Kintyre Care Centre
Care Home Service

Shore Street
Campbeltown
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Telephone: 01586 553615

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Unannounced

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Service provided by:
Argyll and Bute Council

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HAPPY TO TRANSLATE

About the service

Kintyre Care Centre is a care home service that provides nursing care for 38 older people, including people living with dementia. The provider is Argyll and Bute Council.

The service is based in Campbeltown, close to shops and local amenities. There are car parking spaces available next to the home.

People have access to a communal lounge and dining facilities on each of the two floors of the home. The accommodation offers single bedrooms with ensuite toilet facilities. Shared bathrooms and shower rooms are available on each floor. There is an enclosed patio area which people can access through the lounge area on the ground floor. There is lift access to the upper floor.

There were 33 people living in Kintyre Care Centre at the time of the inspection.

About the inspection

This was an unannounced inspection which took place on 13 April 2025 between the hours of 16:30 and 21:30, 14 and 15 April 2025 between the hours of 09:30 and 18:00, and 16 April 2025 between the hours of 09:00 and 14:00. The inspection was carried out by three inspectors from the Care Inspectorate.

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

In making our evaluations of the service we:
- spoke with 10 people using the service and seven of their family members
- spoke with 15 staff and management
- observed practice and daily life
- reviewed documents
- spoke with two visiting professionals.

Key messages

- We followed-up six requirements and four areas for improvement made at previous inspections. Two requirements and three areas for improvement were met.
- People were supported by staff who were compassionate and worked well together.
- People's nutritional needs were well managed and followed professional advice and guidance.
- Managers were visible, accessible and responsive to feedback from people and their representatives.
- Service level quality assurance processes were effective and used to drive improvement.
- The service did not have a current medication policy or procedure to support safe practice.
- Oversight of staff training was not sufficient to ensure staff had the right training to keep people safe.
- Risks relating to a broken nurse call system and a fault with fire doors were not managed effectively.
- Oversight of maintenance was insufficient to ensure the environment was safe.
- People did not have formal opportunities to contribute to their personal plans as reviews had not taken place.

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?	4 - Good
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate
How good is our setting?	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? 4 - Good

We evaluated this key question as good. We found a number of important strengths in how people's health and wellbeing was managed. These strengths had a positive impact on people's experiences and outcomes.

All people using the service had a personal plan which outlined their health and wellbeing needs. Health assessments had been completed thoroughly and contained detailed information about how health should be monitored and managed. Where input from external professionals was required, this had been noted with follow-up actions and advice recorded in people's personal plans. Feedback from health professionals was positive and assured us that the service had effective relationships with external colleagues to keep people safe and well. This meant that people's health needs were well managed and they had input from the right professionals at the right time.

Medication processes were managed appropriately and staff responsible for administering medication understood their responsibility to manage medication safely. Safe processes were in place to monitor 'as and when' or 'covert' medication and advice from health professionals had been recorded. Daily 'handover' meetings were used to share information about people's health and medication needs and to ensure follow-up actions were taken where required. This meant that people's medication was right for them and had been prescribed and monitored appropriately. There was no medication policy or procedure in place for the service. The provider assured us this was being developed. Please see 'What the service has done to meet any requirements we made at or since the last inspection.'

People had access to a range of tasty and nutritious food and staff understood people's nutritional needs. We observed mealtimes which were relaxed and well managed with staff discreetly supporting people to eat and drink where necessary. This was done with kindness and it was clear that people enjoyed their mealtimes. Communication between care staff and the kitchen was effective and meant that people had access to meals that were appropriate for their needs. People were regularly included in discussions about the food on offer, with kitchen staff taking time to speak to people individually and at resident's meetings to understand their preferences.

People's nutritional needs were carefully recorded in their personal plans, alongside professional advice from dieticians or speech and language therapists (SALT), where required. Kitchen staff had good knowledge of different food textures in line with best practice guidance (IDDSI, 2019) and made a big effort to ensure people requiring altered diets had meals that looked and tasted appetising. Where people required additional monitoring in relation to their food or fluid intake, this was discussed at a daily 'flash meeting' which helped to ensure the right information was recorded to be shared with professionals when appropriate. We asked the provider to ensure kitchen staff had formal opportunities to update their IDDSI training so that people could continue to benefit from their skills and enthusiasm. Please see 'What the service has done to meet any requirements we made at or since the last inspection.'

