Suncourt Nursing Home
Care Home Service

19 Crosbie Road
Troon
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Telephone: 01292 317 666

Type of inspection:
Unannounced

Completed on:
9 May 2025

Service provided by:
Suncourt Ltd

Service provider number:
SP2003002273

Service no:
CS2003010279

About the service

Suncourt Nursing Home is registered to provide a care service to a maximum of 44 older people. The home overlooks Royal Troon golf course with coastal views and is close to shops and other amenities. The service comprises of an original building with a two-storey extension, including a lift and disabled access. There are 18 single bedrooms with ensuite toilet and shower facilities and 16 single bedrooms with ensuite toilet and hand washing facilities. The service also has three lounges, dining area and an accessible garden.

About the inspection

This was an unannounced inspection which took place on 4-7 May 2025 between 06:30 and 20:30. This inspection was carried out by two inspectors and an inspection volunteer from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration and complaints information, information submitted by the service and intelligence gathered throughout the inspection year. To inform our evaluation we:

- spoke/spent time with five people using the service and seven of their friends and family.
- spoke with 23 staff and the management team.
- received feedback from the Inspection Volunteer who spoke with six people using the service.
- observed practice and daily life.
- reviewed documents.
- spoke with two visiting professionals.

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 and spend time with people and families during inspections to ensure their views and experiences are reflected accurately in the inspection.

Key messages

- Staff were observed to be kind and respectful to people supported.
- People were having to wait to have their needs met.
- Staffing was not effectively being assessed to ensure that it was sufficient for peoples needs.
- The environment was clean and fresh.
- The care plan documentation did not reflect peoples needs with key information being inaccurate.
- Quality assurance was not driving improvement within the service.

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
How good is our staff team?	2 - Weak
How good is our setting?	4 - Good
How well is our care and support planned?	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 made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

Staff were observed to be kind and respectful to people supported. People told us that they had to wait a long time for their requests for attention to be answered. We saw that staff appeared very busy and struggled to answer the nurse call alerts in a timely manner. This meant that people were having to wait for an unacceptable time to have their needs met.

The medication administration system utilised a buddy system and medication counts. The as required medication did not have information consistently in place to let staff know what the medication was prescribed for and when it was to be given. The effectiveness of the as required medication was not being consistently recorded. Creams and lotions were being administered without guidance being available on where and when they were to be applied. This meant that people were at risk of their medication being administered inappropriately.

(See area for improvement 1)

The documentation of wound care was inconsistent and poor management oversight meant that their was no accurate assessment of peoples wounds. This meant that people were at risk of deterioration without the appropriate treatment being provided. This was discussed with the management team during inspection who then undertook a full audit of wound care.

Staff had a poor understanding of dementia and its impact on people. This was observed to cause distress to people supported when they were repeatedly orientated into the present.

Care staff did not have access to the care plan documentation for people supported meaning that they had no up to date information with regards to peoples care needs. The care documentation contained gaps. This meant that we could not be assured that people were receiving the appropriate care for their needs.

People told us that they spent large parts of their day with nothing to do . We observed very little in he way of meaningful activities for people during our visit. A review of the available records did not demonstrate any reliable recording of interactions. Recruitment for an activities coordinator was in progress. We could not be assured that people were able to spend their days in a meaningful and enjoyable way.

Referrals to external professionals were taking place, however, the appropriate action was not taken consistently by the service in response to issues such as weight loss. While a referral may have been made to the dietician, the enhancement of peoples diet and recording of their intake was not always carried out. This meant that people were at risk of weight loss.

(See Requirement 1)

Mealtimes were task orientated with the dining room split into sections for those who needed assistance and those who didn't. This resulted in people not always receiving the help they required such as encouragement to eat their meal or assistance to cut up food. This system did also not take into account

peoples preferences and wishes with regards to who they spend time with .

The food was home cooked with fresh ingredients. However, we observed that people were not offered breakfast until the kitchen opened. Staff did not ensure that people had something to drink before leaving their room and requests for jugs of water or juice in the rooms were frequently missed. Despite the availability of food and drink we could not be assured that people were able to eat and drink when they wished.

Requirements

1.

