# Care service inspection report

# Letham Park Care Home

## Care Home Service Adults

205/207 Ferry Road
Edinburgh
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Inspected by: Katie Wood

Janet Smith

Type of inspection: Unannounced

Inspection completed on: 29 July 2013

HAPPY TO TRANSLATE

# Contents



## Service provided by:

Renaissance Care (No1) Limited

## Service provider number:

SP2011011731

## Care service number:

CS2011303093

## Contact details for the inspector who inspected this service:


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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

Residents and relatives we spoke with told us that on the whole they were satisfied with the care they or their relative received.

Residents and relatives told us good things about the staff, saying that they were "lovely" and "approachable".

The provider continues to improve the environment through a rolling programme of decorating rooms.

## What the service could do better

The refurbishment of the home needs to continue, particularly the bath and shower rooms, so that residents can have more choice of how they bath.

The service's senior staff and management team need to improve the quality assurance systems they use, to monitor the quality of all aspects of the service. This will help them to identify and prioritise where improvements are needed. It will also give them information that they can share with residents and relatives, to reassure them that the service is providing an adequate standard of care, and working to continually improve that care.

The service needs to improve the way it plans care, to make sure that all of each resident's needs are recognised and met.

## What the service has done since the last inspection

We have seen little progress in the service since our last inspection. The home has been without a deputy manager for some time, and this has meant that the manager has had to focus her time on the day to day running of the home. She has had less time to spend on planning ahead, and checking the quality of the service. The service continues to perform at an adequate level, but we were able to see that the manager was introducing more ways of improving the quality of the service. We anticipate that at our next inspection we will see the improvements that this has brought about. However, there needs to be robust systems in place to monitor the quality of the service, to make sure that the intended improvements are being achieved and sustained.

## Conclusion

Despite the slow rate of progress, we continue to see some improvements in the service. Residents and relatives tell us that they are happy with the quality of service provided.

## Who did this inspection

Katie Wood
Janet Smith

# 1 About the service we inspected

The Care Inspectorate regulates care services in Scotland. Prior to 1 April 2011, this function was carried out by the Care Commission. Information in relation to all care services is available on our website at www.scswis.com.

Letham Park Care Home is a care home service, owned and operated by Renaissance Care (No 1) Ltd, and registered with the Care Inspectorate on 14 November 2011. The service is registered to provide care and accommodation for up to 50 older people. The home is situated in a residential area in the north of Edinburgh, close to local shops and other amenities. It is accessible by public transport. The home is situated in private grounds with some space for visitor parking. There are enclosed garden areas to the rear of the building which are accessible from a conservatory on the ground floor.

Accommodation is provided on three floors, with the specialist dementia unit situated on the ground floor. There is a passenger service lift and stairs giving access to all three floors. Residents' bedrooms are all single rooms with ensuite toilet and wash hand basin facilities. There are shared bathing and additional toilet facilities on each floor, and communal lounge and dining facilities.
In its brochure, the service states that its aim is "the provision of the highest standard of care in an environment which is both welcoming and homely. We will actively encourage individuality, promoting independence and physical and social well being."

**Requirements and recommendations**
If we are concerned about some aspect of a service, or think it needs to do more to improve, we may make a recommendation or requirement.
- A recommendation is a statement that sets out actions the care service provider should take to improve or develop the quality of the service based on best practice or the National Care Standards.
- A requirement is a statement which sets out what is required of a care service to comply with the Public Services Reform (Scotland) Act 2010 ("the Act") and secondary legislation made under the Act, or a condition of registration. Where there are breaches of Regulations, Orders or conditions, a requirement may be made. Requirements are legally enforceable at the discretion of the Care Inspectorate.

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.careinspectorate.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 following an unannounced inspection that we carried out between 10.30 am and 8.30 pm on 8 July, and between 6.45 am and 3.30 pm on 10 July 2013. We gave feedback about our findings during the inspection to the manager and one of the operations directors for Renaissance Care Ltd on 29 July 2013. The inspection was carried out by inspectors Katie Wood and Janet Smith.

During the inspection we gathered information and evidence from a range of sources.

We considered the information that the service gave us in their annual return and self assessment forms, which the provider is required to complete each year.

We sent the service 25 questionnaires for residents and 25 for relatives, and asked the service to distribute these to people who wanted to contribute their views to the inspection. We received five completed resident questionnaires and 13 completed relative questionnaires. We have described the responses we got in the relevant parts of this report.

We also looked at a variety of other evidence including the following:

- 16 residents' care plans;
- residents' medication records;
- staff training records;
- records of staff supervision;
- minutes of meetings;
- newsletters;
- staff rotas;
- records of maintenance and servicing of equipment;
- the participation strategy for the service;
- some of the policies in use in the service;
- activities records;
- the environment of the home;
- equipment used to provide care.

We spoke with the following people:

- three interviews with residents (and engaged in conversation with several others);
- three relatives;
- 10 members of staff who provide care;
- a cook;
- a kitchen assistant;
- a laundry assistant;
- a maintenance person;
- the manager;
- an operations director.

We took all of the information we gathered into account when we wrote this report. We also took into account the National Care Standards Care Homes for Older People, the Scottish Social Services Council (SSSC) Codes of Practice for Social Service Workers and Employers of Social Service Workers, as will as the Public Services Reform (Scotland) Act 2010 and its associated statutory instruments.

## 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 at all times personal plans accurately identify residents' needs and how they will be met. This is to support staff to give the care and support in such a way that it meets the identified needs of the people who use the service.

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

This also takes into account National Care Standards, Care homes for older people, Standard 5 Management and staffing arrangements.

Timescale - One month from receipt of this report.

### What the service did to meet the requirement

We have reported on our findings in relation to care planning in Statement 3 of Quality of Care and Support. While the service had made some changes to the documentation they use to record care planning, and we saw improvement in some of the care plans we looked at, the service still needs to improve the way they plan care. We have extended the requirement about care planning in this report, taking into account our findings.

**The requirement is:** Not Met

### The requirement

The provider must, having regard to the size and nature of the service, the statement of aims and objectives, and the number and needs of residents, ensure that there are at all times sufficient staff working in the service to meet the needs of residents. In order to do so, the provider must record and be able to evidence how their dependency assessments are used to inform staffing levels and deployment.

This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210) Regulation 15(a) - staffing.

This also takes into account National Care Standards, Care homes for older people, Standard 5 Management and staffing arrangements.

Timescale - within one week of receipt of this report.

**What the service did to meet the requirement**

We saw from staffing rotas and from other information provided by the manager that the service was meeting the minimum levels of staffing as set out in the staffing schedule. However, we also noted that staffing levels at times had an impact on the way care was provided, and we have asked the service to look again at how they link dependency levels to staffing levels and staff deployment. We have reported this is Statement 3 of Quality of Staffing.

**The requirement is:** Not Met

**The requirement**

The provider must make proper provision for the health, welfare and safety of service users by having appropriate procedures for the prevention and control of infection. In order to do so, the provider must:
a) Update their policies and procedures for prevention of infection to reflect best practice guidance, such as national guidance provided by Health Protection Scotland.;
b) Ensure that all staff follow best practice in infection control, and that there is management oversight of practice

This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulations 4(1)(a) and (d), 15(b)(i).

This also takes into account National Care Standards, Care Homes for Older People, Standard 4 Your Environment and Standard 5 Management and Staffing Arrangements.

Timescale: Within 3 weeks of receiving this report.

**What the service did to meet the requirement**

We found that this requirement was not met. We have described our findings in Statement 4 of Quality of Management and Leadership.

**The requirement is:** Not Met

**The requirement**

The provider must ensure that the Care Inspectorate is notified of matters listed in the document 'Guidance on notification reporting'. In order to achieve this, staff who take charge of the home should be familiar with this notification guidance.

This is in order to comply with The Public Services Reform (Scotland) Act 2010 and Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This also takes into account National Care Standards, Care homes for older people, Standard 5 Management and staffing arrangements.

Timescale: immediately on receipt of this report and on going.

**What the service did to meet the requirement**

In discussions with staff we found that they were aware of the need for certain events to be notified to the Care Inspectorate. Since the last inspection, we have also noted that the Care Inspectorate had been receiving notifications about a variety of issues, in line with the guidance. While not all staff who may take responsibility at times for being in charge of the home were able to access the electronic notifications system, there was a system in place for information to be shared with key members of staff who were able to do so.