The service continued to provide a very good standard of meaningful activity for people which supported good health and wellbeing. Activities were well planned with involvement of people and their representatives where appropriate. People told us they appreciated the opportunity to contribute ideas and suggestions for activities and that they had lots to do. The service has an activity co-ordinator who worked closely with care staff, people using the service and families to ensure activities were stimulating, individualised and enjoyable for people. Care staff provided support to facilitate activities and had a good understanding of the part they should play in making activity part of people's daily lives.

There was reduced staff cover for activities at weekends and we were made aware of a recent reduction in staff hours for activities. While this had not yet had a significant impact on people, we asked the provider to ensure that staffing numbers were sufficient to support meaningful activity.

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate. We found some strengths in leadership which had a positive impact on people. Key areas of performance need to improve to ensure people have consistently good experiences and outcomes.

Communication between staff at all levels was effective and helped to ensure people's changing needs were identified and addressed. Leaders had implemented systems such as the daily 'flash' meeting which provided oversight of daily priorities for the service. Staff from all departments were included with decisions and follow-up actions recorded.

Leaders completed a range of quality assurance checks including analysis of falls, pressure care, meal time experience, nutritional needs, accidents, and medication. This enabled leaders to identify risk, areas of good practice and areas for development in the service. Responsibility for quality assurance tasks was shared between the manager, deputy manager and senior staff which helped to ensure accountability and shared responsibility for keeping people safe and well. There were no formal staff competency checks taking place which meant we couldn't be assured staff practice was adequately monitored to drive improvement. Please see 'What the service has done to meet any requirements we made at or since the last inspection.' A quality assurance policy was being developed by the provider to ensure quality assurance checks continue to meet organisational requirements and up-to-date best practice guidance.

People and their families told us they were happy with the care provided in the service. Families were welcome to visit at any time and told us that the manager and senior staff were visible and accessible. People were confident to give feedback and we saw examples of good front-line resolution where people had raised concerns. This assured us that leaders were open to receiving feedback and using this to drive improvement in the service. There were limited formal opportunities for people or their representatives to provide feedback about the physical environment. The service has required some environmental upgrades in recent months which have been delayed. We were unable to identify how information about these delays had been shared with people. This is important to ensure people have a say and can contribute to improvements in their home. Please see 'What the service has done to meet any requirements we made at or since the last inspection.'

A range of provider level policies and procedures were available but some key policies and procedures were not available. This included medication management, maintenance and personal planning. Leaders had difficulty accessing key policies due to difficulty navigating provider systems. It is essential that leaders and staff know what policies and procedures are in place for their service. This ensures that people's care and support is being carried out in line with organisational requirements and best practice guidance. Please see 'What the service has done to meet any requirements we made at or since the last inspection.'

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate. We found some strengths in staffing arrangements which had a positive impact on people. Key areas of performance need to improve to ensure people have consistently good experiences and outcomes.

People benefitted from a staff team who were caring, compassionate and motivated to provide good care. This included staff who did not provide direct care, such as administrative, domestic, and kitchen staff. These staff were an integral part of the team and their contribution was recognised by leaders. Staff told us they worked well together and we observed team members supporting each other to manage people's care well.

Safe recruitment processes were in place with all new staff given ample opportunities for shadowing more experienced team members. New staff undertook a range of induction training. This is important to ensure staff joining the service feel confident in their role and are assessed as competent by leaders. Induction training did not include training for dementia or stress and distress. This training should be provided and regularly refreshed in services which support people experiencing dementia.

Oversight of staff training was insufficient to ensure team members had the right training and development opportunities. There had been no analysis of staff training needs and staff did not have individual learning plans. The service did not have an up-to-date tracker for staff training. This meant that we could not be assured staff had undertaken or refreshed key mandatory training required to keep people safe. The provider assured us that they were developing a new system for monitoring staff training. This new system had not yet been implemented for the service. Please see 'What the service has done to meet any requirements we made at or since the last inspection.'

