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Care service inspection report

Pentland Hill Nursing Home

Care Home Service Adults

23/27 Gylemuir Road
Edinburgh
EH12 7UB
Telephone: 0131 334 2383

Inspected by: Rose Bradley

Moria McRae, Frankie Lumsden, David Todd and Michelle Deans

Type of inspection: Unannounced

Inspection completed on: 6 May 2011

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Service provided by:

BUPA Care Homes (CFHCare) Limited

Service provider number:

SP2003002226

Care service number:

CS2003010660

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Summary

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change after this inspection following other regulatory activity. For example, if we have to take enforcement action to make the service improve, or if we investigate and agree with a complaint someone makes about the service.

We gave the service these grades

Quality of Care and Support	3	Adequate
Quality of Environment	4	Good
Quality of Staffing	4	Good
Quality of Management and Leadership	3	Adequate

What the service does well

The service provides a comfortable environment for residents. Staff are polite and respectful toward residents and visitors are made welcome. Staff are developing a more person centred approach to care delivery. Residents and relatives are encouraged to participate in assessing and improving the quality of the service.

What the service could do better

The service would be improved if staff always put into practice the leaning obtained from the training provided. Staff supervision and staff meetings need to be held consistently for all staff in all units. All training records need to be signed and the training matrix needs to give an up to date overview of all training received. Staff knowledge of dealing with concerns and complaints needs to improve. The availability and level of stimulation for residents needs to be reviewed.

What the service has done since the last inspection

Since the last inspection all staff involved in assessing residents care needs and devising their care plans have received training in the provider's procedures for this. All residents needs are being reassessed and care plans rewritten with residents and where appropriate their relatives involvement.
The staffing levels in one unit has been increased because the residents direct care dependency assessment showed this was needed.

One unit now now has two unit managers to ensure a managerial presence each day of the week.
Two clinical services managers are in post to increase the overall monitoring of the quality of the service and staff practice.
Environmental improvements were underway and included redesigning the garden, and developing a dementia cafe and pamper room.

Conclusion

The staff team showed a commitment to improving the overall quality of the service. The management team are aware of the areas where the service needs to improve and the provider is committed to supporting staff in meeting these improvements. The provider and staff are eager to work with us.

Who did this inspection

Rose Bradley
Moria McRae, Frankie Lumsden, David Todd and Michelle Deans

1 About the service we inspected

Pentland Hill Care Home (referred to in the report as 'the service') is owned and Managed by BUPA (referred to in the report as "the provider") and was registered with Social Care and Social Work Improvement Scotland on the 1 April 2011 to provide a care service to a maximum of 120 older people.

The service is situated within a residential area of South West Edinburgh near to local amenities and public transport links. The building has gardens to the front and rear of the building.

The accommodation is on two floors accessed by a lift and stairs and is divided into four units accommodating up to 30 people within each unit. All rooms are for single use and all have en-suite facilities. Each unit has two communal lounges and a dining area within one of those lounges.

The service overall states that they aim to "provide our customers with the highest quality care service. We will use our health and care knowledge, specialist skills and values to deliver an individual service to our customers".

The service employs a team of carers and registered nurses with varying degrees of skill, expertise and qualifications. The service aims to offer a home which would not entail moving. However, the service recognised that there are some aspects of care that might require residents to move, for example, if a resident required more specialised care in relation to progressive mental health or advanced disease process.

Based on the findings of this inspection this service has been awarded the following grades:

Quality of Care and Support - Grade 3 - Adequate
Quality of Environment - Grade 4 - Good
Quality of Staffing - Grade 4 - Good
Quality of Management and Leadership - Grade 3 - Adequate

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change following other regulatory activity. You can find the most up-to-date grades for this service by visiting our website www.scswis.com or by calling us on 0845 600 9527 or visiting one of our offices.

2 How we inspected this service

The level of inspection we carried out

In this service we carried out a high intensity inspection. We carry out these inspections where we have assessed the service may need a more intense inspection.

What we did during the inspection

We wrote this report after an unannounced inspection that took place at the service. The inspection was carried out by Inspectors Rose Bradley, Moria McRae, Frankie Lumsden, David Todd and Michelle Deans on the following dates:

- 14 April 2011 between the hours of 10am and 5.30pm (Rose Bradley, David Todd, Frankie Lumsden and Moria McRae inspected.)
- 15 April 2011 between the hours of 9.30am and 5pm (Rose Bradley and David Todd inspected.)
- 18 April 2011 Between the hours of 9am and 6pm (Rose Bradley and Michelle Deans inspected.)

During this inspection we gathered evidence from various sources, including the relevant sections of policies, procedures, records and other documentation including evidence from:

- The service's most recent self assessment
- A sample of eleven residents' files
- Staff training records
- Staff supervision records
- Minutes of staff , residents and relatives meetings
- Complaint, accident and incident records
- Maintenance records
- Residents' direct care dependency assessment
- Staff duty rota
-Activity programme
-Finance records
-Sample of medication records
-Sample of staff recruitment files
-Audits of clinical and maintenance issues
-Observation of the environment and equipment
- Observation of staff practice
- Observation of staff interaction with residents, visitors and fellow workers in all four units
- Consideration of consultation methods

- Consideration of residents' and visitors' comments
- Observation of lunches, breakfasts and morning and afternoon teas being served in all units
- Time spent with residents in all units during the inspection
- Consideration of the content of fourteen resident care standards questionnaires which were completed and returned directly to us.
- Consideration of the content of eleven relative care standards questionnaires which were completed and returned directly to us.
- Consideration of the National Care Standards, Care Homes for Older People.

Discussion with various people including:
the manager
two clinical service managers
four unit managers
two activity coordinators
three registered nurses
various care staff
two students
some residents in all units
nine relatives individually

The outcomes of the inspection was discussed on the 6 May 2011. The area manager, the service manager, two clinical service managers, a representative from Edinburgh City Council, one SCSWIS inspector and inspector manager were present during this meeting.

Grading the service against quality themes and statements

We inspect and grade elements of care that we call 'quality themes'. For example, one of the quality themes we might look at is 'Quality of care and support'. Under each quality theme are 'quality statements' which describe what a service should be doing well for that theme. We grade how the service performs against the quality themes and statements.

Details of what we found are in Section 3: The inspection

Inspection Focus Areas (IFAs)

In any year we may decide on specific aspects of care to focus on during our inspections. These are extra checks we make on top of all the normal ones we make during inspection. We do this to gather information about the quality of these aspects of care on a national basis. Where we have examined an inspection focus area we will clearly identify it under the relevant quality statement.

Fire safety issues

We do not regulate fire safety. Local fire and rescue services are responsible for checking services. However, where significant fire safety issues become apparent, we will alert the relevant fire and rescue services so they may consider what action to take. You can find out more about care services' responsibilities for fire safety at www.firelawscotland.org

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

The requirement

The provider must review residents' personal plans to ensure they identify the social needs of residents and demonstrate how these social needs will be met.
This is in order to comply with SSI/114 Regulation 5 (2) - Personal plans.
This also takes into account National Care Standards Care Homes for Older People Standard 17 Daily Life.
Standard 6 - Support arrangement, 8.1 - Making choices
Timescales: 30 March 2011

What the service did to meet the requirement

The service has begun the process of reassessing all residents and rewriting personal plans/care plans including residents' social needs and how these would be met. Although this process had started it had not been completed for every resident. Therefore the requirement will be carried forward under new legislation the Public Services Reform (Scotland) Act 2010 and incorporated into requirement 1 of Theme 1, Quality Statement 1.2 and the timescale reviewed to allow the provider time to complete the work.

The requirement is: Not Met

The requirement

The provider must ensure that the content of all personal plans provides clear guidance for staff to enable the appropriate and up to date care to be given to service users.
In order to achieve this the manager must:
a)ensure personal plans accurately reflect all aspects of service users' needs including nutrition, communication, continence, behaviour, pain, memory, anxiety, sleep, personal hygiene including oral hygiene and all aids which are used such as hoists and pressure relieving aids
b)ensure guidance from healthcare professionals and agreements reached during reviews of care are accurately incorporated into personal plans
c) ensure information resulting from incidents and accidents is reflected in assessments and care plans
d) ensure all staff follow the instructions contained within the personal plans
e) ensure information about Power of Attorney is easily accessed.
This is in order to comply with SSI/114 Regulation 4(1)(a) welfare of users - a requirement to ensure the health and welfare of service users.
This also takes into account National Care Standards Care Homes for Older People

Standard 6.3 Support Arrangements and Standard 14 -Keeping well-healthcare.
Timescales: By the 30 June 2011

What the service did to meet the requirement

The timescales for completion of this requirement had not expired at the time of the inspection. This will be carried forward under new legislation, the Public Services Reform (Scotland) Act 2010 in Theme 1, Quality Statement 1.3 to allow the provider time to fully implement the requirement. Progress made in relation to this requirement is reported under Theme 1, Quality Statement 1.3.

