West Dunbartonshire Council Home Care Service
Housing Support Service

Clydebank Health & Care Centre
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Telephone: 01412322317

Type of inspection:
Unannounced

Completed on:
11 April 2025

Service provided by:
West Dunbartonshire Council

Service provider number:
SP2003003383

Service no:
CS2004077075

About the service

West Dunbartonshire Council Home Care Services provides care at home support to people living in their own homes. The service operates throughout the West Dunbartonshire local authority area from two office bases, in Clydebank and Dumbarton.

At the time of our inspection, the service was supporting around 1253 people.

About the inspection

This was an unannounced inspection which took place between 1 April and 11 April 2025. The inspection was carried out by four inspectors from the Care Inspectorate and with the support of an inspection volunteer. Our inspection volunteers are members of the public who have relevant lived experience of care either themselves or as a family carer. They speak to people and families during inspections to ensure their views and experiences are reflected accurately in the inspection.

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 39 people using the service and 15 of their family/ friends/ representatives
- spoke with 23 staff and management
- reviewed survey results from 29 supported people, 127 relatives and 62 staff
- observed practice and daily life
- reviewed documents
- consulted with three visiting professionals.

Key messages

Outcomes for people were being met when supported by regular staff but less so when supported by staff who were not familiar with their needs, routines and preferences.

The service must improve how visit schedules support people to meet their health and wellbeing outcomes.

The effectiveness of the care being provided was being impacted by identified gaps in staffing levels at certain times of the day.

Quality assurance processes had been developed but require to be fully embedded into practice.

Staff training was in place for core areas.

The quality of some care plans had improved. Further work is required to ensure all care plans are in place and have been reviewed and updated.

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?	3 - Adequate
How good is our staff team?	2 - Weak
How well is our care and support planned?	3 - Adequate

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

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

We evaluated different parts of this key question as weak and adequate, with an overall evaluation of weak. Whilst we identified some strengths, these were compromised by significant weaknesses.

We joined staff for several visits on different days and areas. We met staff who knew people and their support needs well, enabling them to build positive relationships. When being supported by regular staff people felt they experienced compassion, dignity and respect. People gave positive feedback about regular staff but many told us of their frustrations with ongoing staff changes and when agency staff attended. This caused anxiety for people and their relatives as most reported that changes were not communicated to them. Lack of robust care planning was affecting how support was being provided. People told us how they were being impacted by not knowing who would be attending or at what time. For some people this had impacted on their medication and meal times. This impacted people as they found it difficult to plan their day. This meant that people's health and wellbeing did not always benefit from their care and support. The service had made some improvement in relation to recording changes to schedules and in quality assurance. We have restated a previous requirement to reflect what areas still need to be improved (requirement 1). See section 'What the service has done to meet any requirements made at or since the last inspection' for more information in relation to scheduling.

People were positive about how the service had enabled them to remain living at home. Despite many people having very brief care plans, regular staff had good knowledge of people and their preferred routines. However, this knowledge was being lost when being supported by unfamiliar staff. Overall, people were still grateful for the support they received and told us they could not manage without it.

The online recording platform in place had clear chronologies and had input from other health and social care professionals. Some other recordings were not clear about what happened to concerns that were raised by staff. Some of the visits we attended did not match with what was written in people's care plans and these had not always been updated to reflect current support needs (see requirement in 'How well is our care and support planned?).

Requirements

1. By 5 December 2025, the provider must ensure that people's health, welfare and safety is supported by the effective delivery of visit schedules.
To do this the provider must at a minimum:

a) Plan visit schedules in advance and review these regularly to ensure they reflect people's care and support needs.
b) Any changes to agreed schedules are to be communicated with people receiving care or their representative.

This is to comply with Regulation 3 and 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 Health and Social Care Standards (HSCS) which state that: 'Any treatment or intervention that I experience is safe and effective.' (HSCS 1.24).

How good is our leadership? 3 - Adequate

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

There had been some improvement in management oversight of the service. Care plans and six-monthly reviews were mostly being signed off by senior staff and issues were being highlighted. However, records did not show what follow up actions were taken to remedy the issues. Records showed that care plans were not always being updated following people's six-monthly reviews. This applied to people who had required increases or decreases to their support, as well as for people who required no change.

We checked recruitment processes and found that some of the recent examples we looked at had not been fully completed. We met with the relevant department who were aware of the Safer Recruitment guidance and agreed to revisit this.