Staff supervision was not carried out regularly and was not sufficient to support staff development. The provider had implemented a new 'annual appraisal' and most staff in the service had met with their line manager to discuss this. The annual appraisal did not provide opportunities to discuss training needs or to have reflective discussions about safe and effective practice. There were no opportunities to discuss the Health and Social Care standards or professional registration and codes of conduct. People should expect that staff have had adequate training as well as regular opportunities to discuss their practice to ensure they are competent. Please see 'What the service has done to meet any requirements we made at or since the last inspection.'

The service used a dependency tool to analyse people's support needs. This was used by leaders to support decision making about staff numbers and deployment. The skills mix was effective with a combination of nursing staff, senior carers, carers, wellbeing and domestic staff available during shifts. Staff told us their rotas were planned in advance and they had been consulted about their availability. This worked well for team members and we could see that staff were dedicated and committed to their roles. Staff also told us they felt supported by leaders and that communication in the service was good. The service was still using a high number of agency hours due to recruitment difficulties in the area. The service had recruited additional 'bank' staff and was undertaking ongoing recruitment to try to reduce agency use. This is important for continuity to help ensure people receive care from staff who are familiar to them and know them well.

The nurse call system for the service has not been operational for a number of months. This meant that additional staff may have been required to ensure people's needs could be monitored. Additionally, due to a fault with the internal and external fire doors, all fire doors were kept closed to manage risk. This meant that people with mobility needs were less able to move freely around the home, requiring additional support and monitoring from staff. The service was using additional assistive technology to help manage this, but it was not appropriate for everyone using the service. The staffing levels overall were not sufficient to fully meet people's needs while these technical faults were ongoing. Please see Requirement 1 under Key question 4 'How good is our setting.'

How good is our setting? 2 - Weak

We evaluated this key question as weak. Weaknesses in the environment substantially affected people's experiences and outcomes. We asked the provider to undertake structured and planned improvement in the service, as a matter of priority, to ensure people's welfare and safety were not compromised.

The service design was suitable for people living with a range of care and support needs. Wide corridors supported people to mobilise and use equipment suitable for their needs. A range of spaces were available in the service for private, small group and larger group living. This supported people to experience a range of activities and interactions, depending on their needs and preferences. We noted some limitations due to the age of the building, but found that staff managed the spaces well to meet people's needs. Leaders had previously completed a Kings Fund audit (Is your care home dementia friendly? Kings Fund, 2014). We asked that this was updated to support ongoing reflection on how well the environment supports people living with dementia. We noted that there was a lack of directional signage, for example, which can limit people's independence. Leaders took action to address this during the inspection.

The environment was kept clean and tidy. Domestic staff had a clear understanding of their responsibilities, and cleaning activities were well managed. There was plenty of fresh air and light, and people's rooms were comfortable and individually decorated and furnished. This meant that people were comfortable and the risk of spread of infection was managed well.

The fire alarm system for the service had recently been upgraded. This upgrade had caused an issue with fire doors in the home which were not closing when the alarm was activated. To manage this risk, the service kept all fire doors and bedroom doors closed. This had an impact on people living in the service as they were unable to move around freely. Heavy fire doors in corridors were closed which posed a risk to people with cognitive and physical impairments who were trying to open these doors. This had also created some dissatisfaction as people did not have the option to keep their bedroom door open. This can provide reassurance for some people who have difficulty communicating their needs. While the provider had taken action to try to reduce risk, this situation had been ongoing for several months and temporary measures were not adequate to keep people safe.

The service had been without an operational nurse call system for several months. The provider had undertaken surveys to have this replaced, but there was no timescale for this to be resolved. Temporary measures had been put in place to reduce risk to people. This included additional assistive technology such as bed or chair monitors and door alarms. We observed that these measures were not adequate to keep people safe, as they relied too heavily on one staff member being available to monitor them. The lack of nurse call system was having an impact on staff and their ability to summon additional help in an emergency. While staff were aware of the need to be vigilant, we observed situations where people did not get a timely response from staff when required. **See requirement 1.**

The environment was generally in a poor state of repair. There had been a delay replacing a carpet in the corridor in the Davaar Unit, and several areas of the home were in need of decorating. We saw holes in walls where the fire alarm system had been replaced and where electric heaters had been upgraded. Flooring in several areas was damaged and in need of replacement. We were concerned to learn that, despite the poor state of repair of the building, maintenance hours had been reduced. This meant that we could not be assured essential repairs and upgrades would be made timeously to ensure people's home environment was of a comfortable standard. The provider confirmed a date for replacement of the carpet in the Davaar unit during the inspection.

