Isleshavn (Care Home)
Care Home Service

Isleshavn Care Centre
Mid Yell
Shetland
ZE2 9BT

Telephone: 01595 745 720

Type of inspection:
Unannounced

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Service provided by:
Shetland Islands Council

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About the service

Isleshavn is a care home for up to 10 adults and older people in the rural community of mid-Yell, on the island of Yell, Shetland. There were seven people living in the service at the time of the inspection. Due to recruitment difficulties, the service has supported no more than seven people at any one time for a number of years.

The service provides accommodation over one floor in single bedrooms, each with an en suite toilet and wash hand basin. There is a shared dining and lounge area and an enclosed garden. The service is accessible by ferry and bus.

About the inspection

This was an unannounced inspection which took place between 1 to 3 July 2025 from 09:00 and 17:45. The inspection was carried out by one inspector and one team manager from the Care Inspectorate.

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

In making our evaluations of the service we:

- spoke with six people using the service and two of their family
- spoke with 10 staff and management, seven responded to our survey
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals.

Key messages

- Staff were compassionate and caring and skilled at communicating with people.
- Leaders and staff had worked hard to drive improvements since our last inspection.
- Significant improvements had been made in relation to the cleanliness and clutter in the home.
- Staff required further access to training and development relevant to their roles.
- Improvements were still required to support quality assurance work.
- Care planning had improved.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	3 - Adequate
How good is our staff team?	4 - Good
How good is our setting?	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 found important strengths that had a positive impact on people's experiences and personal outcomes. We evaluated this key question as good.

People appeared well-presented and well-cared for and comfortable in their home. Importantly, people told us they were happy there. People and their families spoke highly of the staff.

"My relative's wellbeing has greatly improved during their time in this care setting."
"Made such a difference to their life, been great for them."
"Good here, got everything I need."

Overwhelmingly, families felt their loved one was safe and got the care they needed. However, some felt that more staff and a stable staff team would improve the service.

Staff chatted with ease to people. There were numerous times where staff demonstrated their knowledge of people and their local community. That reinforced the sense of home to people where others and places that were important to them was very much part of the conversation. Agency staff positively engaged with people to better understand people's lives and the local culture. People benefit from staff who are curious to understand what matters to them. Staff are then better placed to offer care and support in a meaningful way. Staff were respectful of people's choices and wishes which meant that people were being listened to and choices respected.

People's health benefited from access to community health professionals such as GPs and nurses. Records were in place which evidenced visits from health professionals and contained advice for staff to follow to support people. A regular multidisciplinary team meeting helped staff to explore further health and wellbeing support from a range of health and social work staff. People's needs are best met by a variety of staff with different skills and knowledge.

Medication was used at differing levels by people. Staff took part in training to ensure they were able to support people with medication appropriately. There was room for improvement within audits of medication and how effective they were at recognising good practice or where there was room for improvement. This is discussed within various areas of the report.

People were able to choose where they ate their meals. Communal meals were a mixture of chat and comfortable silences. Meals were enjoyed in an unhurried and relaxed atmosphere. Meals looked appetising and people told us they enjoyed the home cooked food that was offered.

Some people needed to eat food which had been made to a consistency which minimised risks associated with chewing and swallowing. Speech and language therapists were involved in those assessments. In some cases, people and their families had made personal choices around the way in which food was to be prepared. That was respected and evidenced positive responses to people's likes and dislikes.

Staff were familiar with people's eating and drinking care plans and recorded in them as required. It was positive to find that kitchen staff had been able to spend time with people exploring their likes and dislikes. Previously, they were given information from care staff but by having the direct conversations with people, they could be confident about people's views on meals.

Isleshavn benefits from enclosed outdoor space and also access to easy to walk areas with a lovely outlook to the sea. People should be able to choose to spend extended periods outdoors. This supports physical activity, physical and mental wellbeing as well as exposure to sunlight to promote the absorption of vitamin D. We saw some people benefiting from outdoor space but would suggest it could be used more.