By 25 June 2025, the provider must ensure that they are effectively monitoring and tracking the progress of peoples specific health needs to promote their health and well being.

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

a)that a system is in place to ensure that all wounds are identified, tracked and monitored

b)that appropriate action is taken in the event of weight loss including the introduction of fortified food and snacks.

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: 'My care and support meets my needs and is right for me' (HSCS 1.19).

Areas for improvement

1.

To support the safe administration of as required and topical medication the provider should ensure the accurate completion of as required protocols , topical medication administration records (TMAR's) and accompanying body maps.

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

'Any treatment or intervention that I experience is safe and effective (HSCS 1.24).

How good is our leadership? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

Various audits were taking place. However, the same issues were highlighted repeatedly with no effective steps to resolve them being taken. The purpose of the audits were not fully understood and as such were not used to lead to any meaningful changes. This meant that peoples outcomes were not improved.

The service improvement plan did not reflect improvements within the service or progression to wards set goals. This meant that the service was not improving.

(See Requirement 1)

There was no effective engagement with regards to people supported, their families or staff. Meetings were held infrequently and did not result in any changes to the service. This meant that peoples views were not considered.

Lessons learned from adverse incidents and complaints were not evaluated resulting in a risk that they would reoccur. Action with regards to potential risks was slow and inconsistent. This meant that people were at risk of harm.

There was a lack of leadership and accountability with poor practice not being managed effectively which resulted in a disjointed approach to care . This meant that people were at risk of not receiving the care they required.

Requirements

1.

By 27 August 2025, the provider must demonstrate that service users are safeguarded and experience consistently good outcomes, and that quality assurance and improvement is well led.

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

a) the implementation of quality assurance systems that continually evaluate and monitor service provision to inform improvement and the development of the service.

b) utilise a range of quality audit tools including, staffing, clinical governance, activities and medication management.

c) that the outcomes of quality audits inform action plans to address issues identified.

d) that actions taken are reviewed to ensure that they effectively improve outcomes for service users.

e) that feedback from people living in the home and their families is used to inform service development.

This is to comply with Regulation 4(1) (d) (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 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).

How good is our staff team? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

The evaluation of staffing levels was completed considering the dependencies of people supported only. There was no consideration of other key factors such as the lay out of the home or additional duties completed by the staff team. Staff were observed to be very busy and told us that they didn't always have enough staff to do everything they needed to.

(See Requirement 1)

We observed periods of times where the nurse call was going unanswered particularly early in the morning and early evening. People reported long wait times and that the sound was annoying reporting that "I turn my television up to drown out that noise". There was no effective analysis of the nurse call response times taking place. The nurse call was sounding almost continuously throughout our visit. This meant that staffing was not effectively being assessed and deployed to ensure that it was sufficient for peoples needs.

Staff reported that they worked well as a team but that they also felt that no action was taken when someone is not completing their duties to the required standard which they said could be demoralising. They found the management team to be approachable and supportive. The staff we spoke to were enthusiastic and displayed a genuine desire to provide the best care for the people they supported.

Mandatory training and refreshers were taking place. There was a two day induction training which staff told us prepared them for their role. Some staff had been enrolled on the Promoting Excellence dementia training and we would encourage further development of this for all staff.

(See area for improvement 1)

Requirements

1.

By 25 June 2025, the provider must review their staffing tool to ensure that there are sufficient staff at all times to support people. To do this, the provider must at a minimum ensure:

a) they consider the needs of people supported.

b) they take into account the layout of the building.

c) they consider other tasks which may impact on staffs ability to provide support.

d) they analyse nurse call response times.

This is in order to comply with section 7 of the Health and Care (Staffing) (Scotland) Act 2019.

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

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

Areas for improvement

1.

To support the health and well being of residents the provider should ensure staff are trained in the needs of those living with dementia and apply their training in practice

This should include completing Promoting Excellence training for all staff at the appropriate level for their role and completing competency assessments.

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

How good is our setting? 4 - Good

We evaluated this key question as good where several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

The environment was clean and fresh. Domestic staff had cleaning schedules which recorded the tasks completed. There were no odours observed throughout our visit. This contributed to a good living environment for people with effective infection control procedures.

