The Richmond Fellowship Scotland - Stirling, Clackmannanshire and Falkirk Housing Support Service

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Unannounced

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Service provided by:
The Richmond Fellowship Scotland Limited

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About the service

The Richmond Fellowship Scotland - Stirling, Clackmannanshire and Falkirk is a combined housing support and care at home service. This service registered with the Care Inspectorate in April 2011.

The service provides support to adults with learning disabilities and/or mental health problems living in their own homes. People receive support ranging from a few hours a week to 24-hour support. The service was supporting 50 people at the time of the inspection.

Some people live on their own or with one other person. Some lived in accommodation located next to a staff base. This is sometimes referred to as a core and cluster model of support. Others lived on their own or with family in the wider community. There are also two houses of multiple occupancy (HMO). This is accommodation where people have their own tenancy within a shared house and share some facilities and staff.

The overall service is led by the registered manager, with the support of two service managers who have responsibility for designated care packages, with their own staff teams reporting to them. At the time of this inspection seven team leaders were working across the service

About the inspection

This was an unannounced inspection which took place on 2, 3 and 4 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:

- Met with leaders in their main office and in people's homes.
- Visited people and met with staff in one HMO.
- Visited two people who lived in a shared tenancy.
- Visited eight people who lived in their own homes within the two core and cluster models of support.
- Reviewed electronic survey feedback from 36 members of staff and 3 external professionals who work with the service.
- Reviewed health recordings, medication records, support plans and a variety of other documents and recordings.

Key messages

- The quality of care and support had improved since our previous inspection in March 2025.
- People experienced good health and wellbeing outcomes.
- Leadership in the service had improved.
- Staffing levels were generally good and staff were working well together.
- Assessment and care planning was good.
- The management of concerns and complaints could be enhanced.

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?	4 - Good
How good is our staff team?	4 - Good
How well is our care and support planned?	4 - Good

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 made an overall evaluation of good for these quality indicators as there were a number of important strengths which clearly outweighed areas for improvement. The strengths had a significant positive impact on people's experiences and outcomes. However, improvements were required to maximise wellbeing and ensure that people consistently had experiences and outcomes which were as positive as possible.

- **Quality indicator 1.3. People's health benefits from their care and support**
- **Quality Indicator 1.5. People's health and wellbeing benefits from safe infection prevention and control practice and procedures**

People's health and wellbeing was well supported, with improvements made in several key areas since our last inspection. We observed warm and respectful interactions between staff and people using the service. Leaders and staff we met with were dedicated in their roles, and invested in making improvements to the service.

Guidance and clarity around restrictive practices had improved. These practices are defined as making someone do something they do not want to do or stopping them from doing something they do want to do, by restricting or restraining them, or depriving them of their liberty. Restrictive practices relate to different types of restraint. These may include, for example, equipment that limits people's movement or the practice of putting locks on kitchen doors.

Restrictive practices must be lawful, have appropriate consents in place from the individual or their legal guardian, have clear guidelines for staff to follow, and be subject to regular reassessment to ensure they remain necessary and are the least restrictive option. These were lacking at our previous inspection of the service. Leaders had made improvements in several key areas. This included liaising with health professionals to ensure assessments were up-to-date, and seeking clarity for social work around guardianship powers. Leaders had sought guidance from the providers' own Positive Behaviour Support Team. They had provided training and guidance to staff. This helped ensure staff working in a consistent manner that met current best practice guidance. Taken together, these measures had led to improved outcomes for people.

People had been supported to achieve improved health outcomes since our last inspection. This included people's emotional wellbeing improving, which enabled them to access more opportunities in the wider community, including going on holiday with staff. Leaders had taken a proactive approach to ensure people had access to the right health advice and guidance. Partnership working had improved. Leaders were seeking the support of key internal and external professionals.

Additional training needs had been identified across the service. Priority had been given to ensuring staff had the right training to support people who display stress and distress. Leaders had sourced a variety of training and guidance opportunities for staff. More opportunities were planned in the coming months.

Leaders had a good oversight of training levels in each area of the service. A regular cycle of quality assurance was being used to ensure training levels were maintained. We heard that more focus was being placed on ensuring the assessment process identified training needs when people were first introduced to the service. We will continue to check progress in this area at future inspections.

Care plans contained good information on people's health needs. We looked at risk assessments which were created to support people when they displayed significant stress and distress. They were completed to a high standard and contained detailed information on the proactive and reactive strategies staff should take. Staff we spoke with displayed good knowledge of the contents of the plans. This promoted consistent ways of working which in turn contributed to improved health and wellbeing outcomes.