The requirement is: Not Met

The requirement

Following other regulatory activity the following requirement was made.
The Provider must ensure that the views of the resident and, where appropriate, their relative or representative are taken into account when planning care.
In order to achieve this the Provider must ensure that:
* documentation within the personal plan must evidence that the resident's or relatives views have been sought, taken into account in the way care is planned and that all parties have signed their agreement to the plan of care
* that the service records when and in what circumstances relatives and carers will be contacted
* all staff are reminded of the importance of accurately recording the involvement of relatives and other representatives in planning and evaluating residents' care.
This is in order to comply with SSI 2002/114 Reg 5(1) - a regulation regarding personal plans; the National Care Standards Care Homes for Older People Standard 6 - Support Arrangements should be taken into account when complying with this Requirement.
Timescale for implementation: to commence within 24 hours of receipt of this letter and be completed by 30/06/2011.

What the service did to meet the requirement

The timescales for completion of this requirement had not expired at the time of the inspection. This will be carried forward under Theme 1, Quality Statement 1.1 under new legislation the Public Services Reform(Scotland) Act 2010 to allow the provider time to fully implement the requirement. Progress made in relation to this requirement is reported under Theme 1, Quality Statement 1.1.

The requirement is: Not Met

The requirement

Following other regulatory activity this requirement was made

The provider must ensure that where a plan of care has been amended or revised as a result of changing care needs the service must inform the resident's carer or representative.
This is in order to comply with SSI 2002/114 Reg 5(2)(d) - a regulation regarding personal plans.
Timescale for implementation: to commence within 24 hours of receipt of this letter.

What the service did to meet the requirement

We saw that the service was in the process of reassessing all residents care needs and devising new care plans. Relatives had been informed of this and that when the plans are complete would be reviewed with relatives to reach agreement. We assessed this requirement as met.

The requirement is: Met

The requirement

Following other regulatory activity this requirement was made
The Provider must ensure that personal plans identify all of a service user's individual and specific needs, and demonstrate how all of those needs are to be met, including, but not exclusively, needs in relation to oral care, personal care including shaving, food and drink and continence management. In order to do this, the Provider must:
* ensure that all staff are aware of the service's policies regarding assessment, person centred care planning, and meeting residents' care needs
* ensure that all staff who carry out assessments and plan care are trained in the use of the service's assessment tools
* ensure that all staff who are involved in planning and delivering care are trained in person centred care
* ensure that management have oversight of the systems that are in place to ensure that staff actually deliver the planned care.
This is in order to comply with SSI 2002/114 Reg 5(1) - a regulation regarding personal plans. The National Care Standards Care Homes for Older People Standard 6 - Support Arrangements should be taken into account when complying with this Requirement.
Timescale for implementation: to commence within 24 hours of receipt of this letter and be completed by 30/6/2011.

What the service did to meet the requirement

All staff who were involved in devising residents personal plans/care plans had received training in the use of the provider's assessment procedure and person centred planning. The manager had an oversight of the care through care plan audits. Unit managers worked directly with all staff to ensure that staff actually delivered the planned care. Staff hand-overs of information were used to remind staff about residents' care needs and changing needs. Because most aspects of this

requirement are met we have assessed this requirement as met. However because the work on reassessing residents and implementing the new care plans is not fully complete we will carry forward the aspect that there will be a managerial oversight of systems. This will be incorporated into Requirement 1 of Theme 1, Quality Statement 1.3. under new legislation the Public Services Reform(Scotland) Act 2010

The requirement is: Met

The requirement

Following other regulatory activity this requirement was made
The Provider must ensure that all staff who complete observation charts such as daily fluid and food intake and weight charts do so consistently and accurately.
In order to achieve this ensure that the provider must ensure that staff who carry out such observations are trained in the use of the service's assessment tools including how to evaluate the charts and plan care accordingly, seeking appropriate healthcare professionals' advice when required.
This is in order to comply with SSI 2002/114 Reg 13(c)(i) - a regulation regarding staff training. The National Care Standards Care Homes for Older People Standard 5:2 - Management and staffing arrangements should be taken into account when complying with this Requirement.
Timescale for implementation: to commence within 24 hours of receipt of this letter and be completed by 30/6/2011.

What the service did to meet the requirement

Examination of a selection of fluid and food charts across all units showed these were incorrectly completed. By the end of the inspection all staff had received Themed supervision about chart completion. The timescale for completion of this requirement had not expired at the time of inspection and it will be carried forward under new legislation the Public Services Reform (Scotland)Act 2010 to allow the provider time to fully implement the requirement.
This requirement had not been met. See Theme 1, Quality Statement 1.3 for more detailed information.

The requirement is: Not Met

The requirement

Following other regulatory activity this requirement was made
The provider must ensure that residents' care is delivered at all times in a way which preserves their dignity. In order to achieve this staff, staff must ensure that residents are appropriately dressed at all times.
This is in order to comply with SSI 2002 No 114:4(1)(b) - a requirement to provide services which respect the privacy and dignity of service users.
Timescale for implementation: within 24 hours of receipt of this letter.

What the service did to meet the requirement

We saw that residents were appropriately dressed. This requirement had been met.

The requirement is: Met

The requirement

following other regulatory activity the following requirement was made
The provider must ensure that residents' choice is promoted especially in relation to all aspects of meals.
In order to achieve this, the manager must ensure that all staff:
a) ensure that all residents are offered the choice of meals and drinks that are available
b) ensure that if a resident does not eat their meal they are always offered an alternative
c) ensure enough food is always available to accommodate residents' choice at all meals
d) are reminded of SSSC codes of practice and carry out good practice in relation to offering choice.
This is in order to comply with SSI 202/114 Regulation 4(1)(a)(b) - Welfare of users and takes account of the National Care Standards, Care Homes for Older People, Standard 13 - Eating well and Standard 8 - Making choices
Timescales: to commence within 24 of receipt of this report and to be completed by the 15 March 2011.

What the service did to meet the requirement

In the unit concerned we saw that the dining experience for residents had improved. We saw that all residents were offered a choice of drinks and the meals that were available. Alternative meals were offered if a resident did not like or did not eat the meal provided. There was enough food to offer alternative meal choices or extra food at meal times. All staff had been issued with the SSSC codes of practice and the codes were discussed as a standing item during staff hand-overs. This requirement had been met.

The requirement is: Met

The requirement

Following other regulatory activity the following requirement was made
The provider must ensure that there are sufficient stocks of wipes, gloves and continence products at all times. Continence products must be provided as identified in the individual residents care plan. The product must be the correct size and named as belonging to the individual resident. They should be available in the resident's room. This is to comply with the Regulation of Care (Scotland) Act 2002 Scottish Statutory Instruments (SSI) 114, 4.1(a) - make proper provision for the health and safety of the service users.
Timescale: by 31 December 2010.

What the service did to meet the requirement

We saw that there were sufficient stocks of all the above equipment. Continence aids were available in residents room. We were told that the service still ran out of continence products because the service did not receive enough stock from the continence department. The provider was in discussion with the continence department about the budget allocated to the service. This requirement had been met.

The requirement is: Met

The requirement

Following other regulatory activities this requirement was made
It is required that the Provider ensures that proper provision is made to ensure that service users' personal care needs are met. Residents' preferences for bathing/showering should be clearly recorded in their care plans and given in accordance with the plan - this is to comply with SSI 114. 4.1(a) make proper provision for the health and safety of the service users.
Timescale: by 31 December 2010.

What the service did to meet the requirement

As previously stated the provider was in the process of reassessing all residents care needs and rewriting all personal/care plans to reflect all aspects of residents' care needs and preferences. This had not been completed for all residents at the time of inspection. This requirement will be incorporated into the amended requirement about care plans which is made under new legislation the Public Services Reform (Scotland)Act 2010 in Theme 1, Quality Statement 1.3
This requirement had not been fully met

This requirement is: Not Met

Requirement
Following other regulatory activity this requirement was made

It is required that the Provider, where it is identified that there is a concern about tissue viability, must regularly review the resident care plan to ensure that the pressure relieving equipment is appropriate and reflects the current needs of the resident. Where it is identified that alternative equipment is required this must be provided. This is to comply with: SSI 114 12 (b)- provide such other equipment for the general use of service users as is suitable and sufficient having regard to the health and personal needs.
Timescale: Within 7 days of receipt of this letter.
Action taken on Requirement
A selection of equipment including mattresses had been hired and bought as a result of residents identified need. This requirement had been met.