**The requirement is:** Met - Within Timescales

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

1. It is recommended that the service develop a participation strategy that tells people the methods used to support participation within this home and how these methods are reviewed and developed.

We have reported on this in Statement 1 of Quality of Care and Support. We found that this recommendation had not been met, and we have made a similar recommendation but with more detail, taking into account what we found at this visit.

2. The provider should ensure that where staff assess pain levels in residents a recognised pain chart should be in place. For example the Dolopus which is a recognised tool for use with people with dementia.

We saw that staff were using a recognised assessment tool, but it was not being used as effectively as intended. We have reported on this in Statement 3 of Quality of Care and Support. While this recommendation had been met, staff were not using the

assessment tool effectively to be confident of identifying residents' needs for pain relief, so we have made a requirement about this.

3. It is recommended that the storage of continence pads is reviewed. They should be stored in a clean area, preferably a cupboard, or container to prevent contamination and allow through cleaning of all ensuites.

We saw that continence pads were no longer stored on bathroom floors. Most were kept in cupboards or wardrobes, although we noted that some were stored on top of wardrobes in residents' rooms. This was an issue with regards to privacy and dignity, as this let residents' visitors know that they require these products. It was also a concern in case residents tried to reach up for the products and caused injury to themselves. The manager agreed to remove these and store them more safely. We have reported on this is Statement 2 of Quality of the Environment. This recommendation has been met.

4. The provider should ensure that staff receive appropriate training and support to carry out the roles expected of them.
We have talked about staff training in Statement 3 of Quality of Staffing. We found that this recommendation had not been met. The records we were shown indicated that staff had not all received up to date training in the areas that the provider had identified as essential, and there was little evidence of training of any sort over the past year. When we discussed this with the manger, she thought that other training had been provided more recently, but that the records had not been updated to reflect this. As staff training has the potential to affect the quality of care that residents receive, and we were unable to evidence during the inspection that training was recent and up to date, we have made a requirement about this.

5. The provider should ensure that its structured approach to quality assurance is consistently followed to enable areas for improvement to be identified and acted on.
We have reported on the service's systems of quality assurance in Statement 4 of Quality of Management and Leadership. While there were informal systems in place to assess and monnitor the quality of the service, the lack of a structured approach was having an impact on the quality of the service. Many of the areas for improvement that we have identified could have been picked up through a more robust system of quality assurance in the home. We have made a requirement about it. The recommendation had not been met.

## 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.

The service gave us a completed self assessment form before we carried out this inspection. In this, the provider told us what they thought the service did well, and where they intended to make improvements. The service graded themselves realistically based on what they thought they did well. However, when we inspected, we were not always able to evidence that the service was performing at a level that matched their assessment, so some of the grades we awarded were lower.

## Taking the views of people using the care service into account

Before the inspection, we sent the service 25 questionnaires, to pass on to residents who wanted to take part in the inspection. We ask the service to help residents who want to take part but are unable to complete these for themselves, or to find independent advocates or volunteers who may be able to help. We received 5 completed questionnaires back. Overall, everyone either "agreed" or "strongly agreed" with the statement that overall they were happy with the quality of care they received. One person mentioned that clothes sometimes are not returned when they go to the laundry. One person also raised a concern about their mail, which we raised with the provider, without mentioning names. The provider was able to show us that they were aware of the concern, and were already responding to it.

We spoke with three people who were able to answer direct questions about the service. They gave us positive feedback about the care they received. We also observed the way staff provided care and interacted with residents. We have described what we saw in the section of the report headed Quality of Care and Support.

Comments we received included the following:

- Staff are very good";
- I would love to go out, I don't know when I was last out";
- "Very nice staff, couldn't be kinder, all lovely";
- "I don't go out, I don't want to".

## Taking carers' views into account

We also sent out 25 questionnaires for the service to pass on to relatives and other visitors. We received 13 completed questionnaires back. Everyone who completed a questionnaire "agreed" or "strongly agreed" that overall they were happy with the quality of care their friend or relative received. Two people made comments about

the need to improve some aspects of tidiness, and two people commented on a lack of activities, particularly for residents who were more frail, or who had greater levels of dementia. One relative also mentioned items not being returned safely from the laundry.

During our visit, we spoke with three visitors. All three spoke positively about the care they saw their relative receive in the home. One person said they were kept informed by staff about their relatives condition and their care. One person said they found staff very approachable, and another said that their family were very happy to have their relative living at Letham Park.

# 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

We found that the service created some opportunities for people who use or visit the service to have an influence over the way the service was provided and developed. While the ways in which people could become involved in their or their relatives care remained much the same as at our last inspection, we saw that the these methods were beginning to be used more often. The manager was beginning to organise more meetings, and was also very visible out and about in the service, making it easier for residents and relatives to get to know her, and to be able to approach her.

The service had a participation strategy in place. This was the strategy for Renaissance Care Ltd, and set out the company's aim that "all people either delivering or receiving care or participating within our home have access and a forum to deliver their thoughts and ideas". It also described the ways in which all Renaissance Care services should go about gathering people's views and using them to influence the care service. The strategy included recording or minuting meetings and auditing responses to surveys, and drawing up action plans in response to the issues raised. In this Statement we have described those areas of the strategy which were working well, and those where more improvement was needed.

During our visits to the service, we saw that residents were able to make choices about aspects of their daily life, and how their care was provided. For example, we saw that residents chose when to get up or go to bed, where they sat at mealtimes, what they had to eat from the menu.

Information about the service, and any changes, was shared with residents and relatives at meetings, and they were able to comment or make suggestions.

We saw that residents and relatives had some opportunities to express their views. For example we saw that Renaissance Care had carried out a survey of relatives in June 2013, and had collated and analysed the response to that survey. Most of the responses received were positive about the service. However, the service did not evidence what action they had taken in response to the survey.

We saw that the service had considered asking an external company to provide residents' meals, and had invited residents to join a committee to taste the meals provided by this company. The company had organised taster sessions with samples of their food, and residents on the Food Committee had been asked for their views.

Renaissance Care produced a company newsletter that shared information about the company, and about events and changes in each of their services. This was produced quarterly.

On each of the units, white boards were used to share information with residents and visitors about the staff on duty, and the person in charge on each shift. This meant that residents and visitors knew who to speak with if they had any questions, concerns or suggestions.

Of the relatives and residents who responded to our questionnaire, the majority indicated that their or their relatives' views about the service were sought. Ten people responded positively to this question, while three people disagreed. Not everyone who completed a questionnaire responded to this question.

The service had a complaints policy, and a written procedure which told people how to raise concerns about the service. This procedure was displayed around the home.

**Areas for improvement**

We made a recommendation at our last inspection that the Participation Strategy be developed to reflect the range of systems to support participation that were in use in the home, rather than just using the providers very general strategy. The Participation Strategy we saw being used in the service was still the corporate one for Renaissance Care Limited. Each service within the company is different, with differing needs and wishes in each group of residents. We talked with the manager about the benefits of developing the strategy to make it specific to Letham Park and the residents who live there. (See recommendation 1 below)

We have described above the different steps that the service had taken to gather residents' and relatives' views, and to provide them with choices in their daily care. However, we did not always see how those views were used to influence change in the way care was provided. For example, we saw that residents had been consulted about the possible change of catering arrangements, but we did not see any evidence of the outcome of that consultation. Similarly, we could not see how comments or

suggestions from the customer survey had been followed up, or what had changed as a result. One person who responded to our questionnaire said that they were not always made aware of the times of relatives meetings, and did not always receive the notes of those meetings. The service's own Participation Strategy noted that meetings would be minuted, and action plans drawn up to show how any concerns or suggestions were to be responded to. Those action plans were to be shared and mutually agreed. (See recommendation 1 below)

The service's Participation strategy also noted that there would be residents meetings held, but there had been no residents meetings recently. This meant that residents had not been given this opportunity to say what they thought about the service, or to make suggestions about how it could be improved. (See recommendation 1 below)

One of the best opportunities for residents, particularly those with memory or communication problems, to be able to influence the way their care is provided is to have care plans which are detailed, and which reflect the specific wishes or preferences of each resident. We could see that the service was working to improve the way they planned care, to make it more individual and person centred. We have commented about this more in Statement 3 of Quality of Care and Support.

