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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

Andrea Herkes

Type of inspection: Unannounced

Inspection completed on: 20 February 2012

Contents

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	3	Adequate
Quality of Staffing	3	Adequate
Quality of Management and Leadership	3	Adequate

What the service does well

As stated in previous reports, the service is provided in a comfortable environment. Staff are polite and respectful toward residents and make visitors welcome. A more person centred approach toward service delivery continues to be developed. Residents and relatives continue to be offered opportunities to participate in assessing and improving the quality of the service.

What the service could do better

In order to improve the service, staff need to show more awareness of the importance and purpose of recording charts and these need to be accurately completed. The content of care plans must continue to be developed. The evaluation of the effectiveness of care plans needs to be improved and consideration needs to be given to pertinent information such as the content of charts. Pressure relieving mattresses need to be accurately set. Staff need to show awareness of resident safety and not complete safety/location charts before the residents safety has been confirmed. All incidents need to be recorded and investigated. Further work is needed in improving staff practice and the activities available to residents.
Residents' belongings should be recorded as soon as possible after admission. Documentation which is no longer in use should be disposed off to stop the wrong paperwork being used by mistake. The new format for recording the agreed action following meetings should be consistently used in all units.

What the service has done since the last inspection

Since the last inspection the staff have worked hard in meeting the requirements and recommendations made at previous inspections and progress is detailed in the report. Progress included the following. The general cleanliness of the building and equipment had improved. The storage and cleanliness of oral hygiene equipment had also improved. The manager had completed a review of the dependency levels of residents who live in the Turnhouse unit to ensure the available staff hours met their direct care needs. Staff training in medication management had taken place. The management of medication had been reviewed and a new system introduced. A local policy had been developed to direct staff should residents wish access to their deposited funds outwith office hours. The manager had discussed the visitor policy with staff to ensure their understanding of this. Supervision documentation had been amended to include the supervisors name and unit name. We saw improvement in how residents' dignity and privacy was protected because photographs of residents wounds were now stored in accordance with the providers direction and net pants were labelled for individual use. The content of residents' care plans continued to be developed. We had been provided with a copy of the staff training plan and we saw that the training plan was being implemented.

Conclusion

As stated in previous reports, staff are eager to improve the service and are working with us to that end. As also previously stated, because of changes to unit managers and clinical service managers, developing the service will be slower and it may be more difficult to sustain improvement than it would be with a more stable management team. Strategies have been implemented to try and compensate for the personnel changes in management. The manager is aware of the areas for improvement and is fully supported by the provider.

Who did this inspection

Rose Bradley
Andrea Herkes

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 the Care Inspectorate 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 3 - Adequate
Quality of Staffing - Grade 3 - Adequate
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 the report after an unannounced inspection that took place at the service on the 17 and 19 January 2012. A concluding visit took place on the 20 February 2012. The inspection was carried out by Care Inspectorate Inspectors Rose Bradley, Michelle Deans and Andrea Herkes.

Care Inspectorate Pharmacy Adviser, David Marshall, carried out part of the inspection in relation to medication on the 17 January and the 20 February 2012. This was in part to follow up on the one requirement relating to medication outstanding from the previous inspection. The progress in meeting this requirement is detailed under Quality Theme 2, Statement 2.

During this inspection we spent time mainly in three units - Turnhouse, Caerketton and Allermuir. We gathered evidence from various sources, including the relevant sections of policies, procedures, records and other documentation including evidence from:

- The service's action plan to address issues from the last inspection
- A sample of residents' personal plans/care plans
- Minutes of staff meetings
- Complaint, accident and incident records
- Activities programme
- Observation of staff practice
- Observation of staff interaction with residents and fellow workers
- Observation of meal times including lunch and morning and afternoon teas
- Examination of the environment and equipment
- Examination of medication management, storage, facilities, record keeping and practice
- Consideration of residents' and relatives' comments
- Consideration of the National Care Standards, Care Homes for Older People

Discussion with various people including:

the manager
clinical services manager
some registered nurses who were on duty
some care workers who were on duty
an activity coordinator
some residents individually
some relatives individually
The outcomes of the inspection were discussed with the manager, a manager from another service and a clinical services manager on the 19 January 2012.
Following the concluding day of this inspection on the 20 February 2012 further discussion took place with the manager, a manager from another service, a clinical services manager and unit manager.

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 ensure that the content of all personal plans provides clear guidance for staff to enable 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 the settings for pressure relieving aids such as active mattresses
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 for oral hygiene contained within the personal plans
e) ensure body mass index are correctly calculated
f) ensure that management have oversight of the systems that are in place to ensure that staff actually deliver the planned care
g) ensure all overdue care reviews are completed
h) review how care reviews are recorded to ensure there is a full record of discussion and agreements
i) ensure all care plans and care reviews evidence residents or their relatives involvement such as signatures.
This is in order to comply with SSI 2011/210 Regulation 5- Personal plans, Regulation 4(1)(a) Welfare of 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 December 2011

What the service did to meet the requirement

Progress continues to be made in improving the content of care plans. Aspects d, f, g and i have been met. An amended requirement with timescales will be made under Quality Theme 1, Statement 3.
The requirement was partially met

The requirement is: Not Met

The requirement

The provider must ensure that staff can demonstrate how they will meet residents' social needs which are recorded in their personal plans.
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 October 2011

What the service did to meet the requirement

Further work is needed to meet this requirement. This is discussed under Quality Theme 1, Statement 2.
The requirement was not met.

