North Haven (Care Home)
Care Home Service

North Haven Care Centre
Brae
Shetland
ZE2 9TY

Telephone: 01595 743 850

Type of inspection:
Unannounced

Completed on:
31 March 2025

Service provided by:
Shetland Islands Council

Service provider number:
SP2003002063

Service no:
CS2005097981

About the service

North Haven Care Home is situated in the village of Brae on mainland Shetland and overlooks Busta Voe and Brae area. The service provides long term and respite care to a maximum of 15 adults or older people.

The building is split into two sections, with the residential service on the top floor and a day care service on the ground floor. The service is well presented with two homely communal lounges and a spacious dining area. All of the individual bedrooms have access to en-suite facilities including showers. A shared accessible bathroom is also available to use with an overhead hoist tracking system.

The outside garden area is landscaped with seating areas and there is a central patio area for further outdoor pleasure. Parking is available on site and the service benefits from being within close proximity to the local GP practice.

At the time of inspection 12 people were supported by the service.

About the inspection

This was an unannounced follow-up inspection which took place on 24, 25, 26 and 28 March 2025 between the hours of 09:00 and 19:00. The inspection was carried out by one inspector from the Care Inspectorate. To prepare for the inspection we reviewed information about the service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. We also observed practice and daily life. In making our evaluations of the service we spoke with:

- four people using the service
- six staff and management
- one visiting professional.

Key messages

- We followed up on five requirements that were made at the last inspection, three of these were met, one partially met and one was not met. We have made two new requirements at this inspection.
- We followed up on five areas for improvement, two of these were met and three were not met. We have made a new area for improvement at this inspection.
- Improvement is required to ensure there is effective management and oversight in the service.
- Quality assurance systems were not used to identify where improvements to the service were required and actions taken.
- Improvement is required to ensure people are protected by safe medication management systems and practice.
- People benefitted from meaningful activities to reduce the likelihood of boredom and isolation.

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?	2 - Weak
How good is our leadership?	2 - Weak

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

How well do we support people's wellbeing? 2 - Weak

We followed up on a requirement made at the last inspection, which was partially met. See 'What the service has done since the last inspection' section of the report. We identified significant weaknesses which may be negatively impacting on the quality of care and outcomes for people using the service. Therefore, we have re-evaluated this key question to weak.

A high level of medication errors had occurred in the service since the last inspection. These include multiple types of errors involving multiple people. We were concerned that some errors were being regarded as recording errors only, without being fully investigated. These findings, alongside a lack of thorough analysis and evidence of responsive actions, pose significant risks to the health and wellbeing of people relying on the service. There is a lack of evidence to demonstrate what the service has done to ensure people are not adversely impacted by missed medication, such as taking advice and input from health professionals or where increased care monitoring may be required. We discussed concerns with the manager that there appeared to be more of a focus on the internal reporting processes of medication errors rather than investigation and follow up action to reduce any potential risks to people. **See requirement 1.**

We found there was an absence of clear processes and post-falls checks when people had experienced falls in the service. This directly impacts the delivery of safe and effective care as without post-falls protocols, there may be delays in recognising injuries or deterioration, leading to delays in medical treatment and potential harm. There was an absence of guidance for staff, which leaves staff without a clear understanding of how to respond to falls, leading to inconsistent approaches and potential oversights. We have shared good practice guidance around falls management with leaders. **See area for improvement 1.**

Requirements

1. By 30 May 2025, the provider must ensure that people are protected by safe and effective medication management systems and procedures. Practice should be in accordance with the organisational medication policy and The Royal Pharmaceutical Society's guidance 'Professional guidance on the safe and secure handling of medicines' 2018. To do this the provider must ensure:

a) there are clear systems in place to ensure medication stock levels are accurate at the start of a new medication cycle. This includes a total balance of medication currently held in the service and medication received

b) a robust and standardised medication audit tool is developed to ensure people have been supported safely and well with their prescribed medication

c) medication audits and spot checks are carried out timeously to ensure any errors highlighted are addressed without delay

d) where medication errors occur, thorough and timely investigation should be carried out to establish the root cause of the error and appropriate action taken to reduce risk to people. This includes identifying where learning can be taken and addressing any practice issues with staff to ensure competency.