This requirement is: Met

Requirement
Following other regulatory activity this requirement was made
The Provider must ensure that personal plans identify all of a service user's individual and specific needs, and demonstrate how all of those needs are to be met, specifically needs in relation to communication, social and leisure interests, culture and religious beliefs, nutrition, continence management and challenging behaviour. In order to do this, the Provider must:
* ensure that all staff are aware of the service's policies regarding assessment, person centred care planning, and meeting residents' spiritual and cultural needs.
* ensure that all staff who carry out assessments and plan care are trained in the use of the service's assessment tools.
* ensure that all staff who are involved in planning and delivering care are trained in person centred care
* ensure that care is planned in a way which minimises any identified risks, through a process of risk assessment
This is in order to comply with SSI 2002/114 Reg 2 - a regulation regarding principles of choice and independence, Reg 5(1) and Reg 5(2) - regulations regarding personal plans.
It is also in accordance with the National Care Standards Care Homes for Older People Standard 6 - Support Arrangements, Standard 7.1 - Moving In, Standard 8.1 - Making Choices, Standard 9 - Feeling Safe and Secure, Standard 12 - Lifestyle, Social, Cultural and Religious Belief or Faith, Standard 18 - Keeping in Touch, and the Scottish Social Services Council (SSSC) Code of Practice for Social Service Workers Sections 1.1, 1.2, 1.6, 4.2 and 6.1.Time scale - 4 weeks
Action taken on Requirement
All staff involved in devising personal plans/care plans had received training in implementing the provider's assessment, care plan and risk assessment process. This requirement had been met.
This requirement is: Met

Requirement

Following other regulatory activity this requirement was made
The Provider must ensure that the views of the resident and, where appropriate, their relative or representative are taken into account when planning care. Documentation within the personal plan must evidence that the resident's or relative's views have been sought, and taken into account in the way care is planned.
This is in order to comply with SSI 2002/114 Reg 5(2) - a regulation regarding personal plans.
It is also in accordance with the National Care Standards Care Homes for Older People Standard 6 - Support Arrangements, Standard 18.4 - Staying in Touch.
Timescale 4 weeks

Action taken on requirement
The provider was in the process of implementing this requirement. As previously stated the provider is currently reassessing all residents' needs and rewriting personal plans/care plans along with the resident or their representative. Because this has not been fully completed this requirement had not been fully met. However a similar requirement was made following other regulatory activities and the timescale for that requirement had not expired. The outstanding aspects of this requirement will be incorporated under new legislation the Public Services Reform (Scotland)Act 20 into requirement 1 of Theme 1, Quality Statement 1.1 to allow the service time to fully implement the requirement.
We will assess this requirement as met.

This requirement is:Met

Requirement
Following other regulatory activity this requirement was made.
The Provider must ensure that all staff working in the service are suitably trained for the work they are to perform. In order to do this, the Provider must ensure that all staff have received up to date training in adult support and protection and managing challenging behaviour.
This is in order to comply with SSI 2002/114 Reg 4(1)(a) - a regulation regarding the health and welfare of service users, and 13(c)(i) - a regulation regarding staffing.
It is also in accordance with the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing Arrangements, the SSSC Code of Practice fro Employers Sections 1.4, 1.5, 2.2, 3.1, 3.2, 4.3, and the SSSC Code of Practice for Social Service Workers Sections 3.2, 4.2, 4.3, 6.1, 6.8.
Timescale 12 weeks
Action taken on requirement
The staff training record matrix showed that training was outstanding for some staff. The manager was able to confirm that the training matrix was not up to date and confirmed which staff had received the training. There was a small number of identified staff who were due to receive the training in the first week of May 2011 which would complete this requirement. This requirement had been met.
This requirement is: Met

Requirement
Following other regulatory activities this requirement was made
The Provider must ensure that staff are aware of and fully implement the service's own complaint's policy.
This is in order to comply with SSI 2002/114 Reg 25(3) and 25(4) - regulations regarding complaints
This is also in accordance with the National Care Standards Care Homes for Older People Standard 5.1 and 5.2 - Management and Staffing Arrangements, and the SSSC Code of Practice for Social Service Workers Section 3.7 timescale 1 week

Action taken on the requirement
We saw one instance where staff did not fully implement the complaints procedure. While some staff who spoke with us could describe the complaints process others were less knowledgeable. This is discussed in more detail in Theme 4, Quality Statement 4.4.
This requirement is not met.

The requirement is: Not Met

What the service has done to meet any recommendations we made at our last inspection

Following other regulatory activity the following recommendation was made
The Provider should review the systems in use for sharing information to ensure that at all time, staff working in the service have the necessary information to enable them to meet individual resident's needs.
This is in accordance with the National Care Standards, Care Homes for Older People Standard 5.4 - Management and Staffing Arrangements, and the SSSC Codes of Practice for Employers Sections 1.4 and 2.2
Action taken on this recommendation
There was evidence that the service continually reviewed and amended methods of sharing information to ensure residents needs were met.
This recommendation had been implemented.

Recommendation
Following other regulatory activity this recommendation was made
The Provider should ensure that all staff working in the service are aware of the service's policy on visiting.
This is in accordance with the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing, Standard 16.4 - Private Life, Standard 17.4 - Daily Life, And the SSSC Code of Practice for Social Service Workers Sections 1.1 and 1.2.
Action taken on the recommendation

The manager stated that all staff had been reminded about the visitors' policy through Themed supervisions. However as examination of records showed all staff had not received supervision sessions we concluded that all staff could not have been reminded. We will make this recommendation again under Theme 3, Quality Statement 3.3.
This recommendation had not been implemented.

Recommendation
Following other regulatory activity this recommendation was made
The Provider should remind all staff of the importance of accurately recording the involvement of relatives and other representatives in planning and evaluating residents' care.
This is in accordance with the National Care Standards, Care Homes for Older People Standard 5.1
Action taken
This had been addressed as part of the care plan training provided to staff who were involved in devising and assessing residents care. Staff who spoke with us could describe the importance of recording relative involvement. This recommendation had been implemented.

Recommendation
Following other regulatory activity this recommendation was made
The Provider should review the procedures in place for managing incidents or emergencies in the Home, and ensure that all senior staff are aware of the procedures to follow in such an event.
This is in accordance with the National Care Standards, Care Homes for Older People Standard 5 - Management and Staffing Arrangements, and the SSSC Code of Practice for Employers Section 1.4.
Action taken on the recommendation
The manager stated that all registered nurses had received Themed supervision on how to manage incidents this year. However the Themed supervising matrix viewed during the inspection did not record this.
Collated information had to be forwarded to us which confirmed all staff had been made aware of the procedures.
This recommendation had been implemented.

The annual return

Every year all care services must complete an 'annual return' form to make sure the information we hold is up to date. We also use annual returns to decide how we will inspect the service.

Annual Return Received: Yes - Electronic

Comments on Self Assessment

Every year all care services must complete a 'self assessment' form telling us how their service is performing. We check to make sure this assessment is accurate.

We received a fully completed self assessment document from the service manager. We were satisfied with the way the service manager had completed this and with the relevant information they had given us for each of the headings that we grade them under.

The service provider identified what they thought they did well, some areas for development and any changes they planned.

Taking the views of people using the care service into account

Prior to the inspection we issued fifty Care Standards Questionnaires to the service and 14 residents completed and returned these to us.
From the content of questionnaires we saw that those who returned the questionnaires were satisfied with the service provided. They felt staff treated them with respect and were polite. They felt staff had the knowledge and skills to meet their care needs and that staff would access specialist help such as GPs if needed. They felt their privacy was respected and their property cared for.

We also saw that:

- four disagreed that the service sought their views about how it could improve the service
- one felt it was not applicable for the service to seek their reviews on how to improve the service
- seven felt there were not enough trained and skilled staff on duty to meet their needs
- one disagreed that they were encouraged to discuss any views about the service with their keyworker
- one did not know if the service was free from bullying
- five did not know if they had a written agreement about their occupancy rights
- one disagreed that staff helped them keep in touch with family/friends
- six were not aware of the services complaints procedure
- seven were not aware they could complain to us
- one disagreed that staff knew their likes and dislikes

We also spent time in each unit in the company of all residents and we spoke individually with 16 residents. Every resident who spoke with us said they were satisfied with the service.

Direct comment from residents and questionnaires included:
"Staff are nice and I enjoy living here"
"I like it"
"I hate it, don't like them (staff), nothing good" (the resident's views were more positive the following day)
"Nothing to do here, we don't get out to do things"
"Dentures are not cleaned often enough"
"The activities are a bit samey. I would appreciate if someone would read out what activities are on."

Residents' comments are reflected in the report.

Taking carers' views into account

Prior to the inspection we issued forty Care Standard Questionnaires to the service and eleven relatives completed and returned these. Ten were satisfied with the service and one was dissatisfied. Ten felt staff were respectful and polite, had the knowledge and skills needed to meet their relatives care needs and would access specialist help such as GPs if needed. Ten felt their relatives privacy was respected and their property cared for. The content of Care Standard Questionnaires showed that:

- two disagreed that the service provided the type of food their relative liked
- one did not know if their relatives likes and dislikes were detailed in the personal plan.
- one did not know if staff knew their relatives likes/dislikes
- three disagreed there were enough trained and skilled staff on duty to meet their relatives needs
- one did not know if their relative had a keyworker who coordinated all aspects of care
- one did not know if the keyworker made sure their relative know all choices that were available for their care
- two disagreed that meals were nutritious
- two did not know if their relative had a written agreement about their occupancy rights
- two stated their relative did not have a personal plan or care plan
- three disagreed the home was clean
- one disagreed that their relatives personal belongings were cared for
- one disagreed that staff had the knowledge and skills to meet their relatives needs
- one disagreed that the service would meet their relatives health needs
- one disagreed that the service would ensure their relative could access specialist services outwith the home

Direct comments from relatives included
"more care should be taken with false teeth"
"my XXX receives consistently good care. Management is approachable, listen to concerns and suggestions. The housekeepers do an excellent job and activity staff try to provide a variety of activities. The standard of food is inconsistent with some meals tempting and others overcooked."
"the staff have worked hard to identify my xxx needs, ie food, pain and this has been amazing for everyone involved."
"the staff, carers and nurses, are very attentive, kind and considerate and work very hard. A very good care home in every respect."
"they need a lot more trained staff and more cleaners."
"constantly changing staff so there is no continuity of care."
"staff are friendly and efficient and always have time to answer any questions. Residents should always have at least water within reach."
"home tends to smell a bit from time to time. Home could do with some redecoration"
"communication could be better. I often get conflicting information or staff who don't know what is happening."