The requirement is: Not Met

The requirement

The provider must ensure that residents' privacy is protected at all times. In order to do so the provider must ensure that:
a) all photographs of wounds must be stored in accordance with the provider's own procedures
b) staff do not leave recording charts in public areas.
This is in order to comply with SSI 2011/210 Regulation 4(1)(b) - Welfare of users Timescale: to commence within 24 hours of receipt of this report and be completed within 7 days

What the service did to meet the requirement

We examined the storage of photographs of wounds in two units (Carnethy and Allermuir) and saw these were stored in accordance with the provider's own procedures. We did not see any charts containing resident information in the public areas. We saw no examples of recording charts in public areas.
The requirement had been met.

The requirement is: Met

The requirement

The provider must ensure that the manager completes a review of the residents dependency assessment in the Turnhouse unit to ensure that the available staff hours meets residents assessed direct care needs.
This is in order to meet the SSI 2011/210 Regulation 15(a) - Staffing Timescale: 30 November 2011

What the service did to meet the requirement

The manager had completed the review and this was documented. We looked at the resident dependency assessment which the manager completes at least monthly to ensure the available staff hours met residents assessed direct care needs. This assessment showed that the available staff hours met the residents assessed direct care needs. We saw no evidence that the staffing arrangement in the service did not meet the needs of the current client group during our inspection.
The requirement had been met.

The requirement is: Met

The requirement

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
c)falls management training
d) medication awareness refresher training
e) the plan must detail the dates of the training and who will attend
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 October 2011

What the service did to meet the requirement

We were provided with the action plan which included all of the above. During the inspection we saw that the training plan was being implemented.
The requirement had been met.

The requirement is: Met

The requirement

The provider must ensure that the environment and equipment in use by residents is safe. In order to do so the manager must
a)ensure all soap dishes and toiletry baskets are clean
b) ensure paper towels are available in all areas
c)ensure that residents bedrooms are clean including widow sills, over tables, drawers and hand-basins.
b)ensure that all cleaning rotas are in place and 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 October 2011

What the service did to meet the requirement

We inspected the environment in three units - Turnhouse, Allermuir and Caerketton. We saw that all soap dishes and toiletry baskets were clean and paper towels were available in all areas. Residents rooms were clean, including window sills, over tables, drawers and hand basins. Cleaning rotas were in place and were signed when tasks were completed.
The requirement had been met.

The requirement is: Met

The requirement

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) following meals staff must offer all residents the opportunity to move away from the dining table within a reasonable period of time
b) review how meals are served in Turnhouse unit to make sure the times between courses is not excessive c) that staff properly position residents who are eating their meal while in bed
d) staff always offer vegetables if available with the main course
e) assess staff competency in assisting residents to eat their meals while in bed. The outcome of this must be recorded.
This is in order to comply with SSI 2011/210 Regulation 3 - Principles and Regulation 4(1)(a) - Welfare of users Timescales: to commence within 24 hours of receipt of this report and be implemented for points a) - d) by 14 October 2011 and for point e) by 30 December 2011

What the service did to meet the requirement

We saw a staff member assist a resident who was eating their meal while in bed. The resident was properly positioned. Staff competency in assisting residents who were eating meals while in bed had been assessed. This was documented and signed by all concerned. We saw that vegetables were offered with all meals when available. There was a plentiful supply of all food. Meal time audits had been carried out in Turnhouse unit and the length of time between courses was one of the areas monitored and no issues had been identified. During our visit we observed one meal in Turnhouse and although there was some delay between courses it was not excessive. On the whole residents were offered the opportunity to move away from the table within a reasonable period of time.
The requirement had been met.

The requirement is: Met

The requirement

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 topical creams stored in residents' rooms are clearly labeled with the residents name and clearly record the date that the topical cream was opened
c))carry out a stock control audit to ensure the number of tablets recorded correspond with those in stock
d) ensure that staff sign for all medication administered and the reason for non administration recorded
e)ensure that staff accurately record handwritten entries, record the date, sign this and record who authorised the change.
f) ensure only one box of the same medication is in use for the same resident at any time
g) ensure that stock medication is stored in line with the provider's expectation for example alphabetically
h) ensure medication audits are correctly completed and recorded
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 and takes account of RSPGB "The Handling of Medicines in Social Care"
Timescale: to commence within 24 hours of receipt of this report and be completed within 7 days

What the service did to meet the requirement

This requirement was inspected by Care Inspectorate Pharmacy Adviser, David Marshall, over two visits on the 17/1/12 and 20/2/12. During the first visit outstanding issues relating to this requirement were highlighted to the manager. At the second visit we saw that the service had made progress in addressing the outstanding elements of the requirement.
a) The Controlled Drugs register was used appropriately,
b) Creams and lotions that were stored in residents' room generally had a date of opening put on them.
c) On our second visit we saw there was a system in place where staff recorded the amount of certain medicines carried forward from the previous cycle, as well as a running balance throughout the cycle. Periodically this running balance was reconciled against actual stock level.
d) On our second visit we found an improvement in the recording/administration of medicines. We did not see many gaps in the administration of regular medicines. Where a medicine was not given as prescribed this was clearly annotated. We noted other improvements in recording of medicine, for example where a "when required" medicine was given the reason for use and outcome were often recorded on the back of the MAR chart.
e) we saw many examples on the MAR of handwritten entries/amendments which were signed by staff, dated and made reference to the prescriber responsible for the change.
f) staff did not have multiple boxes of the same medication open at the same time.
g) Medicines were stored in an organised/tidy manner.
h) We saw that medication audits completed daily.