We were aware that a few people had something to occupy their day but were not confident that they were offered as much as they could have been. However, during recent team meetings staff themselves had highlighted this as an area they would like to work on. Leaders in the service should consider a range of ways to improve stimulation and meaningful engagement for individuals on a day-to-day basis. We look forward to seeing how this progresses.

Please see What the service has done to meet any requirements made at or since the last inspection? and What the service has done to meet any areas for improvement we made at or since the last inspection? for further information.

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, where strengths only just outweighed weaknesses. Whilst strengths had a positive impact, key areas needed to improve.

During our last inspection, we had identified significant concerns regarding oversight of the service and what that potentially meant for people living there. We found that progress had been made in this area and whilst there was still work to do, things were moving in the right direction.

At our last inspection, we put eight requirements in place. It is testament to the hard work and commitment of all involved that seven of those have been met. Those improvements were important to support good, safe and appropriate care for people. It is important they are sustained and built upon to offer further improvement.

The team leader, seniors and staff had worked hard to develop a more positive working culture within the care home. Staff spoke positively of the changes and the impact on daily work where they felt they were much more considerate of each other. Whilst we were not aware of people being directly impacted by staff disharmony, indirect impact was a potential. People pick up on staff unhappiness. As staff reported a better workplace atmosphere, people should be protected from the impact of any negative behaviours.

Senior staff were noted to be more visible and available to support staff. Placement of senior staff on the daily rota had been better considered but was impacted by the service being a senior down since our last visit. Staff confidence was enhanced knowing they had access to senior staff. People need to have confident staff supporting them and there was a sense that that had improved.

The provider, Shetland Islands Council, was working to develop a quality assurance framework for all care settings to use. This will support leaders and staff to better understand what they need to do to evidence areas of good practice and importantly to recognise where the service could be improved for people. Although work had started in that area, external management acknowledged that there was still work to be done. We have extended the timescale for the requirement related to that feature of work.

An internal service improvement plan was in place. It was used to indicate what needed to be done, when and by who. It contained relevant and important information as to what had been completed in relation to concerns raised in our last report. It also detailed what still had to be done. Going forward, there was a plan to include the views of people, staff and relevant others in the plan. We will look at further progress in our next inspection.

Systems to record and track training, supervision and team meetings had been implemented. These completed records and sampling demonstrated gaps in some important areas. The tracker for training was comprehensive, however recorded dates that core and person-centred training were due made it difficult to see when staff had undertaken training and the frequency of refresher training. There were significant gaps in core training which must be addressed so that people can be confident that staff are trained and competent to support them safely. While there was a system in place for continuous conversations and supervision we were not assured all staff received supervision on a regular basis. We could see that observation had been undertaken in relation to staff practice with hand washing. There was a lack of observations of practice in key areas such as medication, moving and assisting and care delivery (see requirement 1).

Please see What the service has done to meet any requirements made at or since the last inspection? and What the service has done to meet any areas for improvement we made at or since the last inspection? for further information.

Requirements

1. By 19 December 2025, the provider must ensure that all staff are trained and competent to support people safely.

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

a) Ensure staff participate in all training relevant to their role and the needs of the people they support. This should include, but is not limited to, care planning, moving and assisting and dysphagia training.

b) Ensure staff supervision is held in line with organisational guidelines to promote reflective practice and identify individual training needs.

c) Ensure staff competence is monitored through on-site observations to continuously improve staff practice.

This is to comply with Section 8(1)(a) 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 am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities" (HSCS 3.20).

How good is our staff team? 4 - Good

We found important strengths that had a positive impact on people's experiences and personal outcomes. We evaluated this key question as good.

Staff rotas were developed in advance to support good staff deployment. Leaders used a dependency tool which offered a calculation of how much support a person needs for their day. However, there was clear evidence that the professional judgement of the team leader was used to influence staffing levels. Staff numbers were increased when some people needed more support such as during periods of poor health. On occasion, two night shift staff were used to ensure people were safely supported at night.