One relative who spoke with us described situations where clothes were missing or other residents were seen wearing their relatives clothing.
Another relative while stating that staff were polite and pleasant stated some staff came on duty with "hangovers" and talked openly about this.
One relative while satisfied with the service felt their concerns about aspects of their relatives care were not always taken seriously. Another felt the management of falls could be improved.
Five relatives who spoke with us were positive about the care provided and staff approach.
Relatives comments are reflected in the report.

3 The inspection

We looked at how the service performs against the following quality themes and statements. Here are the details of what we found.

Quality Theme 1: Quality of Care and Support

Overall grade awarded for this theme: 3 - Adequate

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Service strengths

We saw that there were good systems in place to encourage residents and relatives to participate in assessing and improving the quality of the care and support provided.

The provider had a participation strategy which outlined their commitment to resident and relative involvement in developing the service. Staff were made aware of the customer service policy and the participation strategy during their induction to the service.

A number of methods were available to enable residents and relatives to express their views of the service. These included: residents' and relatives' meetings and focus groups, care reviews, individual meetings, suggestion boxes, newsletters and verbal comments. There was a participation group where the manager met with relatives to discuss how the quality of service could develop.

All residents were issued with a contract which detailed the terms and conditions of the service. All residents received a Welcome Pack which provided information about aspects of the service.

Residents had identified staff called keyworkers who were responsible for coordinating their care and with whom the resident could discuss any care issues.

There was a quality assurance system and residents, relatives, staff and other stakeholders were sent annual satisfaction surveys to allow them to express their views about the quality of the service. The outcome from the surveys and resulting actions was shared with residents, relatives and staff. The most recent survey of 2010 showed satisfaction levels had increased from the previous year of 2009.

Comments and suggestion cards were available at the main administration block and

in each of the four units. There was a complaint procedure which contained the Social Care and Social Work Improvement Scotland contact details. The procedure was displayed in each unit.

We saw that during residents/relatives meetings all aspects of the service were discussed including changes to staff, staff work practice and how to improve the quality of the service.

As a result of consultation one relative has expressed interest in developing a relative support group and another relative had become involved in producing the service newsletter. Resident consultation had resulted in changes to the menu and activity programme. We saw that residents were consulted regarding paint colours and new furniture in the units. Residents had been consulted about how funds should be spent across the units and this had resulted in the garden being redesigned, the development of a dementia cafe and a pamper room. One unit had employed a hostess to assist with the serving of meals and other aspects such as ensuring wardrobes were tidy.

Areas for improvement

The manager identified in the self assessment document that they were currently developing a dementia mapping tool to establish the views of residents who found it more difficult to express their views because they were living with dementia.

We saw that relatives meetings had not been consistently held across all units because of changes to personnel. In one unit meetings had not taken place since October 2010 although the meetings had recommenced in April 2011. From the minutes we saw that relatives were pleased the meetings had restarted. We saw that all unit managers had set future meeting dates and were told they had agreed the frequency of the meetings and that all relatives would receive copies of the meeting minutes.

From the fourteen resident Care Standard Questionnaires returned to us prior to the inspection we saw that four residents disagreed that their views of the service were sought. One resident disagreed that they were encouraged to share their views of the service with their keyworker or management. Five residents did not know if they had a written agreement detailing the occupancy agreement.
From the eleven relative Care Standard Questionnaires returned to us prior to the inspection we saw that one relative did not know if the resident had a keyworker who coordinated the care or if the key worker made sure the resident knew all the choices available to them. The manager agreed to continue to discuss these aspects during residents and relative meetings. We will make a recommendation that the service continues to develop the participation strategy.

Following other regulatory activity a requirement was made that the service must evidence relative and resident involvement in devising care plans. We saw that the

service was in the process of redeveloping all plans and we were told that residents and relatives would be asked to sign agreement on these. The timescale for completion of this requirement had not expired at the time of inspection. The requirement was made under the Regulation of Care (Scotland) Act 2001 SSI 2002/114 and is carried forward using the new legislation the Public Services Reform (Scotland) Act 2010 SSI 2011/210 to allow the service time to implement the requirement.(see requirement 1)

Grade awarded for this statement: 4 - Good

Number of requirements: 1

Number of recommendations: 1

Requirements

1. The Provider must ensure that the views of the resident and, where appropriate, their relative or representative are taken into account when planning care. In order to achieve this the Provider must ensure that:
   * documentation within the personal plan must evidence that the resident's or relatives views have been sought, taken into account in the way care is planned and that all parties have signed their agreement to the plan of care
   * that the service records when and in what circumstances relatives and carers will be contacted
   * all staff are reminded of the importance of accurately recording the involvement of relatives and other representatives in planning and evaluating residents' care.
   This is in order to comply with SSI 2011/210 Reg 5 - a regulation regarding personal plans; the National Care Standards Care Homes for Older People Standard 6 - Support Arrangements should be taken into account when complying with this Requirement.
   Timescale for implementation: to commence within 24 hours of receipt of this letter and be completed by 30/06/2011.

Recommendations

1. It is recommended that the provider continues to develop the participation strategy to ensure that methods are in place to enable all residents and relatives to assess the quality of the service including quality of care, quality of environment, quality of staffing and quality of management. All staff should continue to receive training in how to deliver the participation strategy. The strategy should be developed to take account of the cognitive abilities of all residents.
   This is in order to meet the National Care Standards, Care Homes for Older People, Standard 11- Expressing your views

Statement 2

We enable service users to make individual choices and ensure that every service user can be supported to achieve their potential.

Service strengths

We found that there were adequate systems in place to enable residents to make individual choices and ensure that they could be supported to reach their potential.

We saw that residents were able to move freely around the building, use the garden and meet privately with visitors. We saw that staff made visitors welcome. Residents told us that special days such as birthdays were celebrated and we saw this happen during the inspection. Contacts with the local community had been further developed and we saw that children from the local nursery visited from time to time. Some residents also attended activities in local community facilities. Residents spiritual needs are supported by local churches who visited the service. Staff supported residents to vote in elections. Residents could chose to deposit small sums of money with staff for safe keeping and were given information about how to access this.

Residents told us they could personalise their rooms, could have a key to their bedroom and could lock the door if they chose. Residents told us that they could choose to have their meals served in their bedrooms or in the dining room. We saw that staff offered residents choice during meal times and gave them time to reach a decision.

There were four activity coordinators who organised structured activities. We saw that an activity programme was displayed in each unit and offered a range of activities, including: games clubs, sing along, balloon exercise and gentle exercises. We saw the activity programme had gradually improved and now contained more entertainment and outings. We saw that residents could opt into these activities. We saw activities in three units - games and balloon exercises and a birthday party.

We saw that personal plans/care plans were being rewritten in a more person centred way with the focus centred on residents likes and dislikes and promoting choice. We saw that the personal plans/care plans were also being revised to identify residents social and leisure interests and there was a "map of life" which detailed residents past and current interest. Staff who spoke to us demonstrated knowledge of residents likes and dislikes.

When we arrived at the service staff told residents who we were and encouraged them to share their experience of the service with us.

Areas for improvement

Examination of the map of life showed it was not signed by the resident or their representative to demonstrate their involvement and agreement with the content. This was identified in 2009 and the documentation was not amended. The manager told us this was because the documentation did not have a space for this information and stated residents agreement on the content would be obtained when the overall personal plan/care plans were reassessed. We made a requirement at the last inspection that personal plans be reviewed to ensure they detailed residents' social needs. Although this process had started it had not been completed for every resident. The requirement was made under the Regulation of Care (Scotland) Act 2001 SSI 2002/114 and is carried forward using the new legislation the Public Services Reform (Scotland) Act 2010 SSI 2011/210 and the timescale reviewed to allow the provider time to complete the work.(see requirement 1)

Care staff we spoke with in two units could not tell us what activities were available to the residents on those days, although they could say when the activity coordinators would be present in the unit. Discussion with and observation of care staff and the activity coordinators showed that they did not work together in a unified way to get the best outcomes from activities for the residents. We saw that due to work load care staff did not engage in activities with residents and there was little social interaction, contact was seen to be task associated. Staff told us they did not have a lot of time to spend socially with residents but they did their best.
Residents told us staff were always busy. Some residents and some staff told us they felt there was not enough activities/stimulation for all residents.