Audit tools and operating procedures had been developed by the service but not all were fully implemented or embedded into practice. In terms of overseeing staff, there had been regular monitoring of workloads for organisers but these did not consider professional development or reflective practice. Supervision for care staff had been happening at a far slower pace and competency checks were over a year old (area for improvement 1).

The service had sought feedback from people which was positive but this was now dated and did not seem to reflect current themes. We asked the service to repeat feedback requests at regular intervals. Newer processes were being put in place and were starting to have some impact on how quality assurance and improvement was being led.

Areas for improvement

1. The service should establish regular and meaningful supervision for all staff groups and include competency checks within their quality assurance processes.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'I benefit from culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

How good is our staff team? 2 - Weak

We evaluated different parts of this key question as weak and adequate, with an overall evaluation of weak. Whilst we identified some strengths, these were compromised by significant weaknesses.

Training statistics showed that levels of training in mandatory topics had increased. Most staff had now completed adult support and protection training. Core topics were being included in induction and within modules that were being completed by the wider staff team.

These topics included IPC (infection prevention and control), skin integrity and recording. Dementia training was taking place but only to awareness level. As the service supports a number of people living with dementia, we asked that this be increased to skilled level (area for improvement 1).

Work was also taking place to ensure any agency staff were meeting mandatory training expectations. The service were actively working on a new medication policy which they told us would clarify which level of support staff should provide for supporting with medication. Mostly staff did have the right knowledge, competence and development to care for and support people.

The service was continuing to go through a redesign process which was having an ongoing impact on staffing. At the time of inspection there were concerns about how staff were being deployed to cover visits at teatime and evenings. This was also impacting weekend supports. Some shifts were being covered by staff picking up overtime or by agency usage. However, this meant that supports were being provided by staff who were unfamiliar with people and their support needs. This came across in feedback from care staff, organisers and from people and their relatives. Staff told us they felt overworked and thought that scheduling needed to improve. People and staff mentioned the impact of disruption to routines and established relationships when staff were moved and changed. It did not appear that staffing arrangements were right and staff were working as effectively as they could be. The service advised us that the next stage of their redesign would improve how staff were deployed and this will be revisited at our next inspection.

Areas for improvement

1. The service should ensure staff supporting people living with dementia have the right knowledge, skills and experience. The service should provide dementia training to skilled level in line with the Promoting Excellence framework in order to increase staff knowledge and improve practice.

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

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

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

The service had been working to improve the standard of assessment and care planning as indicated in a previous requirement. Progress has been made, albeit much slower than the service had anticipated. This had been impacted by the service redesign and moving to different online systems. We have made a new requirement which reflects the current position of the service in relation to care planning. This ensures care planning and reviews remain a focus as must be in place (see requirement 1).

See section 'What the service has done to meet any requirements made at or since the last inspection' for more detail.

Requirements

1. By 5 December 2025, the provider must ensure that care plans are in place and contain sufficient detail to allow staff to provide effective support for people's health, welfare and safety needs. Reviews of care plans must take place at least every six-months, or when a significant change occurs.

This is to comply with Regulations 5 (1) and (5) (2)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

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

Requirements

Requirement 1

By 31 March 2025, the provider must ensure that people's care plans are reflective of care and support that is right for them. To do this the provider must, at a minimum, ensure:

a) People have access to current detailed information about their service which details their support needs including any highlighted risks and how the provider will meet these.
b) Information about how to complain is updated.
c) Information within care plans is person centred including how to promote people's independence where possible with personal care.
d) Person centred strategies that describe how people living with dementia like their support to be provided. This should include information about their likes, dislikes and how staff should introduce care tasks and what they should do if the person declines support.
e) Oral care is highlighted within care plans where appropriate
f) Records and reports are included within care plans about people's wellbeing.
g) Managers are involved in the monitoring and the audit of people's needs and records.
h) Update the improvement work that has happened on care plans with lead inspector bi-monthly.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

This requirement was made on 27 March 2023.

Action taken on previous requirement
The service had already met parts b), e) and h) at previous inspections.

There were still some people who had not yet had six-monthly reviews and most people had not yet had their care plans updated. For people whose six-monthly reviews had identified that they required increases or decreases in their visits or hours, this was mostly not reflected within their care plans.