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The requirement is met.

The requirement is: Met

The requirement

The Provider must ensure that all staff who complete observation charts such as repositioning and location charts do so consistently and accurately. Staff must evaluate the content of all charts including fluid and weights and plan care accordingly.
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 October 2011

What the service did to meet the requirement

We examined a sample of charts and saw that repositioning charts were accurately completed. However we saw an example where staff had signed a location chart (used to record that residents who are in their rooms for example are well at a particular time) that they had checked the residents safety/well being at 12.00 and 13.00 but it was only 11.25. The content of charts were still not evaluated in a way which would influence/direct the management of the residents care. An amended requirement with timescales will be made under Quality Theme 1, Statement 3
The requirement was partially met.

The requirement is: Not Met

The requirement

The provider must ensure that service users are treated with dignity and respect at all times. All net pants in use at the service must be individually named and for individual use only. This is in order to comply with the SSI 2011/210 Regulation, 4(1)(b) - Welfare of users
Timescale: To commence within 24 hours from receipt of this report and be completed within 7 days

What the service did to meet the requirement

We sample a selection of residents clothing in three units - Turnhouse, Caerketton and Allermuir and saw that unnamed net pants were not in use.
The requirement had been met.

Requirement
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 14 October 2011

What the service did to meet the requirement
We examined a sample of residents' rooms and saw that all oral hygiene equipment was clean and appropriately stored. There were signs that the equipment had been used.
The requirement had been met.

The requirement is: Met

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

Recommendation

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
What the service did to meet the recommendation
Staff had reviewed how activities were advertised. The times and location of activities were now on a weekly planner which was given to residents and also displayed on the notice board at the entrance to the units. The recommendation was implemented. However we found the planner difficult to use because the print was small and it was not easy to see the month and the date. We felt that if we had problems reading the document then other people may also experience this. We discuss this further under Quality Theme 1, Statement 2.
Recommendation

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 funds 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.
What the service did to meet the recommendation

A written local policy had been developed.
The recommendation had been implemented.

Recommendation

The manager should encourage staff to give consideration to how excessive noise levels can adversely affect residents' quality of life.
This is in order to meet the National Care Standards, Care Homes for Older People, Standard 5, Management and staffing arrangements.
What the service did to meet the recommendation

Discussions had taken place with staff around the keyworker role and dignity and both these included discussion around noise. These were recorded on the Stimulation, Background Assessment and Reconciliation form (SBAR). Audits had also been carried out in the units which had not identified excessive noise as an area for improvement. Discussion with the manager and clinical services manager showed they were aware this would be an ongoing issues and they will continue to monitor.
The recommendation had been implemented.

Recommendation

The manager should ensure that all residents receive the offer of morning tea or drink of their choice.
This is in order to meet the National Care Standards, Care Homes for Older People, Standard 8- Making choices
What the service did to meet the recommendation

We saw that morning drinks were served in all units. The staff allocation of task document detailed which staff was responsible for serving morning drinks. Staff could describe the process.
The recommendation had been implemented.

Recommendation

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

What the service did to meet the recommendation

We saw improvement in this area. The recommendation had been implemented.

Recommendation
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

What the service did to meet the recommendation

Supervision documentation had been amended.
The recommendation had been implemented.

Recommendation

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

What the service did to meet the recommendation

The staff have made progress toward implementing this recommendation. Because of the volume of information to be imputed onto the training record and the introduction of new systems this had taken the staff longer than they anticipated.
The recommendation will be made again under Quality Theme 3, Statement 3.

Recommendation

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.

What the service did to meet the recommendation

The manager had discussed the visitor policy with staff. Staff who spoke with us could explain the policy.
The recommendation had been implemented.

Recommendation
The service should ensure that relatives and significant others are fully involved in any changes of accommodation for their relative. In addition the service should seek agreement from relatives and significant others for any such change and document this.
National Care Standards Care Homes for Older People: Standard 5.1 Management and staffing arrangements; Standard 8.2 Making choices.

What the service did to meet the recommendation
We were shown an example which showed this recommendation had been implemented. The 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 did not ask the manager to provide a self assessment before this inspection. The manager completed a self assessment before the inspection of May 2011.

Taking the views of people using the care service into account

We saw most of the residents during the inspection and spoke with several about their experience of living at the service. All residents spoke positively about living here and how nice staff were to them.
Some residents felt there was a good range of activities available at the service and they could choose to opt in or out of these. However outwith these, some residents felt there was not a lot to do. (see Quality Theme 1, Statement 2)
Some residents felt that while staff were very nice and very kind, they were slow to respond to the call buzzers. (see Quality Theme 2, Statement 2)
From our observation we saw that residents were comfortable around staff who were respectful, polite and friendly in their approach.