There were multiple areas where people could sit to be on their own or with others. The lounge areas made the most of the stunning views and the gardens were well maintained. We would encourage the exploration of ways to maximise the larger areas for small group living.

There were shared bathing facilities as not all rooms had shower facilities. These were decorated to a high standard and well maintained. This meant that people could chose to bathe according to their wishes.

Routine checks and maintenance oversight were in place . There were maintenance contracts in place for

specialist services. There was an effective system in place to track required repairs. This helped to keep people safe.

Peoples rooms were personalised and contained items that were important to them. This helped them to feel settled and at home.

How well is our care and support planned? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

The care plan documentation did not reflect people's needs with key information being inaccurate. Assessments were not completed accurately or updated consistently .Care staff did not have access to care plan documentation. This meant that we could not be assured that people were being offered care appropriate for their needs and in accordance with their wishes.

The monthly review of care plans and assessments was not completed to an acceptable standard and auditing did not result in a improvement in peoples outcomes.

Staff knew people well however, this was not reflected within the care plan. The use of agency staff and the gaps within the care plans resulted in a potential risk to peoples well being. This meant that we could not be assured that people were being offered care to meet their needs.

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

Requirements

Requirement 1

By 7 March 2025, for the comfort and safe wellbeing of people experiencing care, records must demonstrate how people's needs will be met. In order to achieve this, as a minimum, the provider must ensure:

a) staff are familiar with and follow best practice in respect of record keeping ensuring records are accurately and sufficiently detailed to reflect the care and treatment provided. This must include, but is not limited to, the completion of pain assessments/care plans, and accurate post falls monitoring to demonstrate how care is being managed effectively.

This is to ensure care and support is consistent with Health and Social Care Standard 1.19: My care and support meets my needs and is right for me.

This is in order 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 requirement was made on 6 December 2024.

Action taken on previous requirement
This requirement was made following a complaint investigation.

The majority of nurses and senior carers had completed roles and responsibilities, record keeping and care plan training .

The 72 hours post falls documentation had been completed as required. The pain assessment tool had been implemented for those requiring it however the recording of this and the evaluation of the effectiveness of pain relief was inconsistent . This meant that the need for pain relief and the impact of the medication could not be fully evaluated.

The care plans contained out of date information and did not reflect the care needs of people supported. This meant that the care plans could not be used to guide care and support.

This requirement had not been met and we have agreed an extension until 25 June 2025.

Not met

Requirement 2

By 7 March 2025, the provider must ensure that each person receiving a service has an up-to-date personal support plan that sets out accurately how people's health, wellbeing and safety needs will be met.

In order to achieve this, the provider must, at a minimum:

a) ensure personal support plans are reviewed and revised when there are any changes in the condition of an individual's health, or in their support needs.

b) ensure protocols and assessments are up to date and in place to guide and support staff in meeting individual's needs.

c) ensure all assessments completed by external health professionals are available and kept with the personal support plan.

d) ensure detailed information is accurately completed to confirm the daily support provided to each person who receives the service.

e) ensure end of life/anticipatory care plans have been discussed and completed for each person. If a person or their representative chooses not to have this discussion or document completed, information must be recorded to confirm this.

f) ensure management implement an ongoing quality assurance system for reviewing and evaluating personal support plans and daily records to ensure recording standards are maintained.

This is to ensure care and support is consistent with Health and Social Care Standard 1.15: 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.

This is in order to comply with:

Regulations 5(2)(b)(ii) and 4(1)(a) of The Social Care and Social Work Improvement Scotland(Requirements for Care Services) Regulations 2011(SSI 2011 / 210)

This requirement was made on 6 December 2024.

Action taken on previous requirement

This requirement was made following a complaint investigation.

The care plans did not reflect changes in care needs or updates. The assessments completed by external professionals were available but were not always used to inform changes to the care or care plan. The care charts were being audited by the management team daily but still contained gaps and omissions. This meant that we could not be assured that people were receiving personal care, food and fluids to meet their needs.

End of life care plans were in place for people supported completed with the level of detail that the resident and their family members were happy to provide. There was inconsistent information with regards to

resuscitation wishes. This meant that people were at risk of being resuscitated or not resuscitated against their wishes. and that the care plans could not be used to reliably inform care staff.