This meant that care plans were not always reflective of up-to-date care needs and put people at potential risk. This had the greatest impact when support was being provided by unfamiliar staff and especially if support was being provided to people living with dementia. The standard of information held within care plans was variable across different parts of the service and some were very brief. Care staff told us that information in care plans could be better and could be difficult to get updated information added. A few care plans that had been updated were of a good standard and it was positive to note that there was now a process to authorise changes.

Most care plans we sampled did not include information on how to promote people's independence with personal care or include people's preferences. There were a few which had been reviewed and updated. These contained a good level of guidance in this area, but not enough of the plans we sampled had been updated to this standard.

We sampled care plans of people who were living dementia and found that some did reflect how this impacted on support needs and preferences. However, many care plans did not yet capture this information and had not been recently updated. This part of the requirement has been picked up within a new area for improvement.

A new online platform had been introduced which enabled staff to record concerns or changes regarding people. The service were continuing to audit people's care diaries and picking up if people's wellbeing was being captured rather than being purely task- focussed. This part of the requirement has been met.

The majority of care plans and review documents were being authorised by managers. The online platform in use made it easier for managers to have an overview of people's records. Audits and reports were being used to monitor activities that were taking place across the service. This part of the requirement has been met.

Although some progress had been made this was insufficient to meet all outstanding parts of the requirement. To support the service to make further progress we have made a new requirement under key question 5. This will ensure that improvement around care planning will remain a focus. This requirement will therefore not be restated.

Met - outwith timescales

Requirement 2

By 21 March 2025, the provider must ensure people and staff are kept safe by ensuring the workforce is appropriately trained. To do this, the provider must, at a minimum, ensure:

a) All staff have completed core mandatory training particularly adult support and protection training.
b) All staff have the appropriate levels of training for their role including dementia skilled, skin integrity, record keeping and confidentiality training.
c) All staff have clear and SMART (specific, measurable, achievable, realistic, time specific) learning objectives to evaluate their practice and professional development.
d) All staff are aware of their responsibility in maintaining accurate records and retaining records.
e) Managers are involved in the monitoring and the audit of staff training.

This is to comply with Regulation 15(b)(i) (Staffing) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 011/210).

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

This requirement was made on 27 March 2023.

Action taken on previous requirement

The majority of staff had now completed core mandatory training. This included adult support and protection which was included in induction and refreshers across the service. Most staff had now completed infection prevention and control training, though we did ask the service to update some very outdated guidance on their staff intranet. This part of the requirement has been met.

The service had introduced modules that were being completed by staff and these included dementia awareness, skin integrity, record-keeping and confidentiality. Dementia skilled training had only been completed by a very small percentage of staff and moving forward this has been reflected within an area for improvement.

Staff supervision sessions had been taking place for care at home organisers but had mostly focused on workloads rather than on professional development. The records that we saw showed that most care staff had not had regular supervision sessions with line managers. This part of the requirement has been reflected within an area for improvement.

Most staff had now completed record-keeping and documentation training. Care plans and care diaries were being audited across the service and feedback given to the staff team. This part of the requirement has been met.

The service had implemented an effective overview of staff training which was detailed and broken down into areas, staff teams and different months. This part of the requirement has been met.

Although some progress had been made this was insufficient to meet all outstanding parts of the requirement. To support the service to make further progress we have made two new areas for improvement that will reflect the outstanding parts of this requirement. This requirement will therefore not be restated.

Met - outwith timescales

Requirement 3

By 21 March 2025, the provider must ensure that people's health, welfare and safety is supported by the effective delivery of visit schedules.
To do this the provider must at a minimum:

a) Plan visit schedules in advance and review these regularly to ensure they reflect people's care and support needs.
b) Any changes to agreed schedules are to be communicated with people receiving care or their representative.
c) Accurate records are to be maintained when changes are made to visit schedules.
d) Visit schedules and records should be regularly quality assured.

This is to comply with Regulation 3 and 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 Health and Social Care Standards (HSCS) which state that: 'Any treatment or intervention that I experience is safe and effective.' (HSCS 1.24).

This requirement was made on 28 November 2024.

Action taken on previous requirement

Visit schedules showed days and times of planned visits. Some of these schedules contained clear and specific information, though most had no additional content. It was not clear how these schedules were reviewed, particularly as there were still six-monthly reviews outstanding. Audits were taking place to monitor if staff were complying with scheduled times but no evidence that consideration was given to how well the schedules met the needs of people who were receiving the care and support. At the time of our inspection the service was being impacted by the lack of regular staff to cover 'tea' and 'tuck' visits scheduled for evenings. The feedback regarding the shortage at those times was highlighted to us by care staff, organisers, supported people and their relatives.