There was always a minimum of two staff on shift to support seven people. That generally worked well but sometimes staff felt those numbers could be tight depending on people's needs. For example, during the weekend, there was not always a senior around to call on for extra support if needed. One member of staff also told us: "At times I do feel rushed and don't always have time to spend with the clients." It is important that leaders consider such comments within the team and explore what impact it has on people's care and support.

Mornings tended to be busier. Some people needed only a small amount of support to get ready for the day. Some needed longer. We recognised that staff had to be quite organised to use the time as effectively as possible. Some people were creatures of habit who loved to get up earlier, some liked a lie in. Staff worked around people's wishes and preferences. However, at times, people needed more support which could change the easy flow of the morning. In those cases, it was important that leaders looked at staff deployment to see if more staff were required. It was also important to ensure that staff were following care plans around getting washed and dressed. It was a very intimate aspect of the caring role for people and dignity and respect were essential to also consider in terms of the context of timing.

During our last inspection, we were very concerned at the lack of domestic support staff. It was positive to find that situation had improved. That resulted in significantly better levels of cleanliness in the home which offered a more pleasant place to live.

Please see What the service has done to meet any requirements made at or since the last inspection? and What the service has done to meet any areas for improvement we made at or since the last inspection? for further information.

How good is our setting? 4 - Good

We found important strengths that had a positive impact on people's experiences and personal outcomes. We evaluated this key question as good.

Significant progress had been made in the care home since our last visit. It was brighter, cleaner and clutter had been removed. That all made for a much more welcoming and respectful setting for people to live in. There was a stronger sense of 'home.'

Work had taken place to re-establish a smaller sitting area to be used by people and families. That meant they had a space to chat and have a cup of tea in privacy. Whilst it was being used, staff hoped that people and families would be able to enjoy the space more as time goes on.

The outdoor courtyard was in full bloom. One of the people living there had derived great pleasure from using their gardening skills and others benefited from the bright area.

Routine maintenance checks were in place as were domestic audits to confirm all areas were cleaned as required. The current domestic staff team contributed heavily to noted improvements. As a result, people could be confident about their safety and the environmental cleanliness within the home. Improvements in the cleanliness of the home included a much cleaner and tidier laundry area which made this area in particular safer and a more pleasant working environment for staff to use.

Staff had worked hard to reduce levels of clutter. A few staff felt there was room for further improvement. It is for people and staff to look at that and decide on any further actions.

Walls by people's rooms had been decorated with lovely photos of people which offered a brighter walkway. The photos also offered good talking points with people. Other walls had been decorated with pleasant wall stickers which also brightened up the place. The care home is the oldest in the Shetland Islands Council group, as such it is tired in some areas. Going forward, it is important that people are fully involved in any major decoration plans.

Care homes have to operate within the fine balance of being a person's home but also a staff workplace. It is first and foremost a home. We have suggested that leaders and staff review the use of infection prevention and control posters as they were used excessively and detract from the fact it is a person's home.

Please see What the service has done to meet any requirements made at or since the last inspection? and What the service has done to meet any areas for improvement we made at or since the last inspection? for further information.

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

We found important strengths that had a positive impact on people's experiences and personal outcomes. We evaluated this key question as good.

Progress was clear in care plans and risk assessments since we last inspected. That meant that people's preferences and desired outcomes related to care and support were more up-to-date. Staff were able to access information which guided them on how best to support people.

Care planning was generally carried out by staff in leadership roles. Staff in other roles had also been involved to varying degrees in the past. We shared the Scottish Social Services Council (SSSC) guidance - Job role information for workers in a care home service for adults. It is important that staff who are involved in care planning activities are properly registered on the SSSC register and working towards the correct qualification for that level of work. People can then be confident that staff are trained to carry out the role of care planning.

The provider is currently undertaking a piece of work around the role of keyworkers and was keen to explore training opportunities for staff involved in care planning.

Reviews had taken place but documentation was not always in place for these. Without the agreed action plans from reviews, there was a risk that changes to the main care plan could be missed out. We appreciated care home staff may not be responsible for producing the minutes of reviews, however, they must take details of actions. Leaders started to follow up on that during the inspection and we were confident they would complete that task.