Overall, the grade we have awarded for this Statement reflects the fact that there were some formal systems in place, which were beginning to be implemented more effectively that they had been previously. We were seeing some improvements in this. It also reflects what we saw and heard when we observed practice. We saw that staff interacted well with residents, and offered them choices in their day to day lives. However, to sustain this grade, the service needs to continue to develop and refine the way it involves residents and relatives in decisions about the service, and to evidence the outcomes from this involvement.

**Grade awarded for this statement:** 4 - Good

**Number of requirements:** 0

**Number of recommendations:** 1

**Recommendations**

1. The provider should:
   a) further develop the Participation Strategy for the service to ensure that it reflects the specific needs, wishes, abilities and circumstances of the residents of Letham Park;
   b) ensure that the strategy is fully implemented in ways that take into account the views of both residents and their relatives;

c) consider ways in which to evidence that the views of all residents and their relatives have influenced the way the service is provided, or developed in the future.

This takes into account the National Care Standards Care Homes for Older People Standard 11 - Expressing Your Views, the Scottish Government's Standards for Dementia Care in Scotland 2011, and the Nursing and Midwifery council (NMC) Guidance for the Care of Older People 2009.

**Statement 3**

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

**Service strengths**

We looked at residents' care records, observed staff providing care for residents, and spoke with staff residents and relatives. We assessed from all of this that the service was performing at an adequate level in the way they addressed residents' health and wellbeing needs. However, we could see some evidence that the manager was working with staff to make improvements.

When we spoke with residents and relatives, they gave us positive feedback about the quality of care they received. People who completed our questionnaires also spoke positively about the care the service provided. Comments that we received included the following:

- "I am delighted with the amount of care and support I get"
- "Care is quite good and I find it satisfactory"
- "(staff) really do care for our (relative) as an individual"
- "healthcare needs are well met by nursing staff"
- "Staff are available when I need them".

We observed staff practice as they provided care, and saw that most of the staff were caring and attentive to residents' needs.

We saw that the staff were working to improve the way they planned care. At our last inspection we noted that there was new documentation in place, and we could see that this was being used by staff. The new documentation was set out in a way which encouraged staff to record information and plan care in a more logical manner. Care plans using the newer documentation were also more orderly and information was easier to find.

We saw that staff used a range of recognised assessment tools to help them to identify residents' needs and help them to plan care. Some care plans we looked at

had detailed information that was specific to the individual resident. This helped staff to provide care for that person in a way that was person centred, and recognised what was important to the person. We saw evidence of good practice in the way staff looked after residents' wounds, and were clear in the way they recorded this care.

When we spoke with staff, it was clear that they knew the residents as individuals, and were informed about their needs.

We saw that staff considered residents' abilities to make decisions about their care, and were aware of some of the legislation that protected people who were not always able to make these decisions. We also saw that in some cases, staff were aware of residents wishes regarding their care towards the end of their life.

Care records demonstrated that a range of healthcare professionals were involved in the residents' care. For example, the service helped residents to access the services of an optician, dentist and podiatrist. Residents told us that their GP, dentist or podiatrist visited them in the home.

We saw that staff were aware when residents needed to have their food or fluid intake monitored, and were aware of how much each resident should be encouraged to drink throughout the day.

We observed a number of meal times in different units, to see how residents were helped with their meals, and provided with an enjoyable dining experience. We saw that staff were mainly patient and attentive, and where residents needed assistance to eat their meals, this was done discreetly. Where residents did not want the options that were available on the menu, they were offered an alternative. We noted that there were some improvements needed, particularly in Islay Unit, and we have described this in the Areas for Improvement below.

The service employed one full time and one part-time activities co-ordinator, who planned and provided a range of activities for residents. Some of these took place in the home, but there were also some outings, for example boat trips out to Ratho, a bus trip to North Berwick and a trip to Dobbies Garden Centre.. During our visits we saw residents taking part in activities, such as quizzes, word puzzles and household tasks. We saw that there were sometimes entertainers, such as musicians or singers, invited to visit the home. The manager also told us that members of the local community were involved in the home. A local clergyman visited regularly, a mobile library service brought books for residents to borrow, and a group of local school children had recently been involved in a project with residents.

There was a range of policies in place that gave staff guidance on care practices. These included the following:

- Nutritional Policy;
- Pressure Sore Prevention Policy;
- Medication Management Policy;
- Preventing Abuse of a Resident.

**Areas for improvement**

We made a requirement at our last inspection that:

"The provider must ensure that at all times personal plans accurately identify residents' needs and how they will be met. This is to support staff to give the care and support in such a way that it meets the identified needs of the people who use the service."

As we have noted above, we could see that staff were working to improve the way care was planned. Around the time of our visit, a senior member of the management team was looking at care plans, to see where they could be improved. We saw some examples of care plans that were detailed, and specific to the needs, wishes and preferences of the individual resident. However, this was not consistently the case. Not all care plans were sufficiently detailed to show how staff were meeting the residents' needs. We saw some examples of where individual preferences had been recorded in the care plan, but care was not delivered in line with the plan of care. We also saw that care plans were not always updated to reflect changes in residents' needs. Assessments were not always completed accurately.

We also looked at the way staff evaluated care plans, and we found that this also needed to be improved. We saw some evaluations where staff had clearly considered whether the plan of care was helping the resident to achieve their goals, or if the plan needed to be changed in any way. However, this was not consistent, and some "evaluations" we saw were simply a record of the care that had been given, with no evidence that staff had considered whether or not it was effective.

We assessed that, while progress was being made to improve the quality of care planning, there were still improvements that were needed. Care plans needed to have more detailed information about the wishes and choices of the individual resident, to be kept up to date as residents circumstances and abilities changed, and to be regularly evaluated to make sure they gave staff the guidance they needed to provide person centred care. We took all of our findings into account, and have extended our requirement to give the provider more detail about what is needed to improve care planning. (See requirement 1 below)

We made a recommendation at our last inspection that:
"The provider should ensure that where staff assess pain levels in residents, a recognised pain chart should be in place".

At this inspection we saw that staff were using a recognised pain assessment tool, but these were not always being used effectively. Staff needed follow the guidance that came with the assessment tool, and to repeat the assessment as often as was necessary in each resident's case to make sure that the resident was getting the pain relief they needed. (See recommendation 1 below)

We looked at records of medication administration. We found that staff needed to improve the accuracy and clarity of their record keeping to make sure that medicines were being administered safely, and as the prescriber had intended. When we discussed this with the manager, she told us that she had already recognised the problem, and had taken steps to support staff to improve their practice. We will look at this again at our next inspection to make sure that the required improvements were being achieved. For medicines that were to be used "as required", for example to relieve symptoms of anxiety or distress, staff needed to make sure that instructions were clear and specific. There should be individual care plans or protocols that guide staff on the circumstances when these medicines should be given. The protocol should note how the medicine should be used safely and appropriately, and the use of the medication should be regularly and frequently reviewed. All of this was set out in the provider's own policy on PRN ("As Required") Medication, but we did not see it in practice. (See requirement 2 below)

We saw from care records that staff had noted when they had been told that residents had legal arrangements in place for other people, such as relatives, friends or official agencies, to manage their affairs. These arrangements are called welfare or continuing power of attorney, or welfare or financial guardianship. However, there was not always a copy of the legal documents in residents' files. Each person's circumstances will be different, and the documents that evidence these arrangements set out the extent and limitations of the powers they give. For example, they might allow a named relative to choose where the resident lives, but not to consent to medical treatment. Staff providing care need to have a good understanding of the legislation, and access to the documents, so that they know who is legally able to make decisions on the resident's behalf. When we spoke with staff, they were unclear about the legal framework that protected people's rights, and how it affected the way they provided care. During our inspection, one member of staff with whom we had discussed this took time to research the legislation and good practice guidance, to familiarise herself with it. She planned to share her learning with other members of the staff team. We have made a recommendation about how staff should be supported to improve their knowledge and understanding of this legislation. (See recommendation 2 below)