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

This is to ensure that my care and support is in line with Health and Social Care Standards (HSCS) "Any treatment or intervention that I experience is safe and effective" (HSCS 1.24) and "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

Areas for improvement

1. To ensure that people are protected as far as possible when they have experienced a fall, the provider must ensure there are clear falls management systems in place. This should include ensuring post-fall checks have taken place to identify any potential injuries and seeking medical input where required. An analysis of falls that have occurred should be undertaken to identify where measures to reduce risk to people can be made. Staff should be given clear guidance on falls management systems, how to record when someone has had a fall and follow up actions.

This is to ensure care and support is consistent with the Health and Social Care Standards which states that: "I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm" (HSCS 3.21) 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 leadership? 2 - Weak

We followed up on a requirement made at the last inspection in relation to service improvement and quality assurance. This has not been met and we have agreed to extend the timescales of this requirement to 30 June 2025. We have re-evaluated this key question to weak.

We were concerned that there is no quality assurance framework in place to support oversight of critical aspects of service delivery or to identify where improvements may be required to support leaders to take action. The registered manager of the service had recently taken on a temporary role, which meant he had senior management responsibility for a number of other local authority services. We were concerned about the extensive remit and expectation of this new role, which may have contributed to the lack of focus on making progress with the improvements identified at the previous inspection.

We looked at clinical governance information to establish how well people were being supported with their health care needs, such as skin care to prevent pressure ulcers occurring and falls management to identify patterns and trends to help identify measures to reduce risks to people. We found that the data collected monthly by leaders was not being analysed to improve outcomes for people. Data collection alone is insufficient if it is not being used well to gain insight to inform decisions that can improve the quality of care for people. We discussed this with the registered manager, who was unclear on the purpose of the data being collected monthly. The lack of understanding from leaders around the importance of this contributed to further concerns about the management and oversight of the service to maintain regulatory standards and ensure people received safe and effective care. **See requirement 1.**

Requirements

1. By 30 June 2025, the provider must develop a quality assurance framework which will support improvement and ensure good management oversight.

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

a) identify the relevant quality audits that must take place within the service which promote the safety and wellbeing of people and staff

b) identify and detail the associated timescales within which each quality audit must take place

c) identify and detail the required standards that should be met with regards to best practice expectations

d) ensure that actions identified in quality assurance audits are followed up with clear action plans which are reviewed and signed off by the responsible manager

e) ensure governance and adequate oversight arrangements are in place for service quality and to provide guidance and support to leaders in the service.

This is to comply with Regulation 4(1)(a) 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 am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership" (HSCS 4.7) and "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

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

Requirements

Requirement 1

By 21 March 2025, the provider must ensure that people are protected by safe and effective medication management systems and procedures. Practice should be in accordance with the organisational medication policy and The Royal Pharmaceutical society's guidance 'Professional guidance on the safe and secure handling of medicines' 2018. To do this the service must ensure;

a) PRN protocols are in place for as required medication which includes bowel management, pain relief and stress and distress

b) PRN protocols give clear instruction on when medication should be given and when further action should be taken

c) clear links are made between care plans and PRN protocols, to ensure staff have knowledge of the signs to be aware of as well as strategies and techniques to provide responsive care

d) medication audits and spot checks are carried out timeously to ensure any errors highlighted are addressed without delay

e) where additional medication requires to be stored for people, stock control arrangements and checks are in place to ensure people have access to their medication at the right time.

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

This is to ensure that my care and support is in line with Health and Social Care Standards (HSCS) "Any treatment or intervention that I experience is safe and effective" (HSCS 1.24) and "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 28 November 2024.

Action taken on previous requirement

PRN protocols are now in place for people who require 'as and when' medication for bowel management, pain management and stress and distress. The development of these was supported by the Advanced Nurse Practitioner to ensure these met clinical standards. Protocols we sampled provided good information to staff on when to administer medication and when to escalate further actions. Care plans contained clear links to PRN protocols with additional person-centred details around individual support requirements. These help staff to make informed decisions based on individual needs. For example, descriptions of how agitation and anxiety may present for different people and what intervention is required.