Taking carers' views into account

Relatives who spoke with us were positive about the service provided. They felt staff were very helpful and caring. They felt communication was good and they were kept informed of all aspects of their relatives care. They were confident that healthcare needs would be met and felt their relatives were well looked after.

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

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

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports 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 purpose of this inspection was to focus on requirements made at the last inspection, but the strengths identified at the last inspections were still evident.

We saw that resident and relative meetings and care reviews continued to be held.

Areas for improvement

Following the last inspections we made one recommendation that the participation strategy continue to be developed. As this recommendation will be an ongoing process and because we did not follow up the progress of the recommendation at this inspection, we will make this recommendation again. (see recommendation 1)

Grade awarded for this statement: 4 - Good

Number of requirements: 0

Number of recommendations: 1

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

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports we found that the service was demonstrating adequate practice in areas covered by this Quality Statement.

The purpose of this inspection was to focus on requirements made at the inspections, but we saw that the strengths noted in the last inspection reports were still evident.

We made a recommendation at the last inspection that staff be encouraged to give consideration to how excessive noise levels can adversely affect residents' quality of life. At this inspection we found that discussions had taken place with staff around the keyworker role and dignity. Both these included discussion around noise. The discussions were recorded on the "Stimulation, Background Assessment and Reconciliation" form (SBAR). Audits had also been carried out in the units by the clinical service manager and these had not identified excessive noise as an area for improvement. Discussion with the manager and clinical services manager showed they were aware this would be an ongoing issue and they will continue to monitor this. The recommendation had been implemented.

We recommended that a written procedure be developed to guide staff in the event that outwith office hours a resident wished to access funds which they had deposited with staff for safe keeping. At this inspection we saw that a local procedure had been developed and implemented. The recommendation had been implemented.

We recommended that how activities were advertised should be reviewed. At this inspection we saw that staff had reviewed how activities were advertised. The times, date and location of activities were on a weekly planner which was given to residents and also displayed on the notice board at the entrance to the units. The recommendation had been implemented.

Following the inspections we made a requirement about residents' choices and meals. At this inspection we saw a staff member assist a resident who was eating their meal while in bed and the resident was properly positioned. Staff competency in assisting residents who were eating meals while in bed had been assessed. This was documented and signed by all concerned. We saw that when vegetables were available these were offered with all meals. There was a plentiful supply of all food. Staff had completed meal time audits in Turnhouse unit. The length of time between courses was one of the areas monitored and no issues had been identified. During our visit we observed one meal in Turnhouse and although there was some delay between courses it was not excessive. On the whole residents were offered the opportunity to move from the table within a reasonable period of time. The requirement had been met.

We observed lunches in all units and in general these were pleasant and well organised. The tables were nicely set with napkins and menus, residents were offered hand washing facilities before the meal, the food was nicely presented and residents were offered extra portions. Residents who sat in wheelchairs at dining tables told us this was their choice. We saw that new documentation had been developed to record residents' food preferences.

At the last inspection we made a requirement about the storage of wound photographs and charts containing residents information being in public areas. At this inspection we examined the storage of photographs of wounds in two units (Carnethy and Allermuir) and saw these were stored in accordance with the provider's own procedures. We did not see any charts containing resident information in public areas. The requirement had been met.

Following the last inspection we made a requirement that all net pants in use at the service must be individually named and for individual use only. At this inspection we sample a selection of residents clothing in three units - Turnhouse, Caerketton and Allermuir - and saw that unnamed net pants were not in use. The requirement had been met.

Areas for improvement

While staff had reviewed how activities were advertised, we found the planner difficult to follow. Because the print was small, it was not easy to see the month and the date. We felt that if we had problems identifying the information on the planner, then others may also experience this. The format of the planner would benefit from being reviewed. (see recommendation 1)

We made one requirement at the last inspection that staff demonstrate how they will meet residents' social needs. At this inspection we found that the issues remained mainly as stated in previous reports. Although there was some reference to activities in the care plans examined, there was no full evaluation of the effectiveness of activities and it was not always clear how the activities offered linked to residents' likes and hobbies. Outwith organised activities there was little stimulation for residents because care staff were occupied with direct care tasks. Some care staff were unable to tell us what activities were available on the inspection days which raised questions as to how they could support residents to attend formal activities. Some residents told us that there was not a lot to do outwith the organised activities, although they described these as very good and the activity coordinator as "worth every penny of her pay". We were told that the activities were being further developed along with changes in how activities were recorded and evaluated. (see requirement 1)

On the first inspection day we observed lunch in Turnhouse unit and saw that napkins and menus were not used. Clothes protectors were not offered to some residents until the meal was served. Additional clothes protectors were brought into the dining room while the meal was being served. Residents were given no explanation as to why there were no napkins, clothes protectors or menus. We were told that there was a shortage of cloth napkins but we saw that there was a plentiful supply of alternative equipment which could have been used had staff considered this. We were told that a resident health issue had affected the lunch routine. However we saw that the staff member who had been allocated the task of setting tables was available in the area during that time. We visited the dining room on the second day and saw that napkins and menus were in use. We will monitor progress at the next inspection.