There was recognition in care records of residents' ability, or "capacity", to make decisions about aspects of their care, and of their wishes for end of life care. However, this information was not always as detailed as it should be, nor reviewed as regularly as it should be. It was the responsibility of the residents' GP to complete this documentation, and to review it, but we discussed with some of the nursing staff

and the manager the role of registered nurses in working with the GP to make sure the information was detailed and up to date. (See recommendation 2 below)

As noted above, we observed meal times in each of the units. While much of the care we noted was good, some improvements were needed, particularly in Islay Unit, which was specifically for people with dementia. There was a menu board in the lounge, which was designed to take picture cards, showing what was on the menu at each mealtime. This is meant to help residents with dementia who may not be able to remember what they ordered. We saw that this board had the wrong information about the menu choices available. This could add to the confusion for residents with memory problems. We saw that people were assisted to the table up to 20 minutes before the meal was served, and this meant that they had a long wait. Residents may find it uncomfortable to sit on a hard chair for long periods, and residents with dementia may become restless and distracted by the time their meal arrives. The tables in Islay Unit were not set for meal times. Plastic cutlery was given out as the meal was served to each resident, and plastic plates were used for everyone in the unit. While we accept that there may be some residents for whom specially adapted cutlery or crockery was appropriate, this should be decided on an individual basis, and the reasons set out as part of the individual care plan. The dining room in Islay Unit was small, and during our visit we saw that several residents ate their meals in the lounge. We were assured that this was the residents' choice, but staff commented that if everyone chose to eat in the dining room, there would not be enough room. We discussed with the manager the need to consider how the service would continue to offer choice in this circumstance. Of the residents eating in the lounge, we noted that several were poorly positioned to eat their meal, and that some tables were very low, making it difficult for the resident to reach. Many of the interactions we saw during meal service were pleasant, but we did note occasions when residents were being individually assisted, and there was little conversation or interaction. We also saw that no drinks were offered to residents until the end of the meal. The service needs to carry out their own observation of residents' dining experiences on Islay Unit, and plan how this could be improved. (See requirement 3 below)

We have described above some of the activities that were provided for residents. Two people who completed our questionnaires said that they worried that there was not enough activity or stimulation for residents. We saw during our visits that there were times when staff were busy with tasks of care, and residents had little to do to pass the time. This was a particular issue for residents who were more physically frail, or who had greater levels of dementia, and who needed more interaction with, or help from, staff. The manager told us that she was looking at ways to improve the input from the activities co-ordinator. (See recommendation 3 below)

Many of the areas that we have identified where improvements were needed could have been identified and addressed by the service if they had robust systems in place to monitor the quality of the service. We have described in Statement 4 of Quality of

Management and Leadership the ways in which the service monitors quality, and how these should be improved.

**Grade awarded for this statement:** 3 - Adequate

**Number of requirements:** 3

**Number of recommendations:** 3

**Requirements**

1. The Provider must make proper provision for the health, welfare and safety of service users. In order to do so, the Provider must ensure that:
   a) care plans reflect the aims, wishes, choices and preferences of the individual resident;
   b) assessment tools are used accurately to identify service users' needs;
   c) care plans identify all of the individual service user's needs, and clearly demonstrate how those needs are to be met;
   d) care plans are effectively evaluated to ensure they are meeting the identified aims and goals of the individual service user;
   e) care plans are updated to reflect changes in service users' needs or circumstances;
   g) dependency assessments are completed accurately, and reflect the current status of each resident's needs and abilities.
   This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), regulation 3 - a regulation regarding the principles of the Act, and regulation 4(1)(a) - a regulation regarding the welfare of users.
   It also takes into account the National Care Standards Care Homes for Older People Standard 6 - Support Arrangements, the Nursing and Midwifery Council Guidance for the Care of Older People 2009, and the Scottish Government's Standards for Dementia Care in Scotland 2011.

   Timescale for achieving this requirement: By 29 November 2013.

2. The Provider must make proper provision for the health, welfare and safety of service users. In order to do so, the Provider must ensure that:
   a) where medicines are prescribed to be used as required for symptoms of distress, anxiety or agitation, there are individual protocols or care plans in place for each service user that set out clearly:

   - what circumstances or situations might cause the resident to become anxious or distressed;
   - how staff should to try to alleviate these symptoms in other ways before administering medication;
   - the circumstances in which the medication should be administered;

- clear and unambiguous instructions for the administration of the medication.

b) where such "as required" medication has been administered, staff must record the reason for the administration and the outcome:
c) the use of the medication is frequently and regularly evaluated and reviewed.
This is in order to comply with:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), regulation 4(1)(a) - a regulation regarding the welfare of service users.
It also takes into account the National Care Standards Care Homes for Older People Standard 15 - Keeping Well Medication, the NMC Standards for Medicines Management 2010, Rights, Risks and Limits to Freedom Section 3.8 Mental Welfare Commission for Scotland 2013.
Timescale for meeting this requirement: By 1 November 2013

3. The provider must audit the arrangements in the dining rooms in each of the units to identify where changes can be made which will improve the experience of residents. Particular consideration must be given to the needs of those residents with dementia. Following this audit, an action plan must be drawn up for each of the units, which demonstrates what actions are to be taken to achieve those improvements, the timescales for carrying out those actions, and the person who is responsible for ensuring they are successfully carried out. The action plan must take into account, but not be limited to, the findings described in Statement 3 of Quality of Care and support in this report.

   This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011/210 Reg 3 - a regulation regarding the principles of the Act, and Reg 4(1)(b) - a regulation regarding the welfare of users.

   It also takes into account the National Care Standards Care Homes for Older People Standard 13 - Eating Well, and Standard 5.4 - Management and Staffing Arrangements, and the Scottish Government's Standards for Dementia Care in Scotland 2011.

   Timescale for meeting this requirement: The audit must be completed by 25 October 2013 and all necessary changes fully implemented by 15 November 2013. If any of the changes identified as necessary require a longer timescale to achieve, this must be negotiated with the Care Inspectorate.

**Recommendations**

1. The Provider should ensure that staff follow the guidance that supports the service's chosen pain assessment tool, and monitor the way that this guidance is implemented, to ensure that service users, particularly those who are not able to

say what they are feeling, are receiving the pain relief that they need to ensure their comfort.
This takes into account the National Care Standards Care Homes for Older People and Care Homes for People with Physical and Sensory Impairment Standard 6 - Support Arrangements, Standard 14.8 - Keeping Well, Healthcare, Standard 15 - Keeping Well, Medication, Guidance for the Care of Older People NMC 2009, The Assessment of Pain in Older People Royal College of Physicians 2007.

2. The provider should ensure that staff who are responsible for providing care are aware of the legal framework which supports the rights of people who are unable to make decisions about some or all aspects of their care, and the arrangements that can be put into place to protect those rights. Staff should have access to best practice guidance to support their practice, and where necessary, training should be provided for staff as appropriate to their role in the service.

   This takes into account the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing Arrangements, the Scottish Social Services Council Code of Practice for Employers Sections 2 and 3, Rights, Risks and Limits to Freedom Section 3.8 Mental Welfare Commission for Scotland 2013, and the NMC Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives 2008.

3. The provider should continue to develop the activities available for residents, taking particular account of those residents who are less able to express their views, and who need more one-to-one support from staff to be able to take part in both group and individual activities.

   This takes into account the National Care Standards Care Homes for Older People Standard 12 - Social, Cultural and Religious Belief or Faith, Standard 17 - Daily Life, the NMC Guidance for the Care of Older People, and the Scottish Government's Standards of Care for Dementia in Scotland 2011.

## 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

We looked at how the service supported residents and their relatives to express their views about the quality of the environment. We found that all of the information from Quality Statement 1 of Quality of Care and Support was also relevant to this Statement. We found that the service was performing at a good level in the areas covered by this Quality Statement.

Within the units we saw residents coming and going freely between their bedrooms and public areas, including resident who chose to walk around the unit. Staff often walked with these resident to ensure their safety without restricting their desire to walk. We saw residents choosing where they wanted to spend their time during the day, including some who chose to attend activities in the conservatory area near the main entrance to the building.

