

Lochleven Care Home Care Home Service

Panmuirfield Dundee DD5 3UP

Telephone: 01382 775 831

Type of inspection:

Unannounced

Completed on:

15 July 2025

Service provided by:

Thistle Healthcare Limited

Service no:

CS2005098333

Service provider number:

SP2003002348



Inspection report

About the service

Lochleven Care Home is situated on the outskirts of Dundee and is close to local amenities such as shops, a pharmacy, church, pub and children's nursery. The home is purpose-built, and all bedrooms have en suite facilities. There are also enclosed garden areas, which can be used by residents and their visitors.

The home is owned by Thistle Healthcare Ltd and is registered to provide care to older people and people with dementia. It is registered for a maximum of 100 residents and is divided into four separate units, each with 25 places.

About the inspection

This was an unannounced follow up visit for a requirement made during a complaint investigation which took place on 15 July 2025. The inspection was carried out by two 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 looked at accident and incidents reports, individual's care and support plans and risk assessments, and daily care records.

Key messages

The service has a new manager in post.

Staff had not received additional training in falls prevention and post falls management.

Post falls checks were not always being carried out effectively.

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

Requirements

Requirement 1

By 16 June 2025, the Provider must ensure that post fall protocols are established and implemented in the service. In particular the provider must:

- a. Ensure that all staff receive appropriate training to ensure they are aware of their roles and responsibilities post fall.
- b. Ensure that documentation and records are accurate, sufficiently detailed and reflect the care planned or provided.
- c. Ensure that post fall observations are completed and documented in line with the post falls protocol and falls care plan. Where staff are unable to complete post falls observations, this is documented clearly in the care notes.
- d. Demonstrate that management have adequate oversight of all accidents and incidents.
- e. Demonstrate that management are adequately involved in the auditing and monitoring of records.

To be completed by: 16 June 2025

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 is to ensure care and support is consistent with Health and Social Care Standard 4.14: My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event.

This requirement was made on 5 May 2025.

Action taken on previous requirement

At the time of the visit, the manager informed us that she was newly appointed to the role and that the service was in the process of transitioning to new systems.

Staff had not received any additional training in falls prevention or post-fall management. While compliance with the online Falls training was noted to be good, we discussed the importance of supplementing this with face-to-face training to ensure all staff clearly understand their roles and responsibilities in managing falls. Although staff had been issued with a copy of the falls protocol, there had been no follow-up to evaluate their comprehension or ability to apply it in practice.

We reviewed documentation relating to individuals who had experienced a fall and found that the falls protocol was not consistently adhered to. There was a lack of clear guidance regarding the timing and execution of post-fall checks, and it was unclear whether staff had received training in conducting neurological observations. This issue was particularly evident during night shifts, where such checks were not being carried out. Additionally, it was not clear what prompts were being generated by the electronic care planning system, or whether these were aligned with the service's falls protocol. The manager acknowledged these concerns and agreed to investigate further.

We also observed that falls care plans were not consistently updated immediately following an incident. In several cases, updates were deferred until the next scheduled 'resident of the day' review.

Not met

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

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