Processes for oversight of key maintenance tasks were insufficient. The maintenance officer diligently completed daily and weekly records and safety checks but there was no corresponding maintenance policy or procedure. We could not be assured the maintenance checks adhered to current best practice guidelines or organisational expectations. We were unable to see evidence of external oversight of maintenance, and staff and leaders were unable to confirm who had responsibility for this. We had difficulty accessing certification for equipment such as the lift and electrical system. We were informed these records were held centrally, but the service was unable to access them during the inspection. **See requirement 2.**

Requirements

1.
By 28 July 2025, the provider must ensure there are adequate systems in place to keep people safe.

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

a) provide a clear action plan and timescale for a safe and effective replacement for the nurse call system;

b) provide a clear action plan and timescale for the repair of the internal and external fire doors;

c) ensure that the temporary assistive technology used to mitigate the failure of these systems is suitable for people's needs and based on clear and regularly updated risk assessment;

d) ensure adequate staffing numbers so that people get a timely response when their nurse call or alarm is activated; and

e) ensure staff have a safe means of accessing support from colleagues while the nurse call system is out of service.

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:

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

2. By 28 July 2025, to keep people safe, the provider must ensure there are adequate systems in place for maintenance of the environment.

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

a) ensure that daily, weekly, and monthly maintenance tasks are clearly outlined and based on up-to-date best practice guidance;

b) ensure there is a clear policy or protocol for staff to follow when completing maintenance tasks. This should include clear guidance on recording and when to highlight and escalate concerns;

c) ensure adequate oversight of maintenance tasks to identify priority areas for follow-up. Follow-up actions should be recorded with clear timescales for completion; and

d) ensure sufficient staffing in the service to complete the identified maintenance tasks in line with organisational requirements.

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 states:

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

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

We evaluated this key question as adequate. We found strengths in personal planning, which had a positive impact on people, but key areas of performance need to improve to ensure people have consistently good experiences and outcomes.

Personal plans were generally thorough and completed with a good level of detail to reflect people's needs, preferences and outcomes. Risk assessments were used appropriately to support people to live as independently as possible. Personal plans were regularly quality assured with identified actions assigned to appropriate staff members. We asked leaders to ensure these actions were followed-up and any issues discussed with staff during supervision. This is to promote accountability and ensure people's personal plans continue to reflect their needs and preferences.

The service obtained relevant information about legal needs, including copies of guardianship or power of attorney where these were in place. This meant that people's legal rights were understood. Clear records of discussions with external professionals were maintained including follow-up actions to be taken. Personal plans were updated monthly using a 'resident of the day' format. This was thoroughly completed with input from care staff, families, domestic and kitchen staff to ensure personal plans were accurate and up-to-date.

End of life care plans were not consistently completed and did not reflect current guidance in relation to 'Future care planning' (NHS Inform). We asked the provider to ensure the service had access to the most recent guidance to ensure people and their representatives were given opportunities to discuss their preferences about their future care needs.

Processes for completing six monthly care reviews were not sufficient. The provider had made changes and improvements to annual 'social work' reviews. We saw that senior staff had completed their part of the paperwork for this. Where the annual social work reviews had taken place, these were appropriately recorded in people's personal plans. Some of these annual reviews had been delayed and there was no process in place for the service to undertake internal six monthly reviews. This meant that there were long gaps between formal opportunities to discuss people's care and support. These reviews are important to ensure people and their representatives have opportunities to identify changes or resolve concerns. **See Requirement 1.**

Requirements

1. By 28 July 2025, to ensure people's care and support needs are fully considered, the provider must implement a system for completing six monthly care reviews.