Please see What the service has done to meet any requirements made at or since the last inspection? and What the service has done to meet any areas for improvement we made at or since the last inspection? for further information.

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

Requirements

Requirement 1

By 20 June 2025, the provider must ensure that people are safe from harm by administering medication safely and effectively.

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

a) ensure medication is offered to people as per the directions on the prescription

b) ensure medication audits capture the effectiveness of as required medications

c) ensure staff are trained and competent in the use of the Abbey Pain Scale and use the correct recordings for it.

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 state that: "Any treatment or intervention that I experience is safe and effective" (HSCS 1.24) and "I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes" (HSCS 3.14).

This requirement was made on 7 March 2025.

Action taken on previous requirement

Leaders had added a simple but effective direction to every person's care plan. At the front of each plan, there was a clear comment to advise staff to not alter the medication to be used by people unless directed to do so by health professionals. We were pleased to see that no medications had been altered. People's medication needs were met exactly as directed.

As required medications were in use. There was still room for improvement with staff recording the effectiveness of the use of the medication. There were only a few instances of such medication being used. However, we were satisfied with the pace of current improvements and expect further work to continue.

Some guidance on the use of the Abbey Pain Scale was given to staff. An element of information was missing which we shared with leaders and were confident it would be added to the guidance. Staff were making recordings but with added guidance they will be able to use it more effectively. The scale is not in use with everyone as most people can tell staff about any pain they feel. We have suggested that leaders discuss whether it is a helpful scale for them to use and whether it truly made a difference to people's health and wellbeing.

Met - within timescales

Requirement 2

By 20 June 2025, the provider must ensure that people's health monitoring needs are clearly established and that support is tailored to ensure they are safe and well.

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

a) ensure people's health and wellbeing needs have been assessed to ascertain if monitoring charts are required

b) ensure that any monitoring charts detail the purpose of monitoring and the timescale that the monitoring should be in place

c) ensure that staff are aware of targets to be achieved/what information they need to gather

d) ensure recordings are accurate and fully in place

e) ensure that staff are able to analyse the information they have gathered to make a decision on whether to escalate concerns to health professionals.

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 state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11).

This requirement was made on 7 March 2025.

Action taken on previous requirement

Leaders and staff had made considerable progress in this area. This meant that people's health was being monitored when it needed to be.

Monitoring charts were being used only when needed. Staff were clear about why they were in place and what was to be recorded. It was also clear what had to be done if there was a concern. Monitoring charts record information such as how much food and fluids a person has taken. They are often used to monitor bowel movements as well. Importantly, leaders were checking the charts to ensure they were completed properly and addressing any gaps.

Leaders had discussed the need for monitoring charts with local nurses/dieticians. Their expert knowledge supported leaders to make decisions on the continued use of monitoring charts. It also gave them the confidence/permission to remove unnecessary charts. The involvement of local health professionals is critical as staff in the care home are not clinically trained.

We were more confident that charts were being used to inform discussions about people's changing needs and dealing with them as required. That supported people to be kept well.

Met - within timescales

Requirement 3

By 20 June 2025, the provider must ensure people have access to food and fluids that are safely prepared to meet their nutritional needs. To do this the provider must, at a minimum:

a) ensure all staff responsible for preparing, serving and assisting with meals have undertaken sufficient and appropriate training for their role. This must include awareness and understanding of how to prepare modified meals in accordance with the International Dysphagia Diet Standardisation Initiative framework (IDDSI)

b) ensure advice and guidance from relevant health professionals is followed at all times

c) ensure relevant information about people's nutritional needs is shared with the kitchen staff regularly and when there are changes to people's assessed support.

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 state that: "My meals and snacks meet my cultural and dietary needs, beliefs and preferences" (HSCS 1.37) and "I experience high quality care and support because people have the necessary information and resources" (HSCS 4.27).

This requirement was made on 7 March 2025.

Action taken on previous requirement

The staff team had made progress in this area. We were satisfied that the kitchen and care staff were following the health professionals' guidance. People's meals were prepared as required which reduced risks to their wellbeing.