Most of the people who responded to our questionnaire were positive about the physical environment of the home. Comments included the following:

- "Dining room and lounge have been refurbished and look very good"
- "I feel content in my surroundings"
- "(The manager) has instigated many positive changes regarding the home itself and the gardens".

Some of the residents we spoke with told us they were happy with their room. We saw that most of the bedrooms had been personalised, with pictures and objects that were of significance to the occupant.

One of the newsletters we saw gave information about proposed improvements to the environment of the service. Sharing information this way encourages people involved with the service to comment or discuss any concerns or suggestions they may have with staff or management.

We saw that residents were able to choose where they spent their time, and could influence some of the activities that were provided.

An example we saw of the service responding to suggestions made by relatives was the provision of tea and coffee-making facilities in the small lounge outside the manager's office. This had been suggested at a relatives meeting, and these facilities were now in place.

**Areas for improvement**

As we noted earlier, the service has systems in place to ask people what they thought of the service, but these were not yet being used as effectively as the could be. The service was also not always able to show how it responded to the views or suggestions it received. The service needs to get better at showing how they have listened to the views of residents and relatives, and the action they have taken in response.

We saw that residents were able to use the environment relatively freely, although there were restrictions on people leaving the unit in which they lived. We suggested that perhaps residents were more able could be given access to keypad codes so that they could move more freely between areas of the home.

Some people who responded to our questionnaire said that there were problems with the laundry, and that sometimes clothes were not returned to the correct person. The manager told us that she was aware of residents' and relatives' concerns, and had looked at ways to improve this. We spoke with one of the staff in the laundry, who said that they had improved their systems recently, and that they thought there were fewer problems arising now. We did not look specifically at this issue at this inspection, but will follow it up at future inspections, to see how the service has responded to people's concerns.

**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 that the service had a number of systems in place to make sure that the environment of the home was well maintained and safe. This included the following:

- a system to report that damage or faults were reported and actioned. We saw that the maintenance person signed to say that work had been completed;

- a system to keep track of maintenance and servicing checks on equipment, both that carried out by the maintenance person, and by external contractors;
- a system of regular checks of areas of the environment, such as window limiters, water temperatures, bedrails;
- a contract to ensure that clinical and household waste was removed from the service.

The provider employed an external consultancy firm to advise on health and safety matters. They had provided the service with a Health and Safety Policy manual, which gave guidance for staff on matters to do with ensuring the safety of the environment. There were also company policies on medication management and hygiene, both of which made reference to the health and safety policy.

There was a policy to guide staff on how to deal with concerns they may have about adult abuse, and posters with a summary of the information were pinned up in some staff areas.

The home had a secure entry system to prevent uninvited access to the building.

There is a legal requirement under the Lifting Operation and Lifting Equipment Regulations (LOLER) 1998 that the equipment in the home that is used to help residents with mobility problems, such as hoists or special baths, is tested for safety every six months. We saw that these safety checks were up to date.

At our last inspection, we noted that work on the environment, that we had required the service to carry out, was progressing but had not all been completed. At this visit, the manager described to us the further work that had been carried out since our last inspection. We were satisfied that the timescales in the service's action plan had been met.

When we observed staff practice in relation to the prevention and control of infection, we were satisfied that most of what we saw was appropriate. Staff wore protective equipment, such as gloves and aprons, appropriately when providing care or carrying out tasks around the home. We also saw good practice in hand hygiene.

We saw that staff were checking the temperatures of both drug and food fridges. We also saw that there was guidance advising staff to report it if the temperatures fell outwith acceptable limits. We saw too that staff were checking the water temperature before each resident took a bath or shower, to prevent scalding.

Most of the areas we saw during our visit were clean, fresh and well maintained. Some of the bathrooms needed attention, and we have commented on that more in Statement 3 of this Quality Theme.

We made a recommendation at our last inspection that:

"the storage of continence pads is reviewed. They should be stored in a clean area, preferably a cupboard or container to prevent contamination and allow thorough cleaning of all ensuites."

At this visit we did not see any continence products stored on bathroom floors. The recommendation is met. We have made comment below about further changes that need to be made to the storage of continence products.

**Areas for improvement**

The service was using a resource pack produced by the NHS and Care Inspectorate to provide information for staff about how to prevent falls. We also saw that staff used a risk assessment process to identify residents at risk of falling, and to identify ways to minimise that risk. However, some of the assessments we looked at had not been carried out accurately, and so did not reflect the true level of risk. The service also used charts to monitor the circumstances and frequency of falls for some residents, to try to identify factors that might contribute to the fall, and so reduce these. We saw examples of where this process of monitoring was not being used effectively to help to prevent falls. (See requirement 1 below)

In Islay Unit we noted that continence pads were stored on the top of wardrobes in some residents' rooms. This created a risk that residents may try to reach up for the products and pull the wardrobe over, causing injury. Having these products in open view also compromises the confidentiality and dignity of the residents. We have discussed dignity more in Statement 4 of Quality of Staffing. Following our feedback, the manager agreed to remove these products from the top of the wardrobes.

Although there was guidance for staff on their responsibility to report concerns about adult abuse, there was no local telephone number easily accessable, to enable them to report those concerns. The provider must ensure that staff have access to the appropriate contact details for the local authority adult protection team.

We noted that in many of the bathrooms and toilets, there were towels and clothing items hung over the assist rail alongside the toilet. This not only prevented the resident from being able to use the rail to hold on to, but also created a risk of spreading infection. (See recommendation 1 below)

**Grade awarded for this statement:** 4 - Good

**Number of requirements:** 2

**Number of recommendations:** 1

**Requirements**

1. The provider must make proper provision for the health, welfare and safety of service users. In order to do so, the provider must:

a) review the falls risk assessments for all residents to make sure that they take into account all of the factors that may contribute to the risk of falling, and accurately identify the level of risk for each resident;
b) ensure that these assessments are reviewed regularly and are up to date;
c) ensure that care plans are updated to reflect the outcome of the risk assessment;
d) take steps to ensure that staff are familiar with the resource pack in use in the service, including training in the use of the resource pack and the use of the risk assessment, where this is identified as necessary.

This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), regulation 4(1)(a) - a regulation regarding the health, welfare and safety of service users, and regulation 15(a) - a regulation regarding staffing.

It also takes into account the National Care Standards Care Homes for Older People Standard 6 - Support Arrangements, Standard 5 - Management and Staffing Arrangements, the SSSC Code of Practice for Employers Section 2, the SSSC Code of Practice for Social Service Workers Section 4, the NMC guidance for the Care of Older People 2009, NHS Scotland/Care Inspectorate Managing Falls and Fractures in Care Homes for Older People 2011.

Timescale for achieving this requirement: Parts a) and c) by 1 November 2013, parts b) and d) by 29 November 2013.

2. The provider must ensure staff have access to information about and contact details for the local authority adult support and protection team, and that this information is easily accessible to all staff in the service.

This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), regulation 4(1)(a) - a regulation regarding health, safety and welfare.

It also takes into account the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing Arrangements, the NMC guidance for the Care of Older People 2009, and the SSSC Code of Practice for Social Service Workers Section 1.4.

Timescale for achieving this requirement: By 15 October 2013.

**Recommendations**

1. The provider should ensure that all towels and other items are removed from assist rails around the toilets.

This takes into account the National Care Standards Care Homes for Older People Standard 4 - Your Environment.

**Statement 3**

The environment allows service users to have as positive a quality of life as possible.

**Service strengths**

We found that the service was performing at an adequate level in relation to the areas covered in this Quality Statement.

Some areas of the environment had been improved in the last year, and mostly we saw that the home was clean, homely and pleasantly decorated. Bedrooms were all single rooms, with ensuite toilet and wash hand basin. Some residents' bedrooms were personalised with pictures, ornaments and in some cases their own choice of bedding. However, we were concerned about the condition of some of the bathrooms, and the impact this had on choices available to residents. Further work was also needed to make sure that the standard of furnishings was consistently good.

We saw that the service had taken some steps to make the environment more suitable for people with dementia. There was some signage that helped people with dementia to recognise important areas such as bathrooms and toilets. People with dementia can often be restless, and want to walk around and we saw that residents who wanted to walk were able to do so within each of the units. Staff did not try to prevent residents who wanted to walk around, and we saw staff on occasions walking along with residents, to engage them in conversation whilst also making sure they were safe.