We saw there were long periods outwith organised activities when residents had no stimulation, other than a television which was on but the majority of residents did not watch. The activity programmes notices viewed did not state the exact times of the activities only if it was a morning or afternoon event. This would make it difficult for residents to plan their day or for staff to remind residents of activity times. One resident told us they did not always know what activity was on and it would be helpful if someone read out what activities were on.
The majority of activities took place in the sitting area although there were plenty of other rooms which could have been used and would have allowed residents a change of environment, aided mobility and reduced noise level for other residents. One activity took place at a dining table while staff were trying to set tables for meals, albeit this did not appear to cause problems for residents or staff. (recommendation 1)

We found that when residents chose to deposit money with staff for safe keeping there was no written procedure to allow residents to access their money outwith office hours. While we accept that residents were made aware of restricted access before depositing money and staff told us they would get access to the money in an

emergency, it would be best practice to have a written procedure to cover emergency situations. (see recommendation 2)

During meal times we saw that in one unit residents had to wait a long time between courses. In two units following meals residents sat for long periods before being offered the opportunity to move to more comfortable chairs but were not offered the choice. During lunch in one unit we saw that five residents sat in wheelchairs and two of them told us they would prefer to sit in dining chairs. While we saw that staff tried to respond quickly to residents requests for assistance we saw one instance where a resident waited 15 minutes for staff to take them back to their room. The clinical services manager told us that they would continue to review how meals were served in that particular unit and how quickly staff responded to residents calls for assistance in general. The manager told us they would continue to reinforce the importance of offering residents the choice of sitting in dining chairs rather than wheelchairs and moving to comfortable chairs after meals. (see requirement 2)

Following other regulatory activity a recommendation was made that all staff be reminded of the service's visitor policy. The manager stated that all staff had been reminded about the visitors' policy through Themed supervision sessions. As Themed supervision had not been concluded for all staff we will make this recommendation again. (see recommendation 3)

Grade awarded for this statement: 3 - Adequate

Number of requirements: 2

Number of recommendations: 3

Requirements

1. The provider must review residents' personal plans to ensure they identify the social needs of residents and demonstrate how these social needs will be met.
   This is in order to comply with SSI 2011/210 Regulation 5 - Personal plans.
   This also takes into account National Care Standards, Care Homes for Older People, Standard 17- Daily Life, Standard 6 - Support arrangement and Standard 8.1 - Making choices
   Timescales: 30 June 2011

2. The provider must ensure that the residents are treated with dignity and that their choices are promoted at all times. In order to do so the manager must ensure that:
   a) all residents are offered the choice of sitting on a dining chair during mealtimes
   b)following meals staff should offer all residents the opportunity to move away from the dining table within a reasonable period of time
   c) review how meals are served in one unit to make sure the times between courses is not excessive
   This is in order to comply with SSI 2011/210 Regulation 3 - Principles

Timescales: to commence within 24 hours of receipt of this report and be implemented by the 30 June 2011

Recommendations

1. It is recommended that the provider review how activities are advertised to ensure residents, relatives and staff know the times of the activities and can plan their day. The location of activities should continue to be reviewed to ensure the most appropriate location is used and that residents enjoy a change of environment. This is in order to meet the National Care Standards, Care Homes for Older People, Standard 12 - Lifestyle
2. It is recommended that the provider devise a written procedure which staff should follow in the event that outside office hours a resident wishes to access fund which they have deposited for safe keeping with the service.
   This is in order to meet the National Care Standards, Care Homes for Older People, Standard 5, Management and staffing arrangements.
3. The Provider should ensure that all staff working in the service are aware of the service's policy on visiting.
   This is in accordance with the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing, Standard 16.4 - Private Life, Standard 17.4 - Daily Life and the SSSC Code of Practice for Social Service Workers Sections 1.1 and 1.2.

Statement 3

We ensure that service user's health and wellbeing needs are met.

Service strengths

We found that there were adequate methods to ensure that residents' health and well being needs were met.

On arrival at the service we saw that residents were clean and tidy and appropriately dressed. We saw that residents clothing was changed if it became soiled. We saw that staff tried to responded to residents care needs promptly and reported health care issues to the registered nurse. The service operated a named worker system which meant that each resident had a designated person called a keyworker to discuss their care with. Staff could tell us which residents they were keyworker to.

We looked at a total of eleven residents' files. All residents had a care plan based on assessed need and contained information about residents' health and well being. Individual case tracking and discussion with staff and relatives showed us there was regular contact with a range of healthcare professionals including general practitioners, podiatrist, dietitian and community psychiatric and district nurses. The dementia care coordinator held regular surgeries at the service to provide best practice guidance and advice to staff.

We saw that staff were reassessing all residents care needs and rewriting the personal plan/care plans to ensure these accurately reflected the residents care needs. Residents and/or their representatives were involved in the process.

Examination of residents' files showed there were risk assessments for nutrition, manual handling, falls, continence and behaviour management and a system for pain management.

Staff on duty could explain residents' health care needs and could tell us which residents were on fluid charts and soft diets or needed assistance to eat meals. Throughout the inspection we saw that staff ensured all residents had a plentiful supply of drinks. Smoothies and fresh fruit were offered in all units. Staff assisted residents to eat their meals and residents were not rushed. There was a plentiful supply of all food which allowed residents to change their mind about food choices without staff having to contact the kitchen for additional supplies. Food portions sizes were good and the food was well presented. We saw that designated staff were appointed to attend to residents who were having meals in their rooms. We saw that staff reminded and supported residents to attend the toilet. Staff were seen to be respectful, patient and gentle in their approach to residents.

The staff group had a variety of appropriate qualifications to meet residents' healthcare needs. Examination of the staff rota showed that a registered nurse was on duty in each unit at all times. One unit now had two registered nurses on day and evening duty because this had been assessed as necessary..

Examination of documentation, discussion with staff, residents and relatives showed the service had taken into consideration the National Care Standard, Care Home for Older People, Standard 14, Keeping well - healthcare.

Areas for improvement

We were told that staff would be given protected time to complete residents reassessment and devising new care plans and we will monitor this at the next inspection.

We made requirements at the last inspection and following other regulatory activity about the content of care plans. The requirements were made under the Regulation of Care (Scotland) Act 2001 SSI 2002/114 and is carried forward using the new legislation the Public Services Reform (Scotland) Act 2010 SSI 2011/210 because the timescale for completion of the requirement had not expired at the time of inspection. We will carry an amended requirement forward to include additional aspects and allow the provider time to implement the requirement fully. We sampled resident's' files to assess progress on the requirement. While we accept that new care plans and assessments were in the process of being implemented for all residents we still saw conflicting information contained within care plans, which

regardless of whether plans were being rewritten could cause discrepancies in care provision. For example we saw one instance where instructions from another healthcare professional given during a review about using behaviour charts was not implemented. We saw behaviour charts were not consistently used and the information contained in these did not correspond with information in daily records or staff handover sheets. The regularity of weights needed to be addressed with some personal plans recording weights to be taken weekly but were in fact taken monthly. By the end of the inspection the clinical services manager had reviewed nutritional care plans to ensure the regularity of weights linked directly with the nutritional assessment tool in use. We were told that residents' signatures on all documents to evidence their participation in devising all aspects of their plans would be obtained during care reviews when the content of plans would be discussed. (requirement 1)

In one unit we examined a therapeutic mattresses and saw that although the mattress was working the dial setting was broken. We and the registered nurse present were unable to identify what the setting was and as such could not establish if the setting was suitable for the resident's care. We were unable to establish how long the dial had been broken although the expectation was that damaged or broken equipment would be reported immediately for repair by the person identifying this. The registered nurses on duty were not aware the dial was broken as this had not been reported as such. The registered nurse reported it for repair by the end of the inspection. This is addressed in Theme 3, Quality Statement 3.3. (see requirement 1)

We examined a sample of toothbrushes and saw in two units that three brushes were dirty. In one unit the toothbrush was lying on top of a wardrobe shelf and had to be accessed by sliding our hand along the shelf until contact was made. This was despite the fact that a toiletry basket was on the shelf. Staff stated the residents' oral hygiene had been attended to that morning in which case we concluded the brushes could not have been cleaned after use. This is discussed in Theme 3, Quality Statement 3.3. (see requirement 2)

While we saw that residents were offered and given regular fluids throughout our time at the service, we also saw that fluid balance charts were not correctly completed in any unit. The total inputs were not consistently recorded. In one instance only 200ml was recorded as the fluid intake for the day. On another chart it looked as if a resident had no fluids between 12.30pm and 20.30pm. We also noted instances where staff completed charts at the same time and its difficult to understand how the records could be accurate if competed some time after the fluids were drank. We saw similar problems with the recording of food charts. One personal plan/care plan identified a resident as having a fluid chart but on questioning staff we found this was no longer the case and charts had been discontinued. We saw that personal plans/care plan evaluations did not take account of the information contained on fluid balance charts and its difficult to understand how the care could be properly evaluated with out considering the content of these.

The manager stated that she was working with staff in how to effectively evaluate care plans. Following other regulatory activity we made a requirement about the completion of charts and staff training in the completion of these. By the end of this inspection all staff has received a Themed Supervision about how to complete food and fluid charts and the purpose of these. The clinical services managers had reassessed the use of fluid and food charts in all units to ensure that if used that these were necessary. The regularity of weights had also been reviewed to ensure it linked directly with the nutritional assessment tool in use. While we have taken account of this work we were unable to assess fully if this had improved the completion of charts. (see requirement 3)

In one unit while we saw that staff followed good practice and completed incident sheets if unexplained bruising was seen on a resident there was less evidence that staff routinely recorded the outcome of the investigation into how the bruises occurred. (see requirement 4)

The services own audits identified shortfalls in the management of falls, wounds and medication. This is discussed in Theme 4, Quality Statement 4.4.