A consistent approach should be taken to ensure the quality of information contained within all PRN protocols is person-centred and tailored to people needs.

The frequency of spot checks of medication recording systems had increased which was helping to identify some issues at an earlier stage. However, there was a lack of information on what had been looked at during spot checks. We were not able to clearly determine the compliance criteria from completed checks, and follow-up actions that were required or taken. There was no standardised audit tool in place to ensure medication management and practice is safe and effective.

There was no process in place to reconcile carried forward balances of medication stock with new stock received to establish an overall total at the start of a new 28-day medication cycle. This means that investigation into discrepancies cannot be carried out to identify where medication may have been missed. A significant number of medication errors logged as "recording errors" were not adequately investigated to confirm whether medication was administered or not. The lack of evidence around investigations taken by the service meant we were unable to determine what impact this may have had on people using the service.

Elements a, b and c of this requirement have been met. We have made a new requirement to capture the ongoing improvements required to medication management and practice. See 'How well do we support people's wellbeing' section of the report.

Met - within timescales

Requirement 2

By 21 March 2025, the provider must ensure people have access to nutritious food that is safely prepared and meets their nutritional needs. To do this the provider must, at a minimum:

a) ensure all staff responsible for preparing and serving food have undertaken sufficient and appropriate training for their role. This must include awareness and understanding of how to prepare modified meals in accordance with the International Dysphagia Diet Standardisation Initiative framework (IDDSI)

b) ensure relevant information about people's nutritional needs is shared with the kitchen staff regularly and when there are changes to people's assessed support

c) ensure all meals are presented in an appealing manner to encourage people to eat well and enjoy their food.

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

This is to ensure that care and support is in line with Health and Social Care Standards (HSCS) which state "My meals and snacks meet my cultural and dietary needs, beliefs and preferences" (HSCS 1.37) and "I can drink fresh water at all times" (HSCS 1.39).

This requirement was made on 28 November 2024.

Action taken on previous requirement

Kitchen and care staff had received training from Speech and Language teams around meal modification in line with the IDDSI framework. This has helped to ensure staff understand residents' needs and dietary requirements. Staff spoke positively about their learning from this training, new knowledge around food modification and how to present food on the plate with the use of moulds to ensure this appeared appetising.

Each resident now has a personalised eating and drinking action plan, which includes their preferences, likes, dislikes and dietary needs. Those sampled were detailed and provided good information about people's nutritional support needs. These plans have been shared with kitchen staff and we were assured any updates made would be shared with kitchen staff timeously, to ensure people continued to have their meals prepared in line with their individual needs.

Met - within timescales

Requirement 3

By 21 March 2025, the provider must create a service development plan which is Specific, Measurable, Achievable, Realistic and Time-bound (SMART) to evidence and centralise where improvements to the service have been identified, actions agreed and outcomes achieved. This should include but not be limited to;

a) evidencing where feedback from stakeholders including external professionals, people using the service, their families and staff have linked to service development areas

b) ensuring that robust internal audits and quality assurance systems are carried out and any actions identified are linked to the wider service development plan

c) learning from concerns, complaints or any adverse incidents to evidence the link to improvements

d) ensuring the plan is a live document, continually reviewed and updated to demonstrate the progress made toward improvements.

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

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

This requirement was made on 28 November 2024.

Action taken on previous requirement

The current service improvement plan focuses only on the requirements we made at the last inspection and lacks in any detail around operational aspects of the service such as quality assurance systems, feedback from stakeholders or learning from any adverse events. We reviewed records that suggested elements of the improvement plan were met, which we found were not met. We were unable to measure how leaders were actively evaluating service delivery to identify where improvements could be made to the service.

There was no clear outline of what quality assurance should entail, for example a structured internal auditing process to demonstrate who is responsible for completing these, the frequency of when these should occur and when action should be taken. Senior staff had carried out audits of care plans, however the frequency of these were sporadic and consistency is needed to set a clear timescale for completion. Medication spot checks were being carried out, however these were not sufficient to support improvements to how people were supported with their medication.

The registered manager was not conducting any internal audits or ensuring oversight of tasks delegated to others, for example seniors or maintenance workers. This is important to ensure that the service is operating safely within regulatory standards.