Medication administration procedures were generally good. We checked medication records across several areas of the service. Most were completed to a high standard. At our previous inspection we advised leaders that it is best practice to record the outcome of any 'as required' medications to enable health professionals to determine whether the medication or dose of medication is having the intended effect. This had improved in several areas of the service, but not all.

At previous inspections we have also given guidance around the importance of documenting health screenings appropriate to people's age and sex. This should include the date of the screening; result; when it is due again; barriers to accessing screenings; measures staff can take to support the person to overcome the barrier; any further protective measures staff can take in the event it is not possible to access the screening. This guidance had been implemented in some areas of the service but not all. We recognise there had been recent changes in leadership. However, we discussed the importance of standardising practice across each area of the service. The service managers we spoke with were receptive to this feedback. We will continue to monitor practice around 'as required' medication and health screenings at future inspections to ensure health outcomes for people are maximised across every area.

In some areas of the service staff had overall responsibility for ensuring the environment was kept clean in order to reduce the risk of the spread of infection. This included areas where people had complex needs and were unable to carry out cleaning themselves. At our last inspection we had concerns about the standard of cleanliness in one area we visited. There had been significant improvements in this area. Cleaning was being carried out to a higher standard, with quality assurance activities ensuring required standards were maintained. Old equipment had been replaced to help ensure effective cleaning was possible. This had reduced the risk of the spread of infection in that area of the service.

How good is our leadership? 4 - Good

We made an overall evaluation of good for this quality indicator as there were a number of important strengths which clearly outweighed areas for improvement. The strengths had a significant positive impact on people's experiences and outcomes. However, improvements were required to maximise wellbeing and ensure that people consistently had experiences and outcomes which were as positive as possible.

During our previous inspection we identified leadership issues in some areas of the service. This included a lack of managerial presence in some areas, along with a lack of guidance from leaders. This had contributed to staff working in an inconsistent way and a break down in professional boundaries. These issues placed staff and people using the service at risk of harm. This had significantly improved at the time of this inspection. Those areas where there was a previous lack of leadership had benefited from having a consistent leadership presence.

Feedback from staff in these areas was more positive. Some comments included:

- "The support I get from the senior and manager is faultless."
- "The manager and senior are both very supportive and are lovely people."

Staff we spoke with were more knowledgeable about people's current support needs and had recently completed additional training in areas such as trauma informed practice and reactive support. This had contributed to improved health and wellbeing outcomes for people. We spoke with people using the service. They were proud of their achievements over the previous months and had built up trusting relationships with staff.

Leaders had developed a service improvement plan in response in to our previous inspection. The majority of identified actions had been seen through to completion, which demonstrated that improvement had been led well. There had been some recent changes in the larger leadership team, resulting in temporary senior staff, and some changes in the areas senior staff worked. We evaluated that this process could be better supported by ensuring these staff have time to familiarise themselves with people's support needs, particularly where people can display stress and distress. Leaders were responsive to this feedback and stated they would ensure this happened for senior staff in temporary positions.

Improvement would be better supported by ensuring any complaints or concerns people raised were responded to as per the provider's own complaints policy. We spoke with a family member who felt their concerns has not been responded to appropriately. There were limited records of how complaints had been dealt with and it was unclear whether a resolution had been reached. This had resulted in a degree of anxiety for people. We therefore made an area for improvement around how leaders should respond to concerns and complaints.
See area for improvement 1.

Areas for improvement

1. To support a culture of continuous improvement in the service, the provider should ensure any complaints or concerns are responded to as per their complaints policy. Records of both formal and informal complaints should be kept, along with details of any learning and actions. Complainants should in all cases be informed of the outcome of their complaint or concern.

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

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).
And
'I know how, and can be helped, to make a complaint or raise a concern about my care and support' (HSC 4.20).

How good is our staff team? 4 - Good

We made an overall evaluation of good for this quality indicator as there were a number of important strengths which clearly outweighed areas for improvement. The strengths had a significant positive impact on people's experiences and outcomes.

We recognise the current staffing challenges across social care nationally. We were confident the service was recruiting staff on an ongoing basis and current identified vacant posts were minimal. We received survey responses from 36 staff members. 34 respondents stated their induction had adequately prepared them for their role. The provider had made recent changes to induction recordings. Managers had not yet

put this into practice. We will check progress at our next inspection to ensure the induction process is fully preparing staff for their role.

