off by a responsible person.

Maintenance staff were clear about their roles and responsibilities improving the overall environment for people using the service.

We could see clear planned arrangements for regular monitoring and maintenance of the premises. Staff are aware of the need to report any maintenance issues immediately.

### 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

The provider should ensure that people are protected from financial harm by utilising robust finance systems, including a policy detailing clearly expected practice. This should include reference to legal status and details of power of attorney/guardianship.

This is to ensure that care and support is consistent with the health and social care standards (HSCS) which state.

'If I need help managing my money and personal affairs, I am able to have as much control as possible and my interests are safeguarded.' (HCSC 2.5).

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

### Action taken since then

Robust finance processes were in place and administration staff were following this. Processes are checked every month by the manager prior to the board meeting.

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The new policy outlines the steps to take to manage people's finances safely.

Clear financial policy and procedure for the management of peoples money and possessions were documented and evidenced in practice. Where people lack capacity to make decisions about their finances, the service have noted this within the care plan.

Staff and people felt assured that safe systems and processes of managing finances were in place.

This area for improvement has been met.

### Previous area for improvement 2

The provider should ensure people benefit from robust quality assurance processes that keep people safe and 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 that 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 that is well led and managed.' (HSCS 4.23).

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

#### Action taken since then

A new Service Improvement Plan had been implemented and a wide range of audits had been carried out to benefit people using the service.

People using the service were asked for their feedback on the care they were receiving and how this could be improved. Senior staff carried out spot checks and signed off care plans and review minutes for auditing purposes. We saw that the Health and Social Care Partnership input was requested and recorded at each review.

Fire Safety and Building maintenance quality assurance was accessible for any visitors, people using the service, staff and families.

Focus groups with service users and families/carers were planned to gain further views. Information gained from these groups will inform the service improvement plan.

A Quality Assurance tracker was being developed to co-ordinate a wide range of tasks to oversee and manage staff supervisions , reviewing of policies, complaints/ compliments. The management team had begun introducing staff observations of practice.

A clear training plan was in use highlighting any gaps in staff knowledge. This was to be added to the service improvement plan.

The management team have been able to demonstrate improvements in quality assurance and improved safety for people using the service.

This area for improvement has been met.

### Previous area for improvement 3

To keep people safe, the service should ensure that staffing numbers, skills mix, and deployment reflect the needs of the people using the service at all times of the day. Decisions about staffing should be transparent and based on the principles 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).

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

### Action taken since then

We looked at staffing rotas for the past three months. A new policy/process had been introduced for staff leave to take into account staffing levels. This meant people could be confident there was adequate staff to support them.

Peoples needs/dependencies had been reviewed and updated, and this was clear in the care plan.

There had been consultation with the Health and Social Care Partnership regarding the referral process to the service, establishing a common understanding of dependency levels to inform better staff deployment.

Assessments and decisions on placements were made following initial home visits to ensure there was adequate staffing to meet peoples needs. We noted that specific days were being offered and/or referral being identified as on hold until a suitable placement is available.

The staffing complement has not increased since the last visit however peoples needs have been reviewed and placements accordingly rearranged to ensure that dependencies across the week are easily manageable with the current staff team.

This area for improvement has been met.

## Previous area for improvement 4

To ensure people benefit from safe and secure outside space the provider should ensure that opportunities for people to experience outside are explored using a recognised environmental tool such as the King's fund tool.

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

'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).

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

### Action taken since then

The management, board and staff team had met to gain an understanding of the King's Fund Tool (or another relevant environmental tool) and how this can be explored and implemented at Muirshiel Centre.

Outings to a therapeutic horticultural centre within the community have been planned and carried out within the last six weeks with client groups to provide outside experiences for people.

There was ongoing dialogue with a local community group to facilitate appropriate access to a community garden. This had not yet transpired.

People who are attending the day service do not have direct access to safe outdoor space as the setting does not allow for this, there is no garden area. The service have been proactive in supporting some people who wish to access the community and this has happened twice recently using the service minibus.

As the upper floor is no longer in use people's opportunity to mobilize has been reduced so any access out with the service could be of benefit to a persons physical and mental health.

This area for improvement has not been met and will continue to the next inspection.

### Previous area for improvement 5

To ensure people experience high quality care that is right for them, the provider should ensure people's outcomes are clearly detailed within the personal plan. Reviews of care should be formally recorded detailing discussions held and any arising actions identified.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) 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) and
"My needs as agreed in my personal plan, are fully met, and my wishes and choices are met." (HSCS 1.23).

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

#### Action taken since then

In the records we sampled personal outcomes were detailed in all these plans.

The management team continue to develop staff skills in order that personal plans follow good practice guidance and detail peoples outcomes clearly. This was being addressed through staff training and the review process. Staff told us they had discussed peoples outcomes at team meetings.

All reviews were carried out within the timeframes and were audited by a senior member of staff to ensure they were recorded in the appropriate part of the care plan and any actions/changes being updated prior to sign off. We could see that reviews were completed then updated within the care plan to reflect this. Family members were involved.

Formal observations during the inspection noted that people were involved in activities that they had chosen and these activities were recorded in peoples outcomes within the care plan.

The management team were gathering feedback from people of how outcomes have impacted them, either positively or negatively, this was being recorded for review.

We concluded that peoples needs wishes and choices were being met.

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 setting? | 3 - Adequate |
|---|---|
| 4.1 People experience high quality facilities | 3 - Adequate |

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