One relative felt that there was a lack of continuity of care because of changes to staff teams and that sometimes conflicting information was given about health care. The manager was working with staff to improve communication.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 4

Number of recommendations: 0

Requirements

1. The provider must ensure that the content of all personal plans provides clear guidance for staff to enable the appropriate and up to date care to be given to service users.
   In order to achieve this the manager must:
   a)ensure personal plans accurately reflect all aspects of service users' needs including nutrition, communication, continence, behaviour, pain, memory, anxiety, sleep, personal hygiene including oral hygiene and all aids which are used such as hoists and pressure relieving aids
   b)residents' preferences for bathing/showering should be clearly recorded in their care plans and given in accordance with the plan
   c)ensure guidance from healthcare professionals and agreements reached during reviews of care are accurately incorporated into personal plans
   d) ensure information resulting from incidents and accidents is reflected in assessments and care plans
   e) ensure all staff follow the instructions contained within the personal plans
   f) ensure information about Power of Attorney is easily accessed.

g) ensure that where a plan of care has been amended or revised as a result of changing care needs that the resident's carer or representative is informed.
h) ensure that management have oversight of the systems that are in place to ensure that staff actually deliver the planned care.
This is in order to comply with SSI 2011/210 Regulation 5- Personal plans
This also takes into account National Care Standards Care Homes for Older People Standard 6.3 Support Arrangements and Standard 14 -Keeping well-healthcare.
Timescales: By the 30 June 2011

2. The provider must ensure that all oral hygiene equipment is cleaned and appropriately stored at all times.
This is in order to comply with SSI 2011/210 Regulation 4(1)(a) - Welfare of users
Timescales: to commence within 24 hours of receipt of this report for completion by the 30 June 2011

3. The Provider must ensure that all staff who complete observation charts such as fluid and food intake and weight charts do so consistently and accurately. Staff must evaluate the charts and plan care accordingly, seeking appropriate healthcare professionals advice when required.
This is in order to comply with SSI 2011/210 Regulation 4(1)(a) - Welfare of users and takes account of The National Care Standards Care Homes for Older People Standard 5 - Management and staffing arrangements Timescale for implementation: to commence within 24 hours of receipt of this report and be completed by 30/6/2011

4. The provider must evidence that the causes of all unexplained bruises identified on residents bodies are investigated and the outcomes recorded. The provider must be able to evidence that staff are aware of the procedures to be followed in the event that unexplained bruising is found.
This is in order to comply with SSI 2011/210 Regulation 4(1)(a) - Welfare of users
Timescales: within 48 hours of receipt of this report

Quality Theme 2: Quality of Environment

Grade awarded for this theme: 4 - Good

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the environment within the service.

Service strengths

We found that there were good methods in place to ensure that residents and relatives were involved in assessing and improving the quality of the environment. In addition to the strengths detailed in Theme 1, Quality Statement 1.1 we saw that residents were consulted about changes to the environment, paint colours and furnishing.

As a result of consultation we saw that the garden was being redesigned and in one unit a pamper room was being developed.

Areas for improvement

We have made a recommendation under Theme 1, Quality Statement 1.1 that they continue to develop the participation strategy.

Grade awarded for this statement: 4 - Good

Number of requirements: 0

Number of recommendations: 0

Statement 2

We make sure that the environment is safe and service users are protected.

Service strengths

We found there were good systems in place to ensure that the environment was safe and residents were protected.

On arrival at the service we saw that the building was clean and comfortably furnished and there were no obstructions. Residents told us the environment was pleasant and comfortable. The garden area was well maintained and secure.

Equipment used by residents and staff had undergone Portable Appliance Testing (PAT) as legally required. There were maintenance contracts for gas appliances and equipment such as manual handling hoists. The service was subject to Environmental Health checks. There was a selection of equipment such as hoists, stand-aids and

slings which were safely stored.

A keypad access system was used in all units to help building security and all visitors were asked to sign the visitor book to ensure staff knew who was in the building at any time.

There was a selection of policies and procedures to maintain residents' safety including, infection control, management of medication, adult protection, whistle blowing and risk management.

Record keeping systems were in place to record all accidents, incidents and complaints. We saw that incidents were reported as legally required to the police and social services. We saw that internal investigations were carried out when significant incidents occurred, sometimes resulting in staff disciplinary or dismissal. All staff had received adult protection training and had received copies of the whistle blowing policy.

A system was in place for audits of medication and environment and were regularly carried out.

Each unit had a unit manager in post who reported on a daily basis to the service manager.

Some relatives felt there were not enough staff. We saw that the manager carried out a resident dependency assessment at least monthly to ensure the staff hours available met residents direct care needs. The manager was aware that the dependency assessment must be reviewed when residents needs changed. As a result of the outcome from the dependency assessment the staffing levels had been increased in one unit. We considered the staffing rota and reached the conclusion that the service maintained the minimum staffing schedule agreed with us.

We saw that equipment such as hoists and wheelchairs were clean. We saw staff follow infection control procedures. Call bells were appropriately connected and could be reach by residents when they were in bed.

When giving residents hot drinks we saw that staff placed these onto occasional tables next to residents to ensure their safety.

There was a plentiful supply of disposable gloves, wipes and aprons in all units and these were easily accessible to staff.

Areas for improvement

We saw that two therapeutic chairs were burst, although the manager had sourced a company willing to repair these beginning the week of the 10 May 2011. We will monitor progress.

We saw that in some residents bedrooms the soap dishes were dirty. Pedal bins were not available in all bathrooms. While equipment such as hoists were clean and staff could describe the cleaning rota we saw the cleaning rota was not completed. There were no thermometer in the fridges in three unit kitchens. (see requirement 1)

We saw that prescribed creams held in residents' bedrooms were not always named or have the date of opening recorded. Examination of medication procedures showed that the controlled drug book index page was not correctly used. Staff sample signatures were not in place for all current staff. Some needles sampled had passed the expired date. Staff had not signed for all administered medication. Staff had altered the doses of medication on the medication recording sheet. Staff had made one handwritten prescription entry on the medication recording sheet with handwritten dates of administration which did not correspond with the preprinted dates already in place at the top of the page. The total amount of tablets recorded for one medication did not correspond with the amount in stock. (see requirement 2)

We noted a strong mal odour in two units although this was not present later. We saw that some bedroom drawers and wardrobes were untidy and in one there was excessive stock of leg bags. In one unit the locks of several bedroom doors were difficult to open and the manager stated that over sixty new locks were on order. We will continue to monitor this at future inspection.

One relative felt the decoration could be improved. Two relatives told us that there were times when staff were not always present in the lounge areas because they were on their breaks or assisting other residents. We did not witness this during our inspection. We will monitor this at future inspections.

Grade awarded for this statement: 4 - Good

Number of requirements: 2

Number of recommendations: 0

Requirements

1. The provider must ensure that the environment and equipment in use by residents is safe. In order to do so the provider must
   a) devise a system to ensure all soap dishes are cleaned.
   b)ensure pedal bins are available in all bathrooms
   d) ensure thermometers are in use in unit fridges
   e)ensure the cleaning rotas are signed when tasks are completed
   This is in order to comply with SSI 2011/210 Regulation 4(1)(a) - welfare of users and SSI 2011/210 Regulation 10(2)(a) - Fitness of premises
   Timescale: to commence within 24 hours of receipt of this report and be completed by the 30 June 2011

2. The provider must ensure that medication management in the service is carried out in line with best practice guidance. In order to do so the manager must:
   a)ensure that the controlled drug index page is used correctly
   b)ensure that all staff involved in the management of medication provide a sample signature in accordance with the services own procedure
   c)ensure that all topical creams stored in residents' rooms are clearly labeled with the residents name and
   clearly record the date that the topical cream was opened
   d)carry out a stock control audit to ensure out of date equipment is removed from the premises and the number of tablets recorded correspond with those in stock
   e) ensure that staff sign for all medication administered
   f)ensure that if staff alter the medication recording record they date and sign this and record who authorised the change.
   This is in order to comply with SSI 2011/210 Regulation 4(1)(a) - welfare of users and SSI 2002/114 Regulation 19(3)(j) - records
   Timescale: to commence within 24 hours of receipt of this report and be completed by the 30 June 2011

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 4 - Good

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of staffing in the service.

Service Strengths

We saw that a number of good methods were used to ensure that residents and relatives participated in assessing and improving the quality of staffing in the service. In addition to the strengths identified in Theme 1 Quality Statement 1.1 we saw that the services own Satisfaction Survey asked direct questions about the quality of staff skills.

During care reviews those in attendance are asked their views of all aspects of the service provision including the quality of staffing and management.

Changes to staff personnel within units were discussed at residents meetings. We saw that residents and relatives were encouraged to nominate staff who they felt delivered a good service.