There was a system in place for daily and weekly checks, however there was no evidence to support that this had significantly improved practice as incomplete records were submitted to the management on a daily basis and were evident in the archived documents. This meant that we could not be assured of what care was being offered.

This requirement had not been met and we have agreed an extension until 27 August 2025.

Not met

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 and their families can be confident in the support being provided by the service, the service provider should ensure all complaints and concerns are accurately logged, investigated and responded to in accordance with the service providers complaints policy and procedures.

This is to ensure care and support is consistent with Health and Social Care Standard 4.21:

"If I have a concern or complaint, this will be discussed with me and acted on without negative consequences for me.".

This area for improvement was made on 6 December 2024.

Action taken since then

A review of the complaints recording system demonstrated that concerns and complaints were being recorded and tracked as per the company policy. This meant that any concerns or complaints were addressed within the laid down timescales.

This area for improvement has been met.

Previous area for improvement 2

The service provider should ensure people are provided with the opportunity to engage regularly in meaningful and stimulating activities in accordance with their likes, choices and preferences.

This is to ensure care and support is consistent with Health and Social Care Standard 1.25:

"I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors".

This area for improvement was made on 6 December 2024.

Action taken since then

There was no consistent activities provision within the home. People reported that they sat for long periods with nothing to do. This was consistent with observations throughout our visit.

While we did observe some meaningful interactions between staff and people supported these were not recorded on the Relish app,(activities recording system) ,due to an unavailability of devices for staff to record on. This meant that we could not be assured of the frequency of these interactions.

This area for improvement has not been met.

Previous area for improvement 3

To ensure people's nutritional needs are well supported, the provider should demonstrate that assessments, monitoring, and reviews are completed on a regular and continuing basis with input from external health professionals including speech and language therapists, when necessary.

This is to ensure care and support is consistent with Health and Social Care Standard 1.24:

"Any treatment or intervention that I experience is safe and effective."

This area for improvement was made on 6 December 2024.

Action taken since then

The recording of monthly weights and nutritional assessments was variable. There was evidence of referral to both the dietician and Speech and Language Therapy. However, there was a disjointed response by the service to weight loss. It is vital that the necessary steps such as food fortification and monitoring take place to ensure that any weight loss is minimised.

There were diet notification sheets available for residents in the kitchen as well as on notifications board but we could not be assured that this was consistently updated. This meant that the kitchen staff could not reliably use this information.

This area for improvement is no longer in place and has been incorporated into a new requirement under key question 1.3.

Previous area for improvement 4

The service provider should develop a system to ensure all personal plan information is archived securely and respectfully with information being accessible and available when required.

This is to ensure care and support is consistent with Health and Social Care Standard 4.3:

"I experience care and support where all people are respected and valued."

This area for improvement was made on 6 December 2024.

Action taken since then

There was a system in place to archive all information on a weekly and monthly basis for each resident. This was then moved to archive areas . It was observed to be neat and well labelled. This meant that any required documentation could be quickly and easily accessed.

This area for improvement has been met.

Previous area for improvement 5

The provider needs to ensure the quality assurance procedures result in improvements to the service. These audits need to be effective in identifying issues or concerns. This should include analysis of dependency levels and staffing to inform changes and developments to further improve and enhance the service provided.

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

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19)

This area for improvement was made on 15 May 2023.

Action taken since then

Although multiple audits were taking place these contained repeated issues which were not addressed and we could not see any impact on the outcome for residents. Although actions were identified, there was no evidence to support that these has been completed and they were repeated in multiple audits. This meant that we could not be assured that people's outcomes were improved.

This area for improvement is no longer in place and will be considered as part of the existing requirement under key question 2.2.

Previous area for improvement 6

The provider needs to ensure there are appropriate levels of staffing to meet the needs of the people living in the care home and also to ensure there are suitable numbers of domestic and ancillary staff to maintain the cleanliness of the environment and ensure that all necessary health and safety requirements are addressed.

This should ensure that the continuing assessment, planning and evaluation of staffing is transparent, evidence-based and focussed on achieving good outcomes for people. This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that:

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

This area for improvement was made on 2 August 2024.