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

a) schedule six monthly reviews for all people using the service;

b) ensure people, their representatives and key professionals are invited to contribute to these reviews;

c) ensure people's personal plans are updated to include any changes identified at the review. The updated personal plan should be made available to the person and/or their representative, if requested; and

d) ensure any actions agreed at the review are recorded, planned and followed-up.

This is to comply with Regulation 5(2) (Personal Plans) 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 states:

'I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change' (HSCS 1.12).

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

Requirements

Requirement 1

By 31 March 2024, the provider must ensure that people experience a service with well trained and informed staff.

This must include, but not be limited to:

a) ensuring all staff receive induction and training relevant to their role; including dementia care, communication, restraint and restrictive practice, medication and stress and distress training;

b) regular quality assurance checks, to demonstrate how the training received is being implemented in practice throughout the care service;

c) regular monitoring of staff practice to provide assurance, that staff practice is consistent with current good practice guidance; and

d) regular staff supervision, to ensure staff learning and development needs are reviewed and addressed.

This is in order to comply with Regulations 9, (2)(b) (fitness of employees) and 15, (b)(i)(staffing), 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 states:

'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 10 January 2024.

Action taken on previous requirement

This requirement was made in January 2024 and was not met at the time of inspection in July 2024. We previously agreed an extension to 30 November 2024.

Staff undertook induction on joining the service and had good opportunities for shadowing more experienced staff. Induction records were completed by senior staff to ensure new employees met the required competencies for the role.

The provider was in the process of developing a new system for tracking and recording staff training. Details of this system had been shared with the service but had not been implemented at the time of inspection.

We could not see that staff had access to training and development opportunities relevant to their role. This included training in key areas including dementia care and managing stress and distress. The service did not have a clear system for recording mandatory and additional training for staff, and leaders were not able to track compliance rates with staff training. This meant we could not be assured that staff had undertaken essential training to understand their role and keep people safe.

The provider has a process for recording staff competency checks but this had not been implemented by the service. While informal observations were taking place and staff told us they felt well supported, we could not see evidence that staff had been given formal opportunities to reflect on their practice and development needs.

The service had not undertaken an analysis of staff training needs or the key training required to meet the needs of people using the service.

This requirement was not met and we have agreed a further extension until 28 July 2025.

Not met

Requirement 2

By 31 March 2024, the provider must operate within their registration conditions and meet the registration environmental improvement plan that is outstanding.

This must include, but not be limited to:

a) have 38 residents as a maximum number, and use the specified numbered rooms 17 and 37 only for short-term respite stays; and

b) complete outstanding actions from the agreed environmental plan, that is part of the conditions of registration.

This is to comply with Regulation 14. (d) (facilities in care homes) 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 states:

'The premises have been adapted, equipped and furnished to meet my needs and wishes' (HSCS 5.18).

This requirement was made on 10 January 2024.

Action taken on previous requirement
This requirement was made in January 2024 and was not met at the time of inspection in July 2024. We previously agreed an extension to 30 November 2024.

The service had already re-purposed rooms 17 and 37 for short-term stays. The service now accommodates a maximum of 38 residents.

At the inspection in July 2024, we asked the provider to identify a realistic timescale for completing the outstanding environmental improvements. The provider has produced an updated action plan, as requested. A number of environmental improvements had taken place, including replacement of some windows in the home. The manager of the service was maintaining the action plan with support from the provider.

The service had been faced with some unexpected environmental issues, including the failure of the nurse call system and the need to replace the fire alarm system for the service. This meant that some of the environmental improvements identified in the original environmental improvement plan had been delayed while urgent improvement works were undertaken elsewhere in the service.

Overall, the actions agreed in the environmental improvement plan had not been completed as agreed at the time of registration.

This requirement was not met and we have agreed a further extension until 28 July 2025.

Not met

Requirement 3

By 31 March 2024, to improve the safety and accessibility of the environment for people supported, the provider must:

a) ensure that all maintenance tasks are actioned in a timeous manner including working assisted bathing options;

b) address actions from the Kings Fund Tool using specific, measurable, achievable realistic and timely (SMART) principles; and

c) make outdoor space accessible for people by removing coded access to doors.