This requirement has not been met and we have agreed to extend the timescale to 30 June 2025.

Not met

Requirement 4

By 21 March 2025, the provider must have a clear plan to ensure mandatory and service specific training is up to date and regularly reviewed. To achieve this the provider must:

a) carry out a training audit of all essential training staff require in line with their individual roles and responsibilities. This should include, as a minimum, moving and assisting, adult protection, fire safety, health and safety and infection prevention and control (IPC)

b) put a training plan in place, prioritising training for new staff and core training which has lapsed for existing staff

c) monitor the training plan to ensure it is kept up to date and any remedial action required is taken

d) ensure staff have completed medication administration training in line with their job roles and have had, at a minimum, an annual assessment of their practice to ensure competency.

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

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

This requirement was made on 28 November 2024.

Action taken on previous requirement

Significant progress has been made with mandatory training compliance in all areas including moving and assisting, adult support and protection (ASP), fire safety, health and safety and infection prevention and control (IPC) which is evidenced on the new training matrix. High compliance levels were achieved, in particular in relation to ASP and medication training. These were further supported by observation of practice to ensure staff were competent to deliver effective care.

Staff had completed bespoke training delivered by Speech and Language therapist and District Nursing teams in areas such as catheter care and how to support people with modified diets. We asked the manager to add this information to the current training matrix, as this will showcase how the service supports person-centred practice and seeks input from other professionals.

Reflective practice and discussions after medication errors need to be better documented to evidence where any further learning or development needs have been identified for staff. The manager took on board this feedback and will look to embed this better in practice.

Met - within timescales

Requirement 5

By 21 March 2025, the provider must ensure that people's personal plans and risk assessments contain up to date and essential information to give staff clear instruction on how to meet their needs safely. To do this the provider must, at a minimum:

a) carry out regular reviews of care plans and risk assessments to ensure these reflect people's current needs and record when these have been completed. Risk assessments should have clear control measures identified to reduce the risks of harm to people

b) ensure that amendments to care plans and risk assessments are made timeously when people's needs have changed

c) communicate people's changing needs clearly to all staff and keep a record of how this has been communicated. Daily handovers, emails with significant changes. Handover book taken to handover meetings

d) use care plan audits to ensure information about people and their needs are accurate and issues identified are addressed effectively.

This is to comply with Regulation 5(1) (Personal Plans) 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 (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).

This requirement was made on 28 November 2024.

Action taken on previous requirement

Care plan audits were being completed by senior staff. Those sampled had varied timescales of completion from monthly to three-monthly. Clarity is required on the frequency of when these should be completed to ensure a consistent approach is taken by all senior staff responsible for these. We saw that various actions were noted in the audits completed, which were assigned to "key workers" to update relevant sections of care plans. We saw that actions had been 'ticked off'. We fed back to leaders that adding dates and signatures when actions were completed would strengthen this process. This would also enable senior staff to follow up on actions highlighted to ensure that updates were made timeously.

We sampled risk assessments and noted that they had been reviewed recently, and aligned to people's current support needs.

Staff were kept informed of changes to people's support at shift handover meetings, communication logs, and also received emails where people had significant changes to their care needs. This ensured that all staff were aware of people's changing needs and knew how to provide their support.

Team meetings had occurred more frequently, which had helped to foster better communication and enabled staff to influence decisions around people's care and support.

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

To ensure people are supported safely and well with their assessed needs, the provider should ensure monitoring records in relation to people's health and wellbeing are recorded clearly. This should enable decisions to be made and immediate action taken without delay. To achieve this the provider should at a minimum:

a) give staff clear instruction on how to complete monitoring records in relation to people's support with their skin integrity. Guidance should be made clear to all staff when nursing input is required

b) ensure monitoring records are regularly reviewed to make sure they are completed effectively.

This is to ensure that my care and support is in line with Health and Social Care Standards which state "benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "My care and support is consistent and stable because people work together well" (HSCS 3.19).

This area for improvement was made on 28 November 2024.

Action taken since then

We reviewed records relating to how people were supported with their skin integrity. The service was using the NHS pressure ulcer cross to record any issues in relation to people's skin. Senior staff were unclear on how to use this tool effectively, resulting in insufficient guidance for staff and recordings that may not be accurate.