Action taken since then

Residents told us that they waited a long time for the nurse call to be answered and the nurse call system was observed to be sounding constantly throughout our stay.

Observations we undertook in the early evening and first thing in the morning showed lengthy waits for residents to receive attention. There was no effective evaluation of the nurse call response times .

The staffing was evaluated using people's dependency levels however this does not consider other areas which impact on staffing such as the layout of the building. We could not be assured that the staffing was sufficient to meet people's needs.

This area for improvement is no longer in place and has been incorporated into a new requirement under key question 3.3.

Previous area for improvement 7

There have been changes to the staff team within the care home since the last inspection. The service management should continue to develop and implement the staff training and supervision programme, to ensure that all staff complete mandatory training requirements and update and refresh when necessary relevant to their roles and responsibilities.

This needs to continue in a consistent manner and we will review the progress of this at future inspections. This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states 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 15 May 2023.

Action taken since then

There was a comprehensive two day face to face induction process in place . The majority of staff had received refresher training and two staff were being trained to deliver moving and handling training. There is a training tracker which clearly demonstrates renewal dates and a supervision tracker which demonstrates that supervisions are taking place.

This area for improvement has been met.

Previous area for improvement 8

The provider should ensure that people experience a high quality environment that promotes their choices and meets their needs. This could include a deep cleaning of the care home environment and ensure there are enough domestic staff to keep the home clean, tidy well presented and free from offensive odours.

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

'I am able to access a range of good quality equipment and furnishings to meet my needs, wishes and choices' (HSCS 5.21).

'I can use an appropriate mix of private and communal areas, including accessible outdoor space, because the premises have been designed or adapted for high quality care and support'(HSCS 5.1).

'I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings, and equipment' (HSCS 5.22).

This area for improvement was made on 2 August 2024.

Action taken since then

The home was clean and fresh and in good order. There were cleaning schedules in place which both listed tasks and showed completion of those tasks. A new member of domestic staff was being recruited which would bring the department up to their full allocation of staff.

This area for improvement has been met.

Previous area for improvement 9

The provider needs to ensure that the content of the care and support plans are consistent and developed in consultation with the individual and their representative to reflect a responsive, person-centred approach, taking account of individuals choices, preferences and abilities.

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 area for improvement was made on 15 May 2023.

Action taken since then

The care plans demonstrate some knowledge of peoples wishes and likes. A review of the plans revealed that some of the information contained within the plans was inaccurate and did not reflect changes in peoples wishes. This meant that the plans could not reliably be used to inform care.

This area for improvement is no longer in place and will be considered as part of the existing requirement under key question 5.1.

Previous area for improvement 10

To ensure individuals and their families have confidence in the service, the care provider should offer reassurances by sharing information when requested about the care and support of individuals. To further support this, the care provider should ensure recording systems are implemented that will capture communication with families.

This is in order to comply with:

Health and Social Care Standard 4.4:

"I receive an apology if things go wrong with my care and support or my human rights are not respected, and the organisation takes responsibility for its actions".

This area for improvement was made on 4 June 2024.

Action taken since then

Family members reported that they were kept up to date with regards to their relative's condition and any changes. This is recorded within the daily notes and care plan documentation.

This area for improvement has been met

Previous area for improvement 11

To ensure people's health, wellbeing, and safety needs are met, the care provider should ensure written guidance is in place for staff regarding the reporting of repairs, in addition, they should ensure management implement a system of ongoing review of repairs and maintenance to be carried out and actions to be taken.

This is in order to comply with:

Health and Social Care Standard 5.22: I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment.

This area for improvement was made on 4 June 2024.

Action taken since then

There is a system of daily checks in place. The manager oversees and signs any repairs and staff report deficits in a book which is then reviewed by both the maintenance person and manager.

This area for improvement is met.

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
1.3 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

How good is our staff team?	2 - Weak
3.3 Staffing arrangements are right and staff work well together	2 - Weak

How good is our setting?	4 - Good
4.1 People experience high quality facilities	4 - Good

How well is our care and support planned?	2 - Weak
5.1 Assessment and personal planning reflects people's outcomes and wishes	2 - Weak

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