This is to comply with Regulation 14. (d) (facilities in care homes) 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 states:

'I can easily access a toilet from the rooms I use and can use this when I need to' (HSCS 5.2)

and

'I experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment' (HSCS 5.24).

This requirement was made on 10 January 2024.

Action taken on previous requirement

This requirement was made in January 2024 and was not met at the time of inspection in July 2024. We previously agreed an extension to 30 November 2024.

The service had previously addressed actions from the Kings Fund Tool which had improved the environment for people living with dementia. Outdoor space was accessible and the coded access had been removed. We asked the provider to ensure the Kings Fund is completed regularly to continue to identify how well the environment meets the needs of people using the service.

The assisted bath in the Caledonia unit had been replaced and people had access to sufficient bathing options.

This requirement was met, but we have made a new requirement relating to the maintenance of the service under Key Question 4 ' How good is our setting?'

Met - outwith timescales

Requirement 4

By 31 March 2025, the provider must ensure adequate governance of the service.

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

a) ensure policies and procedures are in place which are appropriate for the service type. This includes, but should not be limited to, an appropriate medication policy and maintenance policy. Policies should be regularly reviewed and updated as required;

b) ensure a process is in place for clinical supervision of the manager of the service;

c) ensure a clear process is in place for oversight of local quality assurance processes; and

d) ensure the manager of the service is included in governance procedures and informed of the outcome of external audits or reports.

This is to comply with Regulation 3 (Principles) 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:

'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 4 September 2024.

Action taken on previous requirement

The service did not have access to the range of policies required for this service type. In particular, there was no current policy or procedure in place for medication management. While practice was seen to be effective in relation to medication, this relied on good local procedures developed by the service. Leaders did not have access to an up-to-date medication policy based on current best practice in the field. The provider was in the process of developing a medication policy suitable for this service type.

The service did not have a policy or up-to-date procedures in place for maintenance of the service. While we found the maintenance officer to be knowledgeable and committed to completing maintenance tasks, we could not be assured that these checks were based on current best practice guidance or organisational requirements. As there was no written procedure for the service, there was a risk that maintenance tasks would not be completed in the absence of the maintenance officer.

While we recognise that developing policies can be a protracted process, the provider must provide adequate procedures and best practice guidance to ensure the service has the right guidance in place to keep people safe.

Clinical supervision for the registered manager had been implemented.

Quality assurance processes continued to be completed effectively by the management team. These processes were overseen by senior managers in the provider organisation. The provider was in the process of developing a policy and procedure to streamline quality assurance processes. Managers had been consulted to ensure the new policy aligned with the particular needs of the service. The provider must ensure the quality assurance process is shared and available to the service to ensure quality assurance processes are taking place in line with organisational requirements and best practice.

The registered manager had been included in regular provider meetings alongside external colleagues and senior managers. This provided opportunities to share issues and learning from the wider organisation.

This requirement is not met. We have agreed an extension to 28 July 2025.

Not met

Requirement 5

By 30 November 2024, the provider must ensure that the environment is safe and free from offensive odours.

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

a) undertake an environmental audit to identify where improvements are required in the environment;

b) produce an environmental action plan based on SMART principles (Specific, Measurable, Achievable, Realistic, and Time-based) that identifies the actions to be taken to improve the environment;

c) take action to eliminate the odour in the Davaar unit;

d) take action to eliminate the risk from electric heaters in communal shower rooms;

e) ensure people who use the service and their representatives have been consulted about environmental improvements and include their views in the action plan; and

f) ensure timescales for improvements are communicated with people using the service and their representatives.

This is to comply with Regulation 10(2)(d) (Fitness of Premises) 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:

'My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells' (HSCS 5.20).

This requirement was made on 25 July 2024.

Action taken on previous requirement

The provider was maintaining the environmental improvement plan to ensure improvements were being tracked and progressed.

The odour in the Davaar unit had been attributed to the carpet in the corridor outside the lounge and dining room. Funding had been approved to replace the carpet and a contractor identified. Unfortunately, the replacement of the carpet had been set back due to maintenance work required elsewhere in the building. The provider was able to confirm a new date for the replacement of the carpet.