Discussions with the dietician were ongoing to identify a suitable tool for recording food and fluid intake that meets the needs of the service and individuals supported. We shared some guidance and resources with senior staff to help with the decision making process.

This area for improvement has not been met.

Previous area for improvement 2

To maintain transparent reporting procedures, the provider should ensure all notifiable events are submitted to the Care Inspectorate timeously.

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 is in line with guidance - 'Records that all registered care services (except childminding) must keep guidance on notification reporting.

This area for improvement was made on 6 October 2022.

Action taken since then

There had been a high volume of medication errors since the last inspection that had not been thoroughly investigated or documented. Therefore, we could not be assured that these did not involve significant medication errors that would have been notifiable to the Care Inspectorate.

This area for improvement has not been met.

Previous area for improvement 3

To promote a culture of learning, development and team work to benefit people's outcomes and experiences, the provider should ensure there are regular opportunities for staff to share their views and knowledge with colleagues and leaders. This includes both on a one-to-one basis and during team meetings. Feedback from these sessions should be used to improve the service and experiences of people supported.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes" (HSCS 3.14) and "My care and support is consistent and stable because people work together well" (HSCS 3.19).

This area for improvement was made on 28 November 2024.

Action taken since then

A tracker is now in place to outline scheduled meetings with staff across the year, incorporating set agenda points to ensure these are carried out consistently.

Regular team meetings and supervisions have been led by senior staff. These encouraged learning and provided opportunities for staff to share ideas for service improvement. Records sampled confirmed staff supervisions were taking place, supporting their individual development.

We asked the manager to implement a system to log when meetings occur throughout the year to keep track of when these have taken place in line with the planned timescales. The manager took this feedback on board.

This area for improvement has been met.

Previous area for improvement 4

To ensure people can continue to experience an environment which is safe and well maintained, the provider should ensure arrangements and safety checks are in place to resolve any maintenance issues timeously.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment" (HSCS 5.24).

This area for improvement was made on 28 November 2024.

Action taken since then

There is no clear guidance in place setting out the checks that maintenance staff are expected to complete and the timescales for completing these. The manager of the service has been liaising with other maintenance teams from other local authority care homes in order to build an auditing/check list. This has yet to be implemented.

This area for improvement has not been met.

Previous area for improvement 5

People should be encouraged to remain active, stimulated and engaged as far as possible to promote their health and wellbeing. To do this, the provider should provide opportunities for people to spend time outside of their rooms. People's choice, inclusion and participation should be promoted. This should be carried out in a person-centred manner, ensuring people's views and wishes are clearly recorded in their care plans.

This is to ensure care and support is consistent with the Health and Social Care Standards which states that: "I am empowered and enabled to be as independent and as in control of my life as I want and can be" (HSCS 2.2) and "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).

This area for improvement was made on 28 November 2024.

Action taken since then

Weekly planners are now placed in people's rooms, with key workers supporting and encouraging participation in activities. We observed an increase in activity and freedom to use communal spaces during the inspection, including varied use of the lounge area.

Staff demonstrated a better understanding of person-centred planning by spending meaningful time with people and learning their interests. Care plans now include more detailed information about people's hobbies, interests and preferences, evidencing a thoughtful, individualised approach.

A number of organised activities have taken place since the last inspection. These included:

- McMillan Coffee Morning, which families participated in, with photographic evidence supporting participation.

- Book Bug Sessions, which is intergenerational storytelling days involving local schools and nurseries. We saw that some people had expressed their desire to opt in when these sessions were taking place in the service, supporting people's preference and choice.

- We saw photos of people who lived in the service interacting with lambs, cats and Shetland ponies, showing their clear enjoyment.

- Bingo Night, which was popular among residents and families alike.

- Up Helly ya Celebration, which was a cultural fire festival with video evidence showcasing people and their families participation and enjoyment.

There was also more focus on one-to-one activities with people who prefer staying in their rooms rather than communal spaces. We spoke with people we met at the last inspection who were spending long periods of time in their room, who were now getting involved in activities. It was positive to hear how things had improved for them to reduce boredom and isolation.

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?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

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