Some information about staff training was provided in the service newsletter and relatives and relatives were offered the opportunity to attend the training sessions.

The staff recruitment policy supports resident involvement in the staff recruitment process.

Areas for improvement

We sampled six files of the most recently recruited staff. We saw that no residents had been involved in the recruitment process and there was no record that residents had been offered the opportunity to be involved.

In the self assessment document the manager identified that an area for improvement would be to develop a method of involving residents and relatives in staff and management supervision and appraisal.

We have made a recommendation under Theme 1, Quality Statement 1.1 that the service continues to develop the participation strategy.

Grade awarded for this statement: 4 - Good

Number of requirements: 0

Number of recommendations: 0

Statement 2

We are confident that our staff have been recruited, and inducted, in a safe and robust manner to protect service users and staff.

Service strengths

We found there were very good systems in place to ensure that staff were recruited and inducted in a safe and robust manner.

We found the provider had a Staff Recruitment policy and procedure which was examined in detail during the inspection year 2009/10. The content of the policy was not reviewed at this inspection. The focus of this inspection was the recruitment process and to this end we examined six files of the most recently employed staff. While interviews were carried out at the service the recruitment process was overseen by the Human Resources Department.

We found that the processes for staff recruitment included;

- the use of an application form which was signed by the applicant,
- uptake of two references, one from the current or most recent employer,
- additional references sought where initial references proved unsatisfactory,
- a declaration of health fitness by applicants,
- enhanced disclosure /protection of vulnerable group checks as well a systems for action to be taken in the event of unsatisfactory disclosure checks,
- rechecking of disclosures for all staff,
- professional register checks,
- evidence of skills, values and experience, including qualifications,
- checking evidence of entitlement to work in this country,
- a formal recorded induction to the service,
- the manager told us the recruitment procedure had been amended to ensure that no staff would be employed before a positive Protection of Vulnerable Groups (PVG) was received.

New staff received a week long induction before working with residents during which they received all mandatory training. A new staff member could describe the induction process to us and they felt the content was comprehensive and useful. They felt fellow workers had been supportive.

From staff and examination of documentation we found that the service had taken account of the National Care Standards, Care Homes for People Older People, Standard 5 -Management and staffing arrangements.

Areas for improvement

All sections of the interview recording tool were not consistently completed. Some interview records did not record all those present on the interview panel and in some

instances it appeared that only one person undertook the interview. The manager stated that a minimum of two people were on the interview panel and could provide their names. By the completion of the inspection the manager had obtained the provider's agreement to amend the documentation. The manager agreed to forward a copy to us on receipt of this report.

Grade awarded for this statement: 5 - Very Good

Number of requirements: 0

Number of recommendations: 0

Statement 3

We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Service strengths

We found there were adequate systems in place to ensure a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

There was a selection of policies and procedures including whistle blowing, adult protection and infection control. A learning and development policy was in place and all staff had a training file and copies of certificates were held there.

We saw that a training needs analysis had been completed and a yearly training plan devised. A training matrix was available and showed which mandatory training staff had received and when refresher courses were due. Mandatory training included moving and handling, infection control, adult support and protection and personal best/customer services. There was also another training matrix which recorded additional training attended such as wound management.

New staff received a week long induction to the service during which they received all mandatory training. A new staff member could describe the induction process to us and they felt the content was comprehensive and useful. They felt fellow workers had been supportive.

There were identified dementia awareness and challenging behaviour champions who delivered staff training to staff in these areas. We saw from training records that dementia awareness and challenging behaviour training was gradually being delivered to all staff.

The manager was registered with the Nursing and Midwifery Council. A training programme was in place to assist staff to gain the necessary qualifications to register with the Scottish Social Services Council (SSSC). Senior carers were either registered or in the process of registering with the SSSC. We were told that the provider's

Human Resources Department was overseeing the registration of other grades of care staff. All staff had been issued with the SSSC codes of practice and these had recently been introduced as a standing agenda item for discussion at staff hand overs to increase staff understating of the codes.

We saw that unit managers worked directly with registered nurses and care staff. We were told that this allowed staff practice to be monitored. Monthly staff meetings had been planed in the diary from April 2011 for the remainder of this year. We were told these meetings were one method of promoting best practice and expected standards of care.

We observed staff practice and saw that staff carried out appropriate moving and handling techniques and infection control procedures. We saw that staff were respectful in manner and polite to residents and mostly responded quickly and discreetly to requests for assistance. Staff could explain residents care needs. From discussion with staff it was clear they were eager to improve their work practice and the overall quality of the service.

The content of Care Standard Questionnaires returned to us before the inspection showed residents thought staff were respectful and polite to them and had the skills and knowledge to meet their needs.

From staff and examination of documentation we found that the service had taken account of the National Care Standards, Care Homes for People Older People, Standard 5 -Management and staffing arrangements.

Areas for improvement

The manager was aware that aspects of staff practice needed to continue to improve and a restructuring of the management team had taken place to help achieve this. One unit now had two unit managers to increase management presence over seven days and there were two registered nurses on duty each day to increase the monitoring of work practice/improve practice. Two clinical service managers were in now in post and we were told they would work directly with unit managers and staff to improve practice. Unit managers and registered nurses would now have the responsibility of carrying out staff supervision and monitor staff practice. One unit manager told us they felt this would be the most beneficial approach as any staff practice issues could be dealt with immediately. All unit managers received 12 hours each week supernumerary time to deal with managerial issues and they confirmed they received this.

The manager told us that the regularity of staff meetings and supervisions had been affected because of changes in personnel but now that vacant posts had been filled this should no longer be a problem. The appointment of an additional clinical services managers had allowed Themed supervisions to be carried out with all staff.

While we saw that staff meetings had taken place in April 2011 and were projected in the diary for the remainder of this year, we saw that prior to this date staff meetings had not been consistently held across all units. We saw that in some cases the last staff meetings had taken place in October 2010. (see recommendation 1)

We saw staff supervision records which showed all staff had not received regular planned supervision. Although the provider's expectation was that each staff member would receive a minimum of six supervision sessions a year we saw that some staff had not received this. Themed supervision where the session focus was on practice issues such as managing complaints, hand-washing, completion of charts had not been provided consistently to all staff, although by the end of this inspection all staff had received this. The themed supervision matrix completed for 2011 which we saw only recorded two staff as receiving themed supervisions. However an updated matrix which contained the dates of the most recent sessions was forwarded to us and showed that by the end of the inspection all staff had received this. Supervision records which we viewed showed a lack of follow up when work practice issues were identified and agreements reached about the regularity of supervision were not always maintained. There was less evidence of positive aspects of work practice being discussed or of support being offered when staff encountered difficulty, albeit this may be related to recording skills. It was difficult to assess how regularly staff received supervising without an overview of the dates supervision was provided for the whole staff team. This overview was not available. From staff files we saw that all staff had not received an annual staff appraisal in accordance with the provider's own policy. (see recommendation 1)

Supervision documentation was difficult to follow because the unit and name of supervisor were not identified and in some cases the signatures were illegible. The clinical services manager had identified this as an issue and planned to amend the documentation. (see recommendation 2)

There was no evidence that all staff delivering supervision had received training in how to implement the provider's supervision methods. We were told this training was to be provided.(see requirement 1)

There were training matrix to record both mandatory and additional training such as continence management. The mandatory training record matrix only recorded training received this year making it difficult for us to establish when staff had initially received the mandatory training or when refresher courses were due, although there was an automatic "flag up" system when refresher courses were due. We saw the matrix was not always updated when training was provided to staff. We were told that some initial teething problems had been experienced with the new recording system. The clinical services manager told us that updating information should improve with less time lapses in updating information now that there were two people updating the information. We saw that staff did not always sign as attending training sessions and it was not always clear if all those recorded

as present at the sessions were from this service or another service owned by the provider. Notices advertising training session did not always include the year making it difficult to track when the training was provided without looking at individual training records. (see recommendation 3)

Staff practice did not always evidence that leaning from training had been put into practice. This was reflected in the management of medication, completion of fluid charts, knowledge of managing concerns and complaints, reporting defective equipment, use of dirty toothbrushes all of which are discussed in more detail in Theme 1 and Theme 2 of this report. The provider's own audits identified shortfalls in relation to the management of wounds, falls and medication. (see requirement 1) See Theme 1 Quality Statement 1.3 and Theme 4, Quality Statement 4.4.

At the last inspection we were told that falls management training would commence in January 2011 but this had been rearranged for June 2011 because care plan training took precedence. From training records we saw that medication awareness training was outstanding for some staff. Some staff had attended wound management training and future training was planned. (see requirement 1)

Following other regulatory activity a recommendation was made that staff be reminded of the visitor policy. All staff had not received Themed supervision in this. (see recommendation 4)

Two relatives who spoke with us felt communication between staff and relatives could be improved and gave examples where staff could not provide requested information or gave conflicting information. One relative described situations where staff all sat together at a dining table writing up records meaning they were not observing residents or engaging with them. We did not see this during the inspection. We will continue to monitor this at future inspection.