We saw one situation in Turnhouse, where staff had offered a resident the choice of dining at the table or where they sat. The resident chose to move to the dining table. However another member of staff approached with an over-table and placed it in front of the resident who then said they would have the meal where they sat. We question how staff action inadvertently influenced choice on this occasion. We also saw staff speak to each other about care tasks within residents hearing. Staff awareness of both issues should be raised. (see recommendation 2)

Grade awarded for this statement: 3 - Adequate

Number of requirements: 1

Number of recommendations: 2

Requirements

1. The provider must ensure that staff can demonstrate how they will meet residents' social needs which are recorded in their personal plans.
   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 May 2012

Recommendations

1. It is recommended that the manager review the format for advertising the location, date and times of activities to ensure the size of print is suitable to be read by the service users.
   This is in order to meet the National Care Standards, Care Homes for Older People, Standard 8 - Making choices, Standard 12 - Lifestyle

2. It is recommended that the that the manager continues to raise staff awareness of how to offer residents choice without inadvertently influencing the outcome. Staff should be reminded not to speak about care task within residents hearing.
   This is in order to meet the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing arrangement and Standard 16 - Private life

Statement 3

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

Service strengths

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports we found that the service was demonstrating adequate practice in areas covered by this Quality Statement.

Following the last inspections we made a recommendation that all residents be offered morning drinks. At this inspection we saw that morning drinks were served in all units. The staff allocation of task document, detailed which staff member was responsible for serving morning drinks. Staff could describe the process. The recommendation had been implemented.

We made a requirement that all oral hygiene equipment be properly cleaned and stored. At this inspection we examined a sample of residents' rooms in three units - Turnhouse, Caerketton and Allermuir and saw that all oral hygiene equipment was clean and appropriately stored. There were signs that the equipment had been use. The requirement had been met.

At the last inspection we reported that Smile (a service which provides dental support, information and education) would provide training in oral care. Due to circumstances this had not taken place but we saw that in house training had taken place and we were provided with copies of the training pack. All staff had been assessed as competent in carrying out oral hygiene care and this was documented. Staff were following the instructions for oral care.

We made a requirement about care plans. We saw that some aspects of this requirement had been met. It was clear that efforts were being made to improve the information held about residents and ensure it was accurate. We saw that overdue care reviews had taken place. A system was now in place to ensure that these were held six monthly and this was double checked by the manager. As previously stated in this report, staff were following the instructions for oral care. Residents and/or relatives were signing their agreement to the content of care plans during reviews. There was evidence that the manager had an overview of the systems in place to ensure that staff delivered the appropriate care. The requirement is partially met. The outstanding issues are addressed under the areas for improvement section of this Statement where an amended requirement with timescales will be made.

We made a requirement at the last inspection about the completion and evaluation of observational charts. At this inspection we examined a sample of charts and saw that repositioning charts were accurately completed. The requirement is partially met. An amended requirement with timescales will be made under the areas for improvement section of this Statement to take account of outstanding and new issues.

Staff could describe residents healthcare needs and preferences. We saw staff give residents reassurance and respond to care needs discretely.

Areas for improvement

In Caerketton unit we saw one resident with long and dirty finger nails. The manager agreed to address this. We will monitor progress and nail care at the next inspection.

We made a requirement about care plans at the last inspection which was partially met. An amended requirement and timescale will be made to address the following areas. Care plans did not consistently record the settings for pressure relieving mattresses. Body mass index were not correctly calculated. Staff had already identified this as an issue and additional staff training was being provided. We still saw examples where incidents and discussions with relatives or other healthcare professionals did not influence the care plan or matters were not recorded if/when followed up. Some care plans did not give enough direction to staff in how to actually deliver the care. Examples of all of the above were given during feedback on the outcomes of the inspection. We were given a firm commitment to continue to improve the content of care plans. (see requirement 1)

We saw one instance where a resident sat in a wheelchair for over two hours. Staff could give no explanation for this although we were later told this was because the staff member was nervous when speaking with us. While we were told that residents sitting for long periods in wheelchairs is not normal practice, we have concerns about the comfort of sitting in wheelchairs and the effect on residents skin. The resident concerned skin was intact. (see requirement 1)

While following progress on a requirement about medication made at the last inspection, we saw the following. The MAR (medication administration recording) chart for one resident showed an anti-fungal cream was prescribed two to three times a day. On two occasions mid-cycle the cream had not been applied because the staff involved did not know where to apply it. Subsequently application instructions had been written on the MAR chart. We looked at the care plan for this resident but could see no plan on the use of the cream. Staff also told us they crushed a resident's oral medication to aid swallowing but we felt the information in the care plan was not clear. We also looked at another care plan for a resident which indicated that medicines could be given in disguised form (covertly), but again felt the information and evaluation of the plan could be more detailed and up to date. (see requirement 1.

This is requirement about care plans)

The daily medication audit highlighted that the morning medication round was lasting a long time. We discussed this with the manager and potential reasons for it. The service had identified this issue themselves and were looking at ways to address it. We will monitor this issue at future inspections.

We found two examples of eye drops used a few days beyond their expiry date. We will monitor this issue at future inspections.

During our first we saw examples of medication which was not given as prescribed and medication that was out of stock. While this was improved by the second visit, we will continue to monitor this at future inspections.