Feedback from staff was generally positive across all the questions we posed. Some positive feedback included:

- "Staff are trained to provide a good quality of support."
- "We can adapt to the changing needs of people we support."
- "My senior support worker is very supportive."
- "The service is particularly good at involving people in shaping the support they receive and enabling them to live their lives their way while keeping them safe and happy."

Feedback about leadership support had improved since our previous inspection. The majority of respondents felt well supported by visible leadership. A minority of respondents did not agree, and felt leadership still needed to improve. We discussed this with managers. There had been recent changes in leadership roles and it was hoped feedback from staff would continue to improve as those new leaders settled into their roles. We will continue to check progress at future inspections.

At our previous inspection there were areas of the service where training needed to improve. Key training opportunities had been missed which put people at risk of harm. This had improved significantly. Leaders had identified training opportunities and many staff teams had already completed additional training, with more opportunities planned in the coming months. This meant people could be more confident that staff had been provided with current best practice guidance, enabling them to work in a consistent manner that promoted positive health and wellbeing outcomes.

How well is our care and support planned? 4 - Good

We made an overall evaluation of good for this quality indicator as there were a number of important strengths which clearly outweighed areas for improvement.

The assessment process for people being introduced to the service had improved. Recent assessment processes were well completed, with leaders ensuring they had the right information on people's needs and wishes. Identifying staff training needs was now a priority during the assessment process. This reduced the risk of harm to people who had recently started using the service.

Care plans were generally completed to a high standard and contained the right information to guide staff on people's support needs and wishes. During the inspection we observed people working alongside staff to contribute to their own care plan. Leaders were incorporating appropriate information and guidance from internal and external colleagues. More emphasis was being placed on positive behaviour support plans, with guidance on the proactive and reactive approaches staff should take. Staff we spoke with were familiar with the contents of these plans. This approach had already supported improved wellbeing for people using the service.

People had individual outcomes listed withi. We evaluated that these would be enhanced by taking a more specific and measurable approach to outcomes. Care plans were generally written in a respectful manner where people's independence was promoted.. A minority of those we sampled would benefit from further quality assurance to ensure they were in written in a way that respected people and took an aspirational approach to their support. Leaders were responsive to this feedback. We will check progress at our next inspection.

Risk assessments were appropriate. More emphasis was being placed on enabling people rather than restricting their actions or activities. At the time of this inspection leaders were in dialogue with local authorities to ensure they had oversight of relevant accompanying documents including guardianship certificates to ensure the support they were providing was in line with agreed legal powers and upheld and protected people's rights.

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

Requirements

Requirement 1

The provider must ensure that people's human rights are protected and promoted, and that staff practice adheres to legislation and current best practice guidance.

By 13 June 2025 the provider must ensure any restrictive practices used in the service have been assessed as necessary at that time, and that staff have received appropriate training and guidance in its use. In order to achieve this, the provider must, as a minimum:

a) Carry out an audit of restrictive practices used throughout the service.
b) Work with key people (this must include, but is not limited to, people using the service, their legal representatives, health, and social work professionals) to establish if the restrictive practice is justifiable, reasonable and proportionate.
c) Where the restrictive practice is assessed as justifiable, reasonable and proportionate, establish clear guidance for staff around its use.
d) Establish a process of on-going monitoring of staff practice to ensure the use of any restrictive practice is carried out in line with agreed guidance.
e) Establish a process for the regular reassessment of restrictive practices at agreed intervals or earlier when people's support needs change.

This is in order to comply with regulation 4 (1) (c) (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 states that:

"If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively" (HSCS 1.3)
and
"I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities" (HSCS 3.20).

This requirement was made on 1 April 2025.

Action taken on previous requirement

The provider had responded well to this requirement.

Leaders had carried out an audit of restrictive practices in the service. Some practices were stopped immediately, with accompanying risk assessments appropriately updated. Where restrictive practices were deemed appropriate, advice and guidance was sought from internal and external colleagues. Leaders were working with statutory bodies to ensure restrictive practices were sanctioned within guardianship powers. Reassessment of restrictive practices had taken place to ensure it was still required, and was the least restrictive measure possible at the time.

Taken together, these measures had reduced the risk of harm to people.

Met - within timescales

Requirement 2

The provider must ensure that the risk of infection and cross contamination is minimised because the environment is clean and well maintained.