People told us that they were unaware when changes were being made. This applied to changes in times as well as to changes in staff. Some people did tell us there were times when staff had not shown up. People gave us very positive feedback about regular staff but were frustrated with staff changes and the use of unfamiliar agency staff. This had been difficult for some people who were living with dementia. The service improvement plan did reflect how changes should be communicated to people, or family members, but we did not see examples of this.

The service had introduced a mechanism within the online platform to capture details of when changes are implemented. This part of the requirement has been met.

Audits of staff compliance with visit schedules were taking place. There were overviews of planned versus actual visit times. This part of the requirement has been met.

The impact of visit schedules and changes on people's outcomes was a common theme and further work is required in this area. The remaining unmet areas of this requirement have been restated in section 'How well do we support people's wellbeing?'

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

The service should comply with the Care Inspectorate guidance 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'. The provider must notify the Care Inspectorate of all relevant events under the correct notification heading, within the required timeframe, include detail of their handling of the event and provide updates if applicable.

This is to ensure care and support is consistent with the Health and Social Care Standards which state 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities.' (HSCS 3.20).

This area for improvement was made on 8 April 2024.

Action taken since then

The service had taken up our offer of training in this area and had developed an operational process. However, this had not yet been put into practice and we had not been notified or updated about the majority of notifiable events.

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

Previous area for improvement 2

The provider should ensure that medication risk assessment processes are reviewed to include the time required between medication doses. People's care visits should be scheduled to allow them to take their medication safely and in accordance with prescribing instructions.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'If I need help with medication, I am able to have as much control as possible' (HSCS 2.23).

This area for improvement was made on 27 March 2023.

Action taken since then

A new medication policy had been developed but had not yet been approved or implemented. The percentage of staff who had completed medication training was low. The evidence we looked at did not make it clear how timings of people's medications influenced visit schedules.

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

Previous area for improvement 3

To ensure complaints are managed effectively and in accordance with their own policy and procedure, the care service should ensure that all who raise complaints or concerns are treated with courtesy, any information requests, concerns and complaints are recorded accurately and responded to promptly, ensuring that follow up actions are met in line with the policy or in an agreed manner.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I know how, and can be helped, to make a complaint or raise a concern about my care and support' (HSCS 4.20)

This area for improvement was made on 27 March 2023.

Action taken since then

There had been some previous discussion with us in regards to complaints handling and the service had developed a new complaint handling procedure. This had not yet been fully implemented. The complaints log did not provide the required information and had not effectively been utilised to monitor outcomes or note how improvements would be made.

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

Previous area for improvement 4

To improve outcomes for people, the provider should ensure that they continually monitor, evaluate and complete all actions that they have identified within their improvement plan.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support because people have the necessary information and resources' (HSCS 4.27).

This area for improvement was made on 27 March 2023.

Action taken since then

The service improvement plan was not fully completed and had not been kept up to date. It was not possible to assess progress towards all the identified actions. Some of our areas for improvement were missing from the improvement plan and it was not clear how the service were monitoring those.

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

Previous area for improvement 5

To support people's health and wellbeing, the provider should ensure that staff are competent with promoting good infection prevention and control practices. This should include but not limited to observing staff in training and in practice.

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).

This area for improvement was made on 27 March 2023.

Action taken since then

Staff that we observed adhered to good IPC (infection prevention and control) standards. People and relatives that we spoke positively about hygiene practices during care visits. Training in this areas was ongoing and was being covered in induction and refresher modules. Care organisers were overseeing staff and were addressing any issues as they arose, although some observations were around a year old and should be carried out more regularly.

This area for improvement has been met.

Previous area for improvement 6

All staff should be provided with clear information on how to access premises if a key safe is being used, or if difficulties are encountered, how they escalate to the person who is on call.

This area for improvement was made on 31 March 2025.

Action taken since then

This area for improvement was made following a recent complaint investigation. Progress on this area for improvement was not assessed at this inspection as it had only been very recently put in place and to give the service time to action.

Not assessed at this inspection.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	2 - Weak
1.1 People experience compassion, dignity and respect	3 - Adequate
1.2 People get the most out of life	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

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

How good is our staff team?	2 - Weak
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	2 - Weak

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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