We made a requirement at the last inspection about the completion and evaluation of observational charts. The requirement is partially met because we saw an example where staff had signed a location chart (used to record that residents who are in their rooms for example are well at a particular time) to record that they had checked the residents safety/well being at 12.00 and 13.00 but it was only 11.25. This practice was also noted in the previous inspection report. The content of charts were still not evaluated in a way which would influence or direct the management of residents' care. An amended requirement and timescale will be made (see requirement 2)

We inspected pressure relieving mattresses and saw one instance in the Turnhouse unit where the mattress was not correctly set. The resident's skin was intact. (see requirement 3)

Grade awarded for this statement: 3 - Adequate

Number of requirements: 3

Number of recommendations: 0

Requirements

1. The provider must ensure that the content of all personal plans provides clear guidance for staff to enable 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 the settings for pressure relieving aids such as mattresses
   b)ensure guidance from healthcare professionals and agreements reached during reviews of care and discussions with relatives are accurately incorporated into personal plans
   c) ensure information resulting from incidents and accidents is reflected in assessments and care plans
   d) ensure body mass index are correctly calculated
   e) ensure the care plans contain enough information to direct staff in how to deliver all aspects of the care
   f) where appropriate, skin integrity assessment must take account of the effects of residents sitting for long period in wheelchairs
   g) care plans for medication must give clear instruction for the application of creams. If medication is administered in disguised form, clear direction about which medication is involved and administration details must be recorded. The effectiveness of the care plan must be evaluated taking account of how/if medication was administered.
   This is in order to comply with SSI 2011/210 Regulation 5- Personal plans, Regulation 4(1)(a) Welfare of 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 May 2012
2. The Provider must ensure that all staff who complete observation charts such as location charts do so consistently and accurately. Staff must evaluate the content of all charts including fluid and weights and plan care accordingly. Staff must not complete location chart before the checks have been completed.
   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 15 March 2012

3. The provider must ensure that all pressure relieving mattresses are set accurately.
   This is in order to comply with SSI 2011/210 Regulation 4(1)- Welfare of users
   Particularly Regulation 4(1)(a) - a provider must make proper provision for the health, welfare and safety of service users
   Timescale: to commence within 24 hours and for completion within 48 hours of receipt of this report.

Quality Theme 2: Quality of Environment

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 environment within the service.

Service strengths

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports we found that the service was demonstrating good practice in areas covered by this Quality Statement.

The purpose of this inspection was to focus on requirements made at the inspections, but we saw that the strengths noted in the last inspection reports were still evident.

As stated in the report of 30 September 2011, one recommendation had been made following other regulatory activity. Because we did not follow up the progress of recommendations at that inspection, we made the recommendation again. We monitored progress in addressing the recommendation at this inspection.
We had recommended that relatives were fully involved in any changes of accommodation for their relative and that agreement from relatives should be sought and recorded. We were shown an example which showed this recommendation had been implemented.

Areas for improvement

The recommendation and areas for development noted in Quality Theme 1 Statement 1 are relevant to this Statement.

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

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

At this inspection we found that the service was demonstrating adequate practice in areas covered by this Quality Statement.

The purpose of this inspection was to focus on requirements made at the previous inspections, but we saw that the strengths noted in the last inspection reports were still evident.

At the last inspection we made a requirement that the environment and equipment be safe. At this inspection we inspected the environment in three units - Turnhouse, Allermuir and Caerketton. We saw that all soap dishes, hairbrushes and toiletry baskets were clean and paper towels were available in all areas. Residents' rooms were clean and tidy including window sills, over tables, drawers and hand basins. Cleaning rotas were in place and were signed when tasks were completed. We noted a marked improvement in the overall cleanliness in all units. Staff told us they had been working hard to try to make the environment cleaner. The requirement had been met.

Following the last inspection we made a requirement that the manager review the residents' dependency level in the Turnhouse unit to ensure that staff availability met residents care needs. At this inspection we established that the manager had completed the review and this was documented. We looked at the resident dependency assessment which the manager completed at least monthly to ensure the available staff hours met residents assessed direct care needs. The assessment showed that the available staff hours met the residents assessed direct care needs. The staff rota had been changed and was now a combination of long and short days and we were told that this helped to increase care staff cover during staff breaks. A new allocation sheet had been developed to record when staff breaks were taken. During this inspection we saw no evidence that the staffing arrangement in the service did not meet the needs of the current client group. The requirement had been met.

The manager had also developed a tool called "Monthly Review Matrix" to try and ensure that the assessment made about a residents care needs was accurate. The matrix provided an overview of residents current care need and pertinent information. For example it recorded information such as falls, weight, infection, wounds, hospital admissions and the risk assessments that were in use. This allowed the manager to compare the information from the previous month and adjust the care dependency assessment accordingly. We saw one example in Turnhouse where an extra care staff member was on duty between 8pm and midnight for two weeks because of changes in a resident's care needs.

We made a requirement about medication at the last inspection which is met. This level of improvement must be sustained if this level of grade is to be maintained or improved. Additional medication issues are discussed under the areas for improvement section of this Statement and in Quality Theme 1, Statement 3.