Kitchen staff had a good understanding of what people needed to eat to keep well. Communication between different staff teams had improved. Continued good communication is essential to ensuring the safety and wellbeing of people.

A PowerPoint presentation had been shared from the speech and language team to support learning in International Dysphagia Diet Standardisation Initiative (IDDSI). Not all staff had completed training in this critical area of support. We suggested to leaders that they should consider alternative means of undertaking that training to improve uptake. However, all care staff have responsibility for their own learning. The Scottish Social Services Council Codes of Practice state: "I must be accountable for the quality of my work and take responsibility for maintaining and improving my knowledge and skills."

There was still a need for further checking of staff practice (see How good is our leadership?) The training supports staff to develop their knowledge and skills. It is important that leaders follow-up with observations of practice, supervision and opportunities for reflection. That enables leaders to be confident that staff can put their training into practice to support them if further development is required. Improvements should ensure that people can be confident that staff are confident and competent in all aspects of their roles.

This requirement is met but a new requirement has been made to address the gaps as noted above in relation to staff competency checks (see How good is our leadership?)

Met - within timescales

Requirement 4

By 20 June 2025, the provider must have an organisational structure in place, clearly setting out the duties, roles and responsibilities of staff and their contribution to the operations of the service.

This includes, but is not limited to:

a) ensuring job roles and functions are clearly established

b) ensuring clarity of when leaders are on shift to support the running of the care home

c) ensuring all staff are involved in discussions and able to offer feedback about their need for direction, mentoring and support.

This is to comply with Regulation 3 (Principles) 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: "I use a service and organisation that are well led and managed" (HSCS 4.23).

This requirement was made on 7 March 2025.

Action taken on previous requirement

Since our last inspection, the number of senior staff dropped from three to two with them returning to full numbers just as we arrived. However, work had moved forward with regard to staff roles and functions.

A system had been implemented with regards to identifying which senior team member was responsible for the care home when on shift and who was responsible for care at home. That offered staff greater clarity as to who could help in the event of needing a senior for support.

Positively, most staff told us that they felt there was an improved culture of teamwork within the service. Significant pieces of work had gone into improving that situation. Staff were encouraged to voice their thoughts and views in team meetings and they were listened to. They spoke of increased visibility of senior staff and finding that to be a more supportive way of working.

Compassionate conversations were a feature of work that had taken place. Staff were encouraged to consider each other's wellbeing. Staff interactions with each other need to be positive, if not there is a risk that people will pick up on staff disharmony.

The team leader had developed a variety of surveys which will be used to gauge how people, families and staff feel about the service. We look forward to seeing the results and any planned actions.

The atmosphere felt very different during this inspection. A few staff felt there was still room for improved staff culture. It is important that they take ownership of that and look at how they can also contribute to improved practices.

Met - within timescales

Requirement 5

By 20 June 2025, the provider must develop a quality assurance framework which will support improvement and ensure good management oversight.

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

a) identify the relevant quality audits that must take place within the service which promote the safety and wellbeing of people and staff

b) identify and detail the associated timescales within which each quality audit must take place

c) identify and detail the required standards that should be met with regards to best practice expectations

d) ensure that actions identified in quality assurance audits are followed up with clear action plans which are reviewed and signed off by the responsible manager

e) ensure governance and adequate oversight arrangements are in place for service quality and to provide guidance and support to leaders in the service.

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 state that: "I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership" (HSCS 4.7) and "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

This requirement was made on 7 March 2025.

Action taken on previous requirement

Since our last inspection, the provider (Shetland Islands Council) had developed a draft quality assurance framework. As it is at draft stage, we appreciated that there was work still to be completed on this. Team leaders from care services across Shetland had been involved in this significant piece of work. That ensures that they are able to contribute to working practices that impact on their local, individualised services.

The quality framework being implemented includes tasks and expected frequencies. However, emphasis should be placed on developing and implementing a suite of standard audit tools that are fit for purpose. Alongside this, the provider should develop a plan for upskilling staff to undertake quality processes such as auditing which will impact on improving the safety and quality of care for people.

The provider has further work to do to meet this requirement.