One relative commented that some staff came to work with "hangovers" and openly discussed this. The relative questioned if the staff concerned were fit to be at work. The manager agreed to discuss this with staff and was firm that this was unacceptable practice.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 1

Number of recommendations: 4

Requirements

1. The Provider must ensure that all staff working in the service are suitably trained for the work they are to perform. In order to do this, the Provider must provide us with a training plan which includes:

a) supervising training for supervisors
b) oral hygiene including the maintenance and storage of equipment such as toothbrushes
d) reporting repairs
e) falls management training
f) medication awareness refresher training
This is in order to comply with SSI 2011/210 Regulation 15(b)(i) - Staffing and takes into consideration the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing arrangements
Timescale: A copy of the training plan must be provided to us by the 30 June 2011

Recommendations

1. The provider should ensure that staff meetings and one to one supervisions take place in accordance with the provider's own policies and procedures.
   This is order to meet the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing arrangements
2. The provider should amend the supervision recording documentation to clearly identify who the supervisor is and the unit where those involved are based.
   This is order to meet the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing arrangements
3. The provider should be able to evidence that all staff working in the service are suitably trained for the work they are to perform and should ensure the training matrix is updated promptly to give an accurate overview of all training received by all staff. All staff should sign training attendance records and clearly identify which service they work in. The training advertisements/notices should detail the year the training is provided in order that training provisions can be tracked.
   This is in order to meet the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing arrangements
4. The Provider should ensure that all staff working in the service are aware of the service's policy on visiting.
   This is in accordance with the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing, Standard 16.4 - Private Life, Standard 17.4 - Daily Life, And the SSSC Code of Practice for Social Service Workers Sections 1.1 and 1.2.

Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 3 - Adequate

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service.

Service strengths

We saw that there were a number of good methods in place to ensure that residents and relatives could participate in assessing and improving the quality of the management and leadership of the service.
In addition to the strengths identified in Theme 1, Quality Statement 1.1 the manager told us that the participation strategy was reviewed every three years by Board members. Residents were offered the opportunity to participate in the annual "Self Assessment Day " to discuss and assess the future direction of the service.

Areas for improvement

The manager identified that more suitable dates and times for relatives meetings needed to be considered in order to maximise attendance. We will monitor progress at the next inspection.

From Care Standards Questionnaires returned to us we saw that six residents were not aware of the services complaints procedure and seven did not know they could complain to us. The manager should continue to raise residents awareness of the complaint procedure during meetings and within the newsletter.

We have made a recommendation under Theme 1, Quality Statement 1.1 that the service continues to develop their participation strategy.

Grade awarded for this statement: 4 - Good

Number of requirements: 0

Number of recommendations: 0

Statement 4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Service strengths

We saw that there were adequate quality assurance systems and processes in place which involved residents and relatives in assessing the quality of the service.

The provider had attained the Investors in People Award.

We saw that satisfaction surveys were carried out to establish residents views of the service provision and the findings from surveys were shared with stakeholders. We saw that the most recent survey carried out in 2010 showed an increased satisfaction level on the previous year of 2009.

The service had a sophisticated Quality Assurance System that monitored all aspects of the service. All audits were readily available to us throughout the inspection.

Designated staff were responsible for certain aspects of quality assurance audits and they could describe their responsibilities.

Maintenance audits were in place for all equipment including wheelchairs, hoists, bed-rails, window restraints, lighting, call bells, furniture and water temperatures.

The Clinical Nurse Managers were responsible for clinical audits which included falls audits, medication audits and wound management audits.

The chef visited each unit on a daily basis to discuss menus with residents and audit the quality of the service.

The manager visited the units each day to monitor work practice and speak with residents, visitors and staff.

The complaint procedure was displayed on the notice board and each resident was issued with a copy. A system was in place to record all complaints and concerns. Copies of concern forms were held in each unit and some staff told us they must complete and forward these to the manager if anyone raises a concerns or a complaint.

The manager was aware of her responsibility to inform Social Care and Social Work Improvement Scotland and Scottish Social Service Council of stipulated events.

Areas for improvement

From examination of incidents and accidents we saw that we had not been notified of certain events since December 2010, although Social Services had. Prior to December 2010 we had been notified appropriately. In discussion with the manager it transpired that around that date she believed we no longer needed to be advised of events if Social Services were notified. Clarification was given and the manager agreed to recommence notifications. (see requirement 1)

We saw one instance where a relative raised concerns about care aspects several times with different staff. While these concerns were noted in the residents file, a concerns form was not completed or forwarded to the manager, even although the

issues had not been resolved. From discussion with the relative it was clear they felt they were raising a concern and it was not being addressed or taken seriously. While some staff had a clear knowledge of the complaints procedure and the need to complete concern forms other staff were less knowledgeable so leading to inconsistency across the units in how concerns were addressed. Themed supervision about the management of complaints had taken place with some staff but was not consistent across all staff. By the end of the inspection all staff had received this but we were unable to assess the impact of this. Following other regulatory activity we had made a requirement that all staff be aware of and fully implement the complaints procedure. We will make this again under new legislation the Public Services Reform (Scotland)Act 20. (see requirement 2)

While clinical audits were completed and issues highlighted there was less evidence that the identified action plan resulted in improved outcomes. For example the medication audit of the 28/3/11 rated performance at 90% and identified that all medication recording sheets were not signed, medication stock for one resident did not match and all staff had not received medication refresher training, but we could find no action plan to address the issues.

Similarly the wound management audit on the 18/3/11 the compliance rate was 87% but we saw no action plan to improve performance. The nutritional management audit of the 17/2/11 set a target date for the 24/2/11 to address the action identified but there was no record to say if the target was achieved.

We saw that the services own audits identified similar clinical practice issues during their audits as we have identified during this inspection. The manager advised us that the service had recognised this was an issue and this was one of the reasons that the service had been restructured and an additional Clinical Services Manager was employed. This would allow the responsibilities of auditing and following up of clinical practice issues to be shared and be more manageable leading to improved outcomes. (see recommendation 1)

The maintenance audit documentation would benefit from having a space for the responsible persons signature. We will monitor this at future inspections.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 2

Number of recommendations: 1

Requirements

1. The provider must ensure that all staff are familiar with and implement the procedure devised to notify Social Care and Social Work Improvement Scotland of specified events.

This is in order to comply with SSI 2002/114 Regulation 21 - Notifications and SSI 2011/210 4(1)(a) - Welfare of users Timescale - to commence within 24 hours of receipt of this report.

2. The Provider must ensure that all staff are aware of and fully implement the service's own complaint's policy. This is in order to comply with SSI 2011/210 Regulation 18 - regulations regarding complaints
   This is also in accordance with the National Care Standards Care Homes for Older People Standard 5.1 and 5.2 - Management and Staffing Arrangements, and the SSSC Code of Practice for Social Service Workers Section 3.7
   Timescale: to commence within one week of receipt of this report and be completed by 30 June 2011.

Recommendations

1. The provider should continue to develop the quality assurance system to ensure that all aspects of the service particularly clinical practice is improved. Where required action has been identified as a result of an audit, the outcome should be clearly recorded to monitor improvement or if further action is needed.
   This is in order to meet the National Care Standards Care Homes for Older People, Standard 5, Management and Staffing Arrangements.

4 Other information

Complaints

Four complaints have been upheld, or partially upheld, since the last inspection.

Enforcements

We have taken no enforcement action against this care service since the last inspection.

Additional Information

No additional information was identified during this inspection.

Action Plan

Failure to submit an appropriate action plan within the required timescale, including any agreed extension, where requirements and recommendations have been made, will result in SCSWIS re-grading the Quality Statement within the Management and Leadership Theme as unsatisfactory (1). This will result in the Quality Theme for Management and Leadership being re-graded as Unsatisfactory (1).

5 Summary of grades

Quality of Care and Support - 3 - Adequate	
Statement 1	4 - Good
Statement 2	3 - Adequate
Statement 3	3 - Adequate
Quality of Environment - 4 - Good	
Statement 1	4 - Good
Statement 2	4 - Good
Quality of Staffing - 4 - Good	
Statement 1	4 - Good
Statement 2	5 - Very Good
Statement 3	3 - Adequate
Quality of Management and Leadership - 3 - Adequate	
Statement 1	4 - Good
Statement 4	3 - Adequate

6 Inspection and grading history

Date	Type	Gradings	
17 Jan 2011	Re-grade	Care and support Environment Staffing Management and Leadership	2 - Weak Not Assessed Not Assessed Not Assessed
1 Nov 2010	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate Not Assessed 4 - Good Not Assessed
13 May 2010	Announced	Care and support	3 - Adequate

		Environment Staffing Management and Leadership	4 - Good 4 - Good 4 - Good
26 Jan 2010	Unannounced	Care and support Environment Staffing Management and Leadership	2 - Weak 2 - Weak 2 - Weak 3 - Adequate
10 Nov 2009	Announced	Care and support Environment Staffing Management and Leadership	2 - Weak 2 - Weak 2 - Weak 2 - Weak
18 Mar 2009	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good 4 - Good 4 - Good 4 - Good
18 Feb 2009		Care and support Environment Staffing Management and Leadership	4 - Good 4 - Good 4 - Good 4 - Good

All inspections and grades before 1 April 2011 are those reported by the former regulator of care services, the Care Commission.

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অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے۔

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