Areas for improvement

At our first visit we were concerned to find in two units of the home (Turnhouse and Careketton) staff returning medication that was unopened, in date and still prescribed for residents. We think this was a response to previous excess ordering/supply of medication, and is a serious waste of resources that could be targeted elsewhere. The best practice document The Handling of Medicines in Social Care, 2007 states "Medicines are valuable and costly even though people who receive social care may not have to pay for them. All medicines returned to a supplier are destroyed. They cannot be used for anyone else. It is unacceptable to return unused medicine each month to the supplier and at the same time request more supplies". http://www.rpharms.com/support-pdfs/handlingmedsocialcare.pdf

On our second visit to the home we found evidence that staff were returning some medicines supplied in original packaging at the same time as receiving a new supply of the same medicine. We do not think this practice should continue. (see recommendation 1)

We saw a few examples where the dose of a medication was changed using the same MAR entry. We think that it is clearer that where a dose of an existing medicine is changed that a new entry be created. (see recommendation 2)

Additional issues identified while inspecting medication are discussed under Theme 1, Statement 3.

We examined samples of the staff allocation sheet and saw that the allocation of tasks and breaks were not consistently recorded in the Turnhouse unit. We were told this was because the new documentation had only recently been introduced. While cleaning rotas were completed we saw a combination of recording sheets in use in

Turnhouse unit. We were told that some of these were old documentation which should have been discarded. It would be beneficial if old documentation was discarded to minimise confusion. We will monitor this at the next inspection.

On examination of a resident's file we saw an entry where a relative had questioned missing property. An incident record was not completed and the manager was not aware of the incident. There was no follow up information in the resident's file about the action taken to address the relatives concern. (see requirement 1)

We examined the resident's property record and saw this had not been completed on admission to the service and only completed two days after the relative raised concerns. (see recommendation 3)

We saw one instance where a staff member had signed the location chart (used to record that residents who are in their rooms for example are well at a particular time) to record that they had checked the resident's safety/well being at 12.00 and 13.00 but it was only 11.25. This practice was also noted in the previous inspection report. The manager told us that the staff member had two additional contacts with the resident and signed for this but had not taken account of the pre-printed times they were signing against. This issue is incorporated into Requirement 2 made under Quality Theme 1, Statement 3.

One resident who spoke with us felt they waited a long time for staff to respond to call buzzers. We used the call buzzer and staff took ten minutes to respond. Staff explained they were busy. The system in use is that the buzzer activates a pager held by staff. Some staff did not have a pager because there are only four pagers for each unit. The pagers are allocated to the four staff at the start of the shift and they are responsible for answering all buzzers. It was less clear how the pager was managed if the staff member was busy for example assisting a resident with personal care. We were told that consideration was being given to upgrading or replacing the call system. (see requirement 2)

In Turnhouse

unit we saw one pressure relieving cushion which was burst. We saw that cushions had been ordered and we were told that the burst cushion would be replaced when these arrived. We will monitor progress at the next inspection.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 2

Number of recommendations: 3

Requirements

1. The provider must ensure that all incidents such as allegations of missing property are fully documented and investigated. The manager must notify us of the outcome of the investigation into the incident detailed in this report.
   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 15 March 2012

2. To ensure residents' safety and wellbeing the provider must ensure that staff respond to buzzers promptly. In addition the system for allocating the four pagers on each unit must be reviewed to ensure that when staff are assisting with individual residents the pagers are transferred to staff who are available to respond.
   This is in order to comply with SSI 2011/210 Regulation 4(1)(a) - Welfare of users
   Timescale for implementation: to commence within 24 hours of receipt of this report and be completed by 15 March 2012

Recommendations

1. 1. The service should ensure staff are aware of best practice guidance on disposal of medicines such as that in The Handling of Medicines in Social Care, 2007, http://www.rpharms.com/support-pdfs/handlingmedsocialcare.pdf, and that practice reflect this guidance.
   This is in order to meet the National Care Standards Care Homes for Older People, Standard 5.12 - Management and staffing arrangement and Standard 15.6 - Keeping well - medication.
2. Where the dose of an existing drug is changed this entry should be discontinued and a new entry created with the new dose
   This is in order to meet the National Care Standards - Care Homes for Older People, Standard 5.12 - Management and staffing arrangements and Standard 15.9 - Keeping well - medication.

3. It is recommended that the manager ensures that staff follow the procedure for the recording of resident's belongings on admission. In addition the manager should ensure that all staff are familiar with the procedure and the timescales for completing the belongings list.
   This is in order to meet the National Care Standards Care Homes for Older People Standard 5 - Management and staffing arrangements

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 3 - Adequate

Statement 1

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

Service Strengths

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports we found that the service was demonstrating good practice in areas covered by this Quality Statement.
The purpose of this inspection was to focus on requirements made at the inspections, but we saw that the strengths noted in the last inspection reports were still evident.

Areas for improvement

The recommendation and areas for development noted in Quality Theme 1 Statement 1 are relevant to this Statement.

Grade awarded for this statement: 4 - 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

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports we found that the service was demonstrating adequate practice in areas covered by this Quality Statement.

The purpose of this inspection was to focus on requirements made at the inspections, but we saw that the strengths noted in the last inspection reports were still evident.