Locally, we sampled some audits. Medication audits picked up on discrepancies but were ineffective in picking up on whether actions were required to minimise discrepancies in the future. Discrepancies in this area were not always picked up until the audit. It is important that staff are checking medication themselves and where they see something that should have been dealt with, they should report it. By reporting things quickly, any required actions can be followed up in a timely manner. Without those quick reports, people could be at risk of not having their medications when needed.

There was evidence of a lot of statistical information being gathered by leaders but there was a need to gather and analyse information in a more meaningful manner. For example, it was positive that leaders could pinpoint how many errors in medication they had in a four week period. However, the next stage would be to look at what impact did that have on people affected? What had caused the error? And what can be learned from it to minimise the chance of it happening again?

Staff had access to training but did not have access to routine observations of practice. These are used to identify good practice and to support individual development or reflection and improvement. Without them, staff may be supporting people without fully following good practice which could put people at risk of unsafe care and support. Incident reports were not consistently up-to-date, particularly around actions taken with medication errors, assessing and managing the risks and impact on people's health.

Incident reports were sampled. We found a few examples where we should have been notified. We shared our document - Adult care services: Guidance on records you must keep and notifications you must make, March 2025.

This requirement has not been met and we have agreed an extension until 19 December 2025.

Not met

Requirement 6

By 20 June 2025, the provider must create a service development plan which is Specific, Measurable, Achievable, Realistic and Time-bound (SMART) to evidence and centralise where improvements to the service have been identified, actions agreed and outcomes achieved.

This must include but not be limited to;

a) evidencing where feedback from stakeholders including external professionals, people using the service, their families and staff have linked to service development areas

b) ensuring that robust internal audits and quality assurance systems are carried out and any actions identified are linked to the wider service development plan.

c) learning from concerns, complaints or any adverse incidents to evidence the link to improvements

d) ensuring the plan is a live document, continually reviewed and updated to demonstrate the progress made toward improvements.

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 state that: "I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership" (HSCS 4.7) and "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

This requirement was made on 7 March 2025.

Action taken on previous requirement

A comprehensive improvement plan was in place relating to Care Inspectorate requirements. It was being developed to gradually bring the service's own findings forward into it. The team leader had worked hard to capture the relevant information and was well placed to make further progress.

As noted above, there was still room for improvement in relation to how audits were carried out and how they were used to inform any required changes in practice or other works within the care home. Those audits should then be used to inform the improvement plan. Meetings, incident reports and reviews should all contribute to the plan. Information gained from them should be analysed to ascertain if they are highlighting a need for improvement.

Plans were in place to gather the views of people, and other relevant individuals, to look at whether the responses identified had room for improvement within the service.

Although we recognised that work was still to be completed around the use of audits, we were content that they will be addressed under requirement 5. Essential elements of this requirement have been addressed and have supported the service to move forward.

Met - within timescales

Requirement 7

By 20 June 2025, the provider must ensure that people's health, welfare and safety are promoted and protected through appropriate infection prevention and control procedures

In order to achieve this, the provider must

a) ensure that there are sufficient staff on duty to complete daily, weekly and monthly cleaning tasks throughout the home

b) ensure all staff adhere to correct infection prevention control procedures in line with the Care Home Infection Prevention and Control Manual

c) ensure a risk assessment is in place with regards to the laundry access for staff and people.

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 (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 experience an environment that is well looked after with clean, tidy and well maintained premises, furnishing and equipment" (HSCS 5.24).

This requirement was made on 7 March 2025.

Action taken on previous requirement

Significant progress had been made in relation to the cleanliness of the home. That not only offered respect to people living there, it also offered better protection from the potential spread of infection.

The home was noticeably cleaner and brighter than our last visit. A domestic staff team was in place, it was heartening to see the pride in which staff undertook their role.

Having staff in place ensured that schedules of cleaning were completed. People benefited from the extensive cleaning that was in place.

During discussions and observations, we were reassured that the guidance contained within the Care Home Infection Prevention and Control Manual was being followed. However, leaders should reflect on how to monitor that and ensure all staff are familiar with the manual.