By 18 April 2025 the provider must ensure that people experience care in an environment that is safe, well maintained and minimises the risk of spreading infection. In order to achieve this, the provider must, at a minimum:

a) Immediately carry out a programme of deep cleaning in the service area identified in this inspection, where the provider has responsibility for environmental cleaning.
b) Implement a cleaning schedule to ensure required standards are maintained.
c) Implement regular quality assurance around cleaning and IPC.
d) Implement an action plan to address any areas for improvement, including the removal of obsolete or worn equipment, with key dates for any areas for improvement to be met.
e) Ensure staff are trained, competent, and aware of their own role in effective Infection Prevention and Control practices, including through observations of practice.

This is in order 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 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)
and
'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

This requirement was made on 1 April 2025.

Action taken on previous requirement

The provider had responded well to this requirement.

We visited the service on 23 April and assessed that infection prevention and control measures had significantly improved. A deep clean had taken place which was followed by regular cleaning. Quality assurance and monitoring ensured cleaning was being completed to the required standard. The environment appeared significantly cleaner.

Standards had been maintained at the time of this inspection in July 2025. The improved practice had reduced the risk of harm to people.

Met - within timescales

Requirement 3

The provider must ensure that every area of the service had effective and visible leadership in place.

By 13 June 2025 the provider must ensure that people experience support in a service where staff are led well, with appropriate leadership mechanisms in place to provide on going support, guidance and direction to staff.

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

a) Carry out an audit of current leadership mechanisms in each area of the service. This must include current procedures for visible senior and team manager presence within each area of the service.
b) Implement an action plan, with key dates for any for improvement to be met, to address issues where current leadership arrangements are not meeting the needs of people, staff, or the expectations of the registered manager.
c) Implement procedures that allow leaders to ensure staff are working in a consistent manner and that professional boundaries are maintained. This should include, but is not limited to, observations of staff practice, team meetings and one to one's with staff.

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

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

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19)
and
'I use a service and organisation that are well led and managed' (HSCS 4.23).

This requirement was made on 1 April 2025.

Action taken on previous requirement
The provider had responded well to this requirement.

Leaders had developed a service improvement plan in response in to our previous inspection. The majority of identified actions had been seen through to completion. There had been some recent changes in the larger leadership team, resulting in temporary senior staff and some changes in the areas senior staff worked. Areas where we were previously concerned about a lack of leadership had benefitted from having a regular leadership presence.

Staff were working in a more consistent manner with improved leadership support and guidance. This had reduced the risk of harm to people.

Met - within timescales

Requirement 4

The provider must ensure that all staff have received training appropriate to their role and responsibilities.

By 13 June 2025, the provider must ensure that people experience support from staff who have received training and guidance relevant to people's support needs. The provider must ensure that training needs are identified during the initial assessment, through the review process, or earlier when people's health of support needs change.

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

a) carry out a full analysis of current training needs in every area of the service.
b) Work with key internal and external partners to source training and guidance opportunities relevant to people's current support needs.
c) implement a programme, with agreed timescales, for all staff to complete any outstanding training.
d) implement quality assurance systems to ensure training levels are maintained, including the completion of refresher training within required timescales.
e) Ensure the initial assessment process is used to determine training needs and that training is delivered within agreed timescales. Staff should receive this training before the person starts using the service. Where this is not possible, it must be agreed by the registered manager, and there must be plans in place for staff to complete the training at the earliest opportunity.

This is in order to comply with section 8 (1) (a) (training of staff) 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:

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).
and
'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

This requirement was made on 1 April 2025.

Action taken on previous requirement
The provider had responded well to this requirement.

Additional training needs had been identified across the service. Priority had been given to ensuring staff had the right training to support people who display stress and distress. Leaders were working with internal and external colleagues to explore a variety of training and guidance opportunities for staff. More opportunities were planned in the coming months.

Leaders had a good oversight of training levels in each area of the service. A regular cycle of quality assurance was being used to ensure training levels were maintained. More focus was being placed on ensuring the assessment process identified training needs when people were first introduced to the service. We will continue to check progress in this area at future inspections.

These measures had contributed to staff having the right skills to meet people's needs and wishes. This had resulted in improved health and wellbeing outcomes and reduced the risk of harm to people.

Met - within timescales

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?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	4 - Good

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement is led well	4 - Good

How good is our staff team?	4 - Good
3.3 Staffing arrangements are right and staff work well together	4 - Good

How well is our care and support planned?	4 - Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	4 - Good

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