Electric heaters in the shower rooms have been upgraded and moved to eliminate the risk identified. This work had been undertaken by an approved contractor following survey from the provider's property department.

Despite good informal relationships with relatives and representatives, we were unable to see how people had been kept updated about the progress of environmental improvements, or how their views about these upgrades had been sought and incorporated into the improvement plans. People should expect to have opportunities to share their views and should expect to be kept up-to-date with progress. This is particularly important where environmental changes impact the quality and comfort of the environment.

This requirement was not met. We have agreed an extension to 28 July 2025.

Not met

Requirement 6

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 Practical Fire Safety Guidance for Existing Care Homes (Scottish Government, 2022).

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; and

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

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 states:

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

This requirement was made on 25 July 2024.

Action taken on previous requirement

A new fire safety risk assessment was in place for the service with a clear timescale for review.

All staff were given training and instruction about fire safety on joining the service.

Regular fire drills were taking place. Leaders in the service were tracking which staff had participated in fire drills. We asked the manager to ensure that fire drills were taking place at different times of the day and frequently enough to ensure that all staff had the opportunity to participate. This is to ensure staff have the right training to understand their role in an emergency.

This requirement has been met.

Met - outwith 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 staff responsible for leading shifts have clear information about people's healthcare needs, the provider should ensure that relevant clinical information is accurately recorded and shared at all shift handovers.

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

'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty' (HSCS 3.19).

This area for improvement was made on 25 July 2024.

Action taken since then

Paperwork to support handover discussions had been updated to include clinical needs. Handover meetings were well-led with clear information shared for monitoring and follow-up of clinical needs. The handover meetings were supplemented by a daily 'FLASH' meeting, led by the manager or a deputy. This helped to ensure any outstanding tasks or onward referrals were followed-up timeously.

This are for improvement has been met.

Previous area for improvement 2

To keep people safe, the service should ensure that in the absence of the manager, there is a clear process for making notifications to the Care Inspectorate. All notifications should be made timeously in line with the guidance document 'Records that all registered care services (except childminding) must keep guidance on notification reporting' (Care Inspectorate, 2020).

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).

This area for improvement was made on 25 July 2024.

Action taken since then

The deputy home manager had been granted access to the Care Inspectorate portal. We reviewed notifications made by the service since the last inspection. These had been completed in line with Care Inspectorate guidance.

This area for improvement has been met.

Previous area for improvement 3

To keep people safe, the service should ensure that staffing numbers, skills and deployment reflect the needs of the people using the service at all times of the day and night. 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 states:

'My needs are met by the right number of people' (HSCS 3.15).

This area for improvement was made on 25 July 2024.

Action taken since then

The service was using a dependency assessment to inform decisions about staffing numbers. We found that the impact of the broken nurse call system and issues with the fire doors had not been adequately considered in staffing decisions. Staffing numbers were static, despite changing needs identified in dependency assessments. Staff had been deployed to provide additional observations due to the fire doors being closed. We found that there were insufficient staff available to respond adequately to people who required additional support due to the fire doors being closed.

The staff rota was on display and information was shared with staff about the rationale for staffing decisions. Feedback from staff about the rota was positive. All staff had access to both informal and formal support and counselling, if this was required. Where staff had experienced periods of ill-health, leaders took care to support them back to work with reasonable adjustments, if required.

This area for improvement was not met.

Previous area for improvement 4

To ensure people have access to all communal areas of the service and to adhere to fire safety precautions, the provider should ensure that no unnecessary equipment or boxes are stored in communal bathrooms, lounges, corridors or fire escape routes.

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

'I can independently access the parts of the premises I use and the environment has been designed to promote this' (HSCS 5.11).

This area for improvement was made on 25 July 2024.

Action taken since then

We found that no unnecessary equipment or boxes were stored in communal areas. There was sufficient storage in the service and staff knew where to store equipment and how to access it.

This area for improvement was 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?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

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

How good is our staff team?	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	3 - Adequate

How good is our setting?	2 - Weak
4.1 People experience high quality facilities	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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یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

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