Lighting is important for older people, as older eyes need more light to be able to see. This can be particularly important for people with dementia, who may not only have poor eyesight but may also have difficulty with depth perception. We found that the lighting in the home was fairly good, with a lot of natural light particularly in public areas.

Staff told us that some residents chose to keep their room locked, so that they could control who had access. We spoke with one lady who told us that she liked to do this.

The service had made the lounge area and conservatory next to the manager's office on the ground floor available for residents' use, creating more public space. During our visit, we saw this area being used by residents for activities. There were also facilities for making tea and coffee, which visitors could use.

Residents in Islay Unit were able to get direct access to the garden through the door from the conservatory on the unit. Residents from other units who were able to go

downstairs were able to get into the garden through the conservatory by the manager's office. The garden to the rear of the building was well maintained, had outside seating areas, and was enclosed so that residents could safely walk around outside. During our visit, we saw residents walking freely in and out of the garden.

We found that the service provided a range of equipment to support residents to be independent or to improve the quality of their life. This included the following:

- slings and hoists to help people with mobility difficulties to move or transfer around the home;
- other mobility aids such as walking frames and wheelchairs;
- sensor mats and alarms which helped residents to have free movement around the unit, while alerting staff to the need to ensure that the resident was safe;
- specialist mattresses to help to protect residents' skin from damage.

The feedback we got from residents and relatives about the environment of the home was mainly positive. People told us that they liked the refurbishment work that had been recently carried out in some of the public areas. People who completed questionnaires also indicated that they were, on the whole, happy with the quality of the environment. A few people had some concerns, and we have written about these in the Areas for Improvement below.

**Areas for improvement**

As we noted above, there were still areas of the environment that needed improvement.

We found that on each of the units there was a bathroom or shower room that was not able to be used because of the poor state of repair. In Skye Unit, the bathroom had a bath that was scratched and marked, and which residents with limited mobility would find difficult to access. There were laundry trolleys stored in this room, and staff told us that it was being used as a "laundry room". In Islay Unit, we saw that one of the shower rooms was also being used to store laundry. The shower cubicle in this room was dirty, stained and damaged, and tiles in the shower were cracked and broken. This risked spreading infection, or causing injury from the sharp edge of broken tiles. The toilet seat was worn and the surface damaged, which meant that it could not be properly cleaned and risked spreading infection. Staff told us that the shower room on Arran Unit was also broken, and had been out of use for a considerable time. The manager confirmed to us that these rooms were now intended to be used as laundry rooms rathr than bathrooms, although we saw from water temperature records that one had been used for residents bathing as recently as May this year. We recognised that there was an alternative bathing facility available on each of the units, but having three of the bath or shower rooms

unavailable for use restricted the choices available to residents. We discussed this following the inspection with the Operations Manager for the service. He told us that the provider now had plans in place to refurbish the two shower rooms that had been out of use, to convert them to wet floor showers. The provider was also reviewing the bathroom that was being used as a laundry room, and hoped to also convert this to a wet floor shower. We have asked the provider to give us an action plan for this work, including timescales for when the work will be completed. (See requirement 1 below)

We also found that some of the furnishings in use in the home were in a poor state of repair. We saw a divan bed with a hole in the base, torn linen on a bed, lumpy pillows, and marked or stained chairs. These, along with the condition of some of the bath or shower rooms we described above, compromises the dignity of residents. (See requirement 2 below)

Some of the bedrooms we saw needed attention to improve the standard of decoration. We acknowledged hat there had been a programme of redecoration ongoing over the past year, and six bedrooms have been redecorated as part of this programme. The manager told us that this is a" rolling programme" in that it is constantly being updated and added to. She said they also take the opportunity to decorate when rooms become vacant. We will look to see how this is progressing at future inspections. However, one relative commented in their questionnaire that their relative's room needed to be decorated. We recommend that the provider prioritise the rooms to be redecorated, and draw up a formal plan, and share that plan with residents and their relatives, so that people know when work is likely to be carried out. This will provide residents and relatives with reassurance and realistic expectations, as well as an opportunity to discuss and influence the plan. (See recommendation 1 below)

During our visits we noted that the television and the radio in the lounge in Islay Unit were both on at the same time, with the sound on the television muted This can be frustrating for residents who might want to watch the television, but is of particular issue for residents with dementia, who may find it adds to their sense of confusion and disorientation. (See requirement 2 below)

The small dining area in Islay Unit meant that the area was very "busy" and noisy during mealtime. Noise and high levels of activity can cause residents with dementia to become agitated and distressed. We discussed this with the manger, who agreed to look at ways of trying to reduce the "busy-ness" of the dining room during meal times. (See requirement 2 below)

While some areas of the physical environment of the home were of a good quality, the areas of improvement were of significance, and this is reflected in the grade we have awarded for this quality Statement.

**Grade awarded for this statement:** 3 - Adequate

**Number of requirements:** 2

**Number of recommendations:** 1

**Requirements**

1. The provider must provide the service in a manner which promotes quality and safety, and affords choice in the way the service is provided to service users. In order to do so, the provider must:
   a) ensure that there are sufficient bathing facilities in the home to enable residents' preferences for the style and frequency of bathing to be met;
   b) ensure that all of the bathing facilities available in the home are fit for use by residents;
   c) submit to the Care Inspectorate a copy of the action plan which shows the work that the provider intends to carry out on each of the three bathing facilities that were out of use at the time of the inspection, including proposed timescales for completeion of that work, which must be agreed with the Care Inspectorate;
   d) discuss with the Care Inspectorate any proposal to permanently reduce the bathing facilities in the home, and be able to demonstrate how this can be achieved without having a negative impact on the service's ability to meet service users' needs and offer them choice in the way their care is provided.

   This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), regulation 3 - a regulation regarding quality, safety and choice, and regulation 10(2)(a) - a regulation regarding fitness of premises.

   It also takes into account the National Care Standards Care Homes for Older People Standard 4 - Your Environment, and Standard 8 - Making Choices.

   Timescale for achieving this requirement: An action plan which sets out the details of the work to be carried out, the timescale for completion of the work, and identifies the person responsible for ensuring the work is completed must be submitted to the Care Inspectorate by 30 November 2013. Timescales for the completion of any work identified in the action plan must be agreed with the Care Inspectorate, and the Care Inspectorate must be informed of any variance from those timescales in the action plan.
2. The provider must carry out an assessment of the physical environment of the service, and identify those areas where improvements are necessary to the decor, furnishings and fittings in the home in order to make it suitable for the purposes of achieving the aims and objectives of the service, and to meet the physical and psychological needs of the service users. This assessment must take into account but not be limited to the issues we have raise in Statement 3 of Quality of the Environment in this report. It must also give particular consideration to the needs of residents who have dementia.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) - Reg 10(1) and (2) - regulations regarding the fitness of premises.

It also takes into account the National Care Standards Care Homes for Older People Standard 4 - Your Environment, the NMC Guidance for the Care of Older People, Stirling University Dementia Services Development Centre (DSDC) Hearing, Sound and the Acoustic Environment for People with Dementia 2010, and the Scottish Governments Standards for Dementia Care in Scotland.

Timescale for achieving this requirement: An action plan which sets out in detail the action that is necessary, the person responsible for that action, and the timescales for completion of the action must be submitted to the Care Inspectorate by 1 November 2013. Timescales for the completion of any work identified in the action plan must be agreed with the Care Inspectorate, and the Care Inspectorate must be informed of any variance from those timescales in the action plan.

**Recommendations**

1. The provider should formalise their rolling programme of redecoration into a written plan, and share that plan with residents and their relatives.

   This takes into account the National Care Services Care Homes for Older People Standard 8 - Making Choices, Standard 11 - Expressing Your Views.

## 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

The information we reported in Statement 1 of Quality of Care and Support about how the service involved residents and relatives in decisions about the service is also relevant to this Quality Statement.

### Areas for improvement

There where systems in place to share information and gather people's views, but we did not see outcomes from these in relation to the quality of staffing in the service. We looked for examples of how the views and opinions of residents or relatives had influenced the quality of staffing in the service. For example we looked at records of staff supervision and at minutes of staff meetings to see if there was any discussion of feedback from residents or relatives, but we did not see this.