A risk assessment was in place for the laundry. Staff were able to refer to it to ensure their practice was promoting the safety of the people in the care home.

Met - within timescales

Requirement 8

By 20 June 2025, the provider must ensure that people's personal plans and risk assessments contain up-to-date and essential information to give staff clear instruction on how to meet their needs safely.

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

a) ensure all care plans are accurate, detailed and reflect the current assessed needs of people

b) ensure all risk assessments are accurate, detailed and reflect the current assessed needs of people

c) ensure people's choices and wishes are fully recorded

d) use care plan audits to ensure information about people and their needs are accurate and issues identified are addressed effectively

e) ensure all six monthly reviews are up-to-date.

This is to comply with Regulation 5(1) (Personal plans) 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 personal plan is right for me because it sets out how my needs are to be met, as well as my wishes and choices" (HSCS 1.15).

This requirement was made on 7 March 2025.

Action taken on previous requirement

We sampled care plans and risk assessments. They had been reviewed by leaders and updated as required. During the reviews, leaders had used an approach which allowed them to question the information in the plans. They questioned what did the information mean for people? That helped to develop meaningful information in the care plans.

People's choices and wishes were recorded. That meant that staff could refer to the care plan to make sure they were supporting people the way they wished to be supported. People's sense of safety and belonging is enhanced when they are supported in a way that promotes their dignity and respect and offers them comfort.

Risk assessment templates were used to identify what was relevant to individuals. Staff were used to the style of the template and completed it with relevant information. We have discussed template design with the team leader as it may be worth reviewing whether the existing templates could be improved upon.

The team leader had taken the approach to bring all care plans up to a better standard and to use a formal auditing process going forward. It is anticipated that good quality assurance processes will pick up on any changes or improvements still to be made to the care plans.

Formal reviews were carried out but minutes were not in care plans. That was in the process of being rectified when we inspected.

Met - within timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To support people's wellbeing and ensure that appropriate actions are taken to minimise the risk of falls, the provider should implement a falls prevention and management protocol, ensuring that:

a) Multifactorial falls risk assessments are up-to-date and regularly reviewed, particularly following a fall.

b) There is managerial oversight and auditing of falls and that learning from any falls is shared with the team.

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 based on relevant evidence, guidance and best practice" (HSCS 4.11).

This area for improvement was made on 14 October 2022.

Action taken since then

Leaders acknowledged that was not an area that they had made much headway on.

We were aware of a couple of instances where people had fallen in recent months. Risk assessments were sampled but had not been updated in the required timescale or using the particular assessment template noted above.

Risks in this area of support were lessened due to the fact that there were not high levels of instances where people fell. Also care and support after the event had been positive. There was a sense of staff knowing what to do but not appreciating they also had formal assessments to complete relating to their work.

This area for improvement has not been met.

Previous area for improvement 2

To improve people's wellbeing, the provider should ensure that they have opportunities to engage in meaningful and stimulating activities in the home. This should include but is not limited to:

a) Ensuring that people have a meaningful choice about their activities, and these are recorded and evaluated in a person-centred way in their care plan.
b) Reviewing staff deployment and the use of space to maximise people's opportunities for meaningful activities and stimulation.
c) Evaluating activities to ensure that people enjoy them, and they benefit their wellbeing.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "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" (HSCS 1.25).

This area for improvement was made on 14 October 2022.

Action taken since then

We observed one person pottering about the courtyard area taking immense enjoyment from their plants. Others enjoyed activities which were craft based. Great enjoyment was had by a couple watching a local ceilidh dance on TV. However, there were a lot of missed opportunities for people to get more out of their day.

A few family members said that was an area they felt could be better supported. Some people may have reached a stage where a very sedentary life may suit them. Some clearly had things they wanted to be involved in which gave them a purpose to their day.

Staff deployment in care homes often concentrates on keeping people physically well but mental and emotional wellbeing is equally as important. Most people thrive on social interactions. Having someone in their company can offer comfort and also reduce any sources of stress or sadness in people's lives. A chat over the well used photograph albums in the home or a gentle hold of someone's hand can make a huge difference to their day and sense of comfort.