At the last inspection we made a requirement that we be provided with a copy of the staff training plan. We were provided with the training plan which included supervision training for supervisors, oral hygiene including the maintenance and storage of equipment such as toothbrushes, falls management training and medication awareness refresher training. During the inspection we saw that the training plan was being implemented and future training dates projected.

At previous inspections we recommended that supervision documentation recorded the name of the supervisor and the unit. We saw that documentation had been amended to include this information.

We also made a recommendation that all staff be familiar with the visitor policy. At this inspection we were told that the manager had discussed the visitor policy with staff. Staff who spoke with us could explain the policy. The recommendation had been implemented.

We made a recommendation that supervision and team meetings be carried out in accordance with the providers own policies. We saw improvement in this area. Staff meetings were taking place and staff competency assessments were also taking place. The recommendation had been met.

We saw that there was an improvement in addressing and recording staff competency. All staff had been assessed as competent in oral hygiene, keyworker responsibilities, the use off/setting pressure relieving equipment, dining experience and medication.

We saw that in addition to mandatory training staff had received training in medication management, effective supervision and support, oral hygiene and managing falls. The training attended was dependent on the staff member's role and responsibilities.

Areas for improvement

Following the last inspection we made a recommendation that the training matrix be updated to reflect accurate information on the training staff received. At this inspection we saw that staff have made progress toward implementing this recommendation. Because of the volume of information to be inputted onto the training record and the introduction of new systems this had taken the staff longer than they anticipated. The recommendation will be made again. (see recommendation 1)

While we saw that team meetings and staff supervisions were taking place because of the changes of unit managers we will continue to monitor the regularity and effectiveness of these at future inspections.

We saw that a new format for recording the agreed actions and timescales arising from meetings had been devised. However we saw this format was not consistently used. We will monitor progress at the next inspection.

We still saw examples where staff practice and knowledge did not evidence competency or that learning from training was being put into practice. Examples are evident throughout this report and include: the setting of mattresses, evaluation of charts, care planning, signing for safety check before the checks have been carried out, not completing incident forms or following up relative concerns. Staff practice needs to continue to be addressed if this quality grade is to be sustained or increased. (see requirement 1)

Grade awarded for this statement: 3 - Adequate

Number of requirements: 1

Number of recommendations: 1

Requirements

1. The provider must continue to evaluate staff knowledge and practice. Staff must be able to demonstrate how their learning has influenced their work practice.

   This is in order to comply with SSI 2011/210 Regulation 4(1) (a) - Welfare of users, and the National care standards, Care homes for older people, Standard 4 -Your environment. Timescale: 30 May 2012

Recommendations

1. 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

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

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports we found that the service was demonstrating good practice in areas covered by this Quality Statement.

The purpose of this inspection was to focus on requirements made at the inspections, but we saw that the strengths noted in the last inspection reports were still evident.

Areas for improvement

The recommendation and areas for development noted in Quality Theme 1 Statement 1 are relevant to this Statement.

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

This statement must be read in conjunction with the unannounced inspection reports dated 6 May 2011 and 30 September 2011.

As stated in those reports we found that the service was demonstrating adequate practice in areas covered by this Quality Statement.

The purpose of this inspection was to focus on requirements made at the inspections, but we saw that the strengths noted in the last inspection reports were still evident.

We saw evidence that the quality assurance systems continued to be developed and were implemented.

The manager continued to show an awareness of the areas of service development and work to improve the service.

Areas for improvement

Since the inspection of September 2011 further changes in the management of three units and in clinical services manager personnel had taken place.

A new clinical services manager had recently commenced in post. The post for the second clinical services manager had been advertised.

The unit manager post in Carnethy was vacant and the senior registered nurse was overseeing the management of the unit meantime. The senior registered nurse was receiving 12 hours each week supernumerary management time.

The unit manager post in Caeketton was vacant. The unit manager of Allermuir unit is managing both units and is completely supernumerary in order to have enough management time.

The clinical services manager is spending more time working in Turnhouse unit while the manager is on leave.

All vacant posts were under recruitment.

Additional management support was being provided to the manager by other service managers and clinical services mangers who were spending time at the service each week. The manager stated she felt well supported and felt this arrangement met the management needs of the service at this point.

We acknowledge that the provider is fully committed to rectifying the situation and is implementing strategies to try and compensate for changes in management personnel. However, we feel the personnel changes must have an impact. We think that developing the service may be slower and it may be more difficult to sustain improvement than it would be with a stable management team. We will monitor the situation at the next inspection. Because of the management personnel changes we have graded this Statement adequate.

At the last inspection we made a recommendation that the quality assurance system continued to be developed. As this is an ongoing process for the service and we did not fully inspect this aspect at this inspection, we will carry forward this recommendation and note progress at future inspections. (see recommendation 1)

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 1

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

No 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 at 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 - 3 - Adequate	
Statement 1	4 - Good
Statement 2	3 - Adequate
Quality of Staffing - 3 - Adequate	
Statement 1	4 - 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	
30 Sep 2011	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 2 - Weak 3 - Adequate 3 - Adequate
6 May 2011	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 4 - Good 3 - Adequate
17 Jan 2011	Re-grade	Care and support Environment Staffing	2 - Weak Not Assessed Not Assessed

		Management and Leadership	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 Environment Staffing Management and Leadership	3 - Adequate 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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ی ہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے-

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