Because we were not able yet to see those outcomes, we have graded this Quality Statement as adequate. The service needs to consider how residents and relatives can be more involved in influencing the quality of staffing in the service, and to develop ways in which they can be supported to do this. (See recommendation 1 below)

**Grade awarded for this statement:** 3 - Adequate

**Number of requirements:** 0

**Number of recommendations:** 1

### Recommendations

1. The provider should consider ways in which residents and relatives can be more involved in assessing and improving the quality of staffing in the service, and should develop systems to support them to do this.

   This takes into account the National Care Standards Care Homes for Older People Standard 11 - Expressing Your Views, and the NMC Guidance for the Care of Older People.

**Statement 3**

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

**Service strengths**

We did not consider all aspects of this Quality Statement, but looked at the systems in place to support a professional and well informed staff team. We found that the service was performing at a level which was adequate.

There was a range of policies in use, to give guidance for staff and to support professional practice. These included the following:

- Disciplinary Policy;
- Grievance Policy;
- Training and Development Policy;
- Dignity at Work Policy.

We saw from staff training records that there had been some training provided in topics related to care over the past three years. For example, some staff had received training in infection control, safe moving and handling and adult support and protection. There was a "traffic lights" system to flag up to the manager when staff were due for training. However, the records we were shown during the inspection showed that there had been very little training in the last 12 months, and we have talked about this in the Areas for Improvement below.

We looked at records of staff one-to-one supervision. These are regular meetings between a line manager and staff member where they can discuss the staff member's work, and consider any support that might be needed, such as training. We saw that until recently there had not been regular supervision, but that this was now improving. Most staff members that we spoke with told us that they had recently had supervision. We have commented further on supervision in the Areas for Improvement below.

Staff told us that there had been recent staff meetings, and that they were able to attend. We saw minutes for meetings that had been held in April for different groups of staff. We could see that practice issues had been discussed at these meetings, information shared about residents discussion of issues to do with employment and staff performance, and training.

**Areas for improvement**

As we noted above, the evidence we were shown indicated that there had been little training in the past year. The most recent training programme we were shown was for 2011. When we spoke with the manager about this, she said that there had been more recent training, but that the records had not been updated to reflect this. We

asked that she send us the updated records before the report for the inspection was completed,and took these updated records into account. Based on the evidence that we saw, we have made a requirement about training. When we return to do our next inspection, we will look at the updated records, and will be able to assess whether or not the requirement has been met. (See requirement 1 below)

The provider had identified training in safe moving and handling, as essential or "mandatory" training for all staff. However, when we looked at training records, only 16 out of 41 staff involved in providing care had received moving and handling training in the last year. It is good practice for this type of training to be updated every year. (See requirement 1 below)

Out of 26 care staff, only 13 had achieved a Scottish Vocational Qualification (SVQ) in care. Depending on their role and job description, some staff may already be legally required to register with the SSSC, while others may have until September 2015 to do this. In order to register, staff must have appropriate qualifications, including SVQs in care. (See recommendation 1 below)

We also noted that 35 out of a total of 55 staff employed in the service had received training in adult support and protection. Everyone working in the home should have some understanding of the legislation and their responsibilities to report concerns, appropriate to their role in the service. (See requirement 1 below)

Only three staff had received training in dementia care over the past two years. At points in this report, we have commented on aspects of care which particularly affect residents with dementia, such as person-centred care planning, the experience of residents at mealtimes, the impact of the physical environment, and the interactions of a very small number of staff. Staff providing care for older people, the majority of whom will be affected to some degree by dementia, should have training in understanding the needs of residents with dementia, and how those needs can be met. (See requirement 1 below)

We made a requirement at our last inspection that:
"The provider must, having regard to the aims and objectives of the service and the number and needs of residents, ensure that there are at all times sufficient staff working in the service to meet the needs of residents. In order to do so, the provider must record and be able to evidence how their dependency assessments are used to inform staffing levels and deployment".

We looked at staffing rotas, and found that the service was meeting the minimum staffing levels as set out in the staffing schedule. However, there was no evidence of how staffing levels were altered to reflect increased dependency levels, as identified by the regular dependency assessments carried out each month. We could see that staffing levels fluctuated, but these fluctuations did not appear to be related to dependency levels. We also found when we looked at staff rotas that at times staff

were identified only by their first name, and that the rotas did not make clear where the staff were deployed to work on each shift. This meant that it was not possible to see which staff were providing care in each unit at any given time. We have extended our requirement about staffing to give more detail to the provider about what improvements are necessary. (See requirement 2 below)

We found when we looked at the content of supervision that practice issues and training were discussed, but we did not see that issues or objectives from previous supervision sessions were reflected on, to see where progress or improvement had been made. As we commented earlier, there was also no evidence that the views of residents or relatives influenced the discussions at these supervision sessions. (See recommendation 2 below)

**Grade awarded for this statement:** 3 - Adequate

**Number of requirements:** 2

**Number of recommendations:** 2

**Requirements**

1. The provider must ensure that staff employed in the service receive training appropriate to the work they are to perform. In order to do so, the provider must:
   a) carry out an assessment of training needs to identify what training is necessary to enable staff to meet service users' needs and the aims and objectives of the service, and to help staff to meet their personal development needs;
   b) draw up a training programme for the next 12 months which addresses those identified needs;
   c) ensure that all staff have received up to date theoretical and practical training in safe moving and handling, appropriate to their role in the service;
   d) ensure that all staff employed in the service have received up to date training in adult support and protection, appropriate to their role in the service;
   e) ensure that all staff working in the service receive training in understanding the needs of people with dementia, and how to meet those needs, appropriate to their role in the service
   f) ensure that accurate records are kept of the training that staff have received, to enable the manager to have an overview of, and be able to evidence, the current status of staff knowledge and skill.

   This is in order to comply with the Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI 2011/210), regulation 15(a) - a regulation regarding staffing.

   It also takes into account the National Care Standards Care homes for Older People Standard 5 - Management and Staffing Arrangements, the SSSC Code of Practice for Employers of Social Service Workers Sections 3 and 5, and the NMC Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives 2008.

Timescale for achieving this requirement: Parts a) and b) by 8 November 2013, part c) by 29 November 2013, part d) by 31 December 2013, and part e) by 1 April 2014.

2. The provider must, having regard to the aims and objectives of the service and the number and needs of residents, ensure that there are at all times sufficient staff working in the service to meet the needs of residents. In order to do so, the provider must:

   a) record and be able to evidence how their dependency assessments are used to inform staffing levels and deployment;
   b) ensure that the home's record of staff employed in the service on each shift is accurate and contains the full names of all staff on duty;
   c) ensure that the home's record of staff employed in the service on each shift identifies the area in which each staff member is deployed for the majority of the shift.

   This is in order to comply with the Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI 2011/28), regulation 4(1)(a) - a regulation regarding records. and SSI 2011/210 regulation 15(a) - a regulation regarding staffing.

   It also takes into account the National Care Standards Care Homes for Older People standard 5 - Management and Staffing Arrangements.

   Timescale for achieving this requirement: By 25 October 2013.

**Recommendations**

1. The provider should:
   a) carry out an audit of all staff providing care, to ensure that those who require to be registered with the SSSC or other professional body are suitably qualified and are registered;
   b) give consideration as to how the remainder of the staff team can be supported to achieve the qualifications necessary to enable them to register with the SSSC, when this becomes necessary in September 2015.

   This takes into account the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing Arrangements, and the SSSC Code of Practice for Employers of Social Service Workers Section 5.

2. The provider should continue to develop the way they use one-to-one supervision to make it even more effective in the support it provides for staff and the way it influences staff performance.

This takes into account the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing Arrangements, and the SSSC Code of Practice for Employers of Social Service Workers Section 2.2.

**Statement 4**

We ensure that everyone working in the service has an ethos of respect towards service users and each other.

**Service strengths**

As we have noted elsewhere in this report, most of the interactions that we saw were polite, caring, patient and respectful.

When we observed staff at work, and spoke with them, we also found that they demonstrated a respectful approach in they way they spoke with each other, or spoke about the residents, other staff members, or the management team in the home.

The language and terminology used in care records was appropriate and respectful of the residents.

The service had policies in place which supported respect and dignity in the home.