Activities do not need to be big, grand events. However, when they do happen they offer great opportunities to see others and to get an update on what is happening around the care home. A recent VE day celebration was thoroughly enjoyed by all and was very much a day for the people of Yell and beyond to get together.

There was room for more work in this area and as previously noted, staff had already expressed their enthusiasm to develop it further.

This area for improvement has not been met.

Previous area for improvement 3

The service should strengthen leadership and governance in relation to staff engagement with support, supervision and training by introducing a system which supports oversight and ensures that staff practice is regularly evaluated.

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 practice and follow their professional and organisational codes" (HSCS 3.14).

This area for improvement was made on 14 October 2022.

Action taken since then

Leadership had developed a spreadsheet which tracked staff training. However, we found gaps in some aspects of refresher training which need to be addressed. It was tricky to always be sure of when staff had completed training and when the refresher training was needed. That had the potential of people being at risk due to staff not being up-to-date with relevant training. However, the issue was being addressed at senior level within the local authority.

Some training had not been followed up with observations of staff practice. Training provides the necessary skills and knowledge to complete tasks. Observations offer leaders an opportunity to assess staff competence and confidence.

Supervision records were sampled. We could not be confident all staff had access to regular supervision within expected timeframes. However, recent team meetings had been used to good effect by all to share views and ideas about the service provision.

This area for improvement is no longer in place and has been incorporated into a new requirement under How good is our leadership?

Previous area for improvement 4

To ensure people's assessed needs are met, the provider should review the staffing deployment within the service. The sleepover shift should also be reviewed to ascertain how well it works for people.

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 is consistent and stable because people work together well" (HSCS 3.19).

This area for improvement was made on 7 March 2025.

Action taken since then

This area for improvement was contained within the service improvement plan. However, the date for review was further into the year. It was understandable that leaders had prioritised what they could deal with now and what could be dealt with later.

We did see examples of good practice though where the sleepover shift was recently replaced with a second waking night shift worker due to the needs of people living in the care home temporarily changing. That evidenced a rota that was designed to support people's needs.

Whilst local leaders can influence staffing deployment to a certain level, only the provider can authorise substantial changes to deployment.

This area for improvement is not met.

Previous area for improvement 5

To support people's wellbeing, the provider should ensure that a robust on-call system is in place. Staff should have access to a leader who is in a position to offer clear guidance and make decisions as required.

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 is provided in a planned and safe way, including if there is an emergency or unexpected event" (HSCS 4.14) and "My care and support is consistent and stable because people work together well" (HSCS 3.19).

This area for improvement was made on 7 March 2025.

Action taken since then

This area for improvement was contained within the service improvement plan. However, the date for review was further into the year. It was understandable that leaders had prioritised what they could deal with now and what could be dealt with later.

On-call responsibilities were tasked to a different care home team lead each week. However, there was a lack of clarity as to exactly what role the on-call support provided. There was a lack of clarity as to why and when staff in the care home would call on-call. An informal on-call had developed where staff simply called local leaders and hoped they were free to respond. That meant that leaders could not be truly assured that their time off was their time off. Providers must not only ensure the wellbeing of people using the service. Staff wellbeing should also be prioritised.

Last minute sickness calls from staff created a need for staff in the care home to call around to find a replacement. If staff were dealing with people who needed support, there was a potential issue as to when they had time to make calls. That area of work needed further exploration for leaders to check any issues that had arisen within such situations and, if so, how could they address it?

This area for improvement has not been met.

Previous area for improvement 6

To ensure people can continue to experience an environment which is comfortable and homely, the provider should declutter across the care home and review storage solutions.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment" (HSCS 5.24).

This area for improvement was made on 7 March 2025.

Action taken since then

We were pleased to have seen a significant improvement in how much less cluttered the home was. It was evident staff had worked hard. It is important that the improvement is sustained. People benefit from a home that is homely but not overrun with things which don't really have a purpose.

This area for improvement has been met.

Complaints

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

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

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

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

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