**Areas for improvement**

During our visit there were two occasions when we heard staff speak about or to residents in a way which we felt was not as respectful as it should have been. We drew these to the attention of the manager, and asked that they address this with the individual staff members. (See requirement 1 in Statement 3 of Quality of Staffing)

Our grading for this Quality Statement also reflects the issues we have discussed in earlier Quality Statements about the dining experience of residents, particularly where residents in Islay Unit were all given plastic cutlery and crockery, and the tables were not set for the meal. We felt that this differed from the way residents on other units experienced their mealtimes, and so treated residents with dementia with less respect than other residents. (See requirement 3 in Statement 3 of Quality of Care and Support)

In considering the grading for this Quality Statement, we have also taken into account the improvements that are needed to some areas of the physical environment. A well maintained physical environment which provides the best possible choices and opportunities for residents reflects a service which values and respects the people who use it. While mostly the environment was well maintained and homely, we identified that the service needed to improve some of the bathrooms and some of the decor, in keeping with the culture of respect that was demonstrated more generally in the service. (See requirements 1 and 2 in Statement 3 of Quality of the Environment)

**Grade awarded for this statement:** 3 - Adequate

**Number of requirements:** 0

**Number of recommendations:** 0

## 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

The information in Statement 1 of Quality of Care and Support shows the systems that the service had in place to gather people's views, and encourage residents and their relatives to be involved in decisions about the service.

### Areas for improvement

As with Statement 1 of Quality of Staffing, we did not yet see outcomes that showed how residents' and relatives' views had influenced the quality of management and leadership in the service. While we recognise that many care homes find this a challenge to achieve and to evidence, we do see examples of how services achieve this. One example is that some services highlight policies which have a direct impact on the day-to-day experience of the residents, and discuss these with residents and relatives. They also consult with residents and relatives when these policies are being changed or updated.

We have asked the service to consider how residents and relatives might be encouraged and supported to become more involved, and to influence the quality of management and leadership in the home. We will look to see how they do this at future inspections.

**Grade awarded for this statement:** 3 - Adequate

**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 found that there were some systems in place which helped the manager to monitor the quality of the service provided.

In Statement 1 of Quality of Care and Support, we have identified some of the ways the service asked for the opinions of residents and relatives, for example through meetings and surveys. We saw that they also held meetings and surveys to ask staff what they thought of the service and what could be done better. All of this helped the manager to assess the quality of the service.

The maintenance person kept records of checks and services that had been carried out, and when these were next due.

Records were kept of staff training, and there was a system to highlight when staff were due for some training that the provider had identified as mandatory. However this was not being used effectively to ensure that staff training was up to date.

Each day, short, summary reports shared information between the staff in charge on each unit and the manager, so that she was aware of any issues or concerns. During our visits we saw that the manager followed up on these reports, to make sure that the issues had been dealt with.

The manager was very visible in the service. We saw when we visited that she spent a lot of time out and around the home, and was in regular contact with staff, residents and families. When we spoke to people, they told us that this was her normal practice, and that they found her approachable and supportive.

We made a requirement at the last inspection that:
"The provider must ensure that the Care Inspectorate is notified of matters listed in the document 'Guidance on notification reporting'. In order to achieve this, staff who take charge of the home should be familiar with this notification guidance".

In discussions with staff we found that they were aware of the need for certain events to be notified to the Care Inspectorate. Since the last inspection, we have also noted that the Care Inspectorate had been receiving notifications about a variety of issues, in line with the guidance. While not all staff who may take responsibility at times for being in charge of the home were able to access the electronic notifications system, there was a system in place for information to be shared with key members of staff who were able to do so.

**Areas for improvement**

We found that quality assurance work carried out in the home was not sufficiently good to help the manager to identify areas where improvement was necessary.

At our last inspection we made a recommendation that:
"The provider should ensure that its structured approach to quality assurance is consistently followed to enable areas for improvement to be identified and acted on".

When we looked at quality assurance at this inspection, we found that there was little evidence of formal quality assurance systems in place in the service, beyond those we have described above. Although the manager was often aware of issues in the service as they arose, we found that there was no formal system of audit or spot checks to monitor quality, identify areas for improvement, or to show where improvements were having a positive impact on the service. Carrying out checks in this way provides evidence which can help the manager to measure not only the quality of the service, but also to demonstrate improvements over time. This information, if shared in an appropriate and meaningful way, can offer reassurance for residents, relatives, and other agencies such as the local authorities who commission care for their clients. (See requirement 1 below)

Throughout this report, we have noted that, where there were areas for improvement, these could have been identified and addressed by the management had there been robust quality assurance measures in place. The service is currently operating at an adequate level. In order to bring about continued improvement, and to be able to sustain that improvement, there needs to be a system of checks in place to identify and prioritise actions which will make the service better, and improve the quality of life for residents. (See requirement 1 below)

We found that the service was not making the most effective use of the quality assurance systems that were in place. Where areas for improvement were identified, there was not always an action plan to show how the service was going to achieve these, and when. We saw too that at times work that had been completed had not been signed off as done, so the improvements were not evidenced. For example, remedial action had been needed after the last LOLER testing, but it was not clear from the paperwork that this had been done. When we asked the manager about this, she was able to provide assurances that this work had been carried out, but it had not been signed off at the time. (See requirement 1 below)

We could see that there were some opportunities for residents, relatives and staff to comment or make suggestions, but we did not always see that these suggestions were followed up, and were used to bring about improvements in the service. It would be good practice for an action plan to be drawn up to show how the service was going to respond, and to share that information with residents and relatives. (See requirement 1 below)

The service could also be more pro-active in the way it involves other agencies with a professional interest in the service in assessing and improving the quality of care. For example, some services use questionnaires or telephone surveys to ask professionals such as GPs or social workers how well they think the service does in caring for their patients or clients, and if there is anything that could be done better. (See recommendation 1 below)

We made a requirement at the last inspection that:

"The provider must make proper provision for the health, welfare and safety of service users by having appropriate procedures for the prevention and control of infection. In order to do so, the provider must:
a) Update their policies and procedures for prevention of infection to reflect best practice guidance, such as national guidance provided by Health Protection Scotland.;
b) Ensure that all staff follow best practice in infection control, and that there is management oversight of practice."

We have reported our findings in relation to infection control practices in Statement 2 of Quality of the Environment. While much of what we observed was satisfactory, there were a few areas where staff practice still needed to be improved. As we have noted in this Quality Statement, quality assurance and management oversight needs to improve, and formal audits or checks put in place, for example spot checks on standards of hygiene in the service. We looked at the service's policy on infection prevention and control, and this made no reference to best practice guidance. We therefore judged that this requirement had not been met, and we have repeated it. (See requirement 2 below)

**Grade awarded for this statement:** 3 - Adequate

**Number of requirements:** 2

**Number of recommendations:** 1

**Requirements**

1. The provider must provide the service in a manner which promotes quality. In order to do so, the provider must:
   a) implement regular and effective systems of quality assurance, including audits and spot checks;
   b) where possible and appropriate, involve residents and/or relatives in quality assurance activity;
   c) ensure that the outcomes from quality assurance activity are clearly recorded to show how it brings about improvements to the quality of the service;
   d) where possible and appropriate, share information about outcomes from quality assurance activity with residents, relatives, staff and agencies with a professional interest in the service, in a way which is easily accessible and meaningful in order to promote further involvement.
   This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), regulation 3 - a regulation about promoting quality.
   It also takes into account the National Care Standards Care Homes for Older People Standard 5 - Management and Staffing Arrangements.
   Timescale for meeting this requirement: 12 weeks from receipt of this report.
2. The provider must make proper provision for the health, welfare and safety of service users by having appropriate procedures for the prevention and control of infection. In order to do so, the provider must:

a) Update their policies and procedures for prevention of infection to reflect best practice guidance, such as national guidance provided by Health Protection Scotland.;
b) Ensure that all staff follow best practice in infection control, and that there is management oversight of practice.

This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), regulation 3 - a regulation regarding promoting quality and safety, and reg 4(1)(d) - a regulation regarding infection control.

It also takes into account the National Care Standards Care Homes for Older People Standard 4 - Your Environment, Standard 5 - Management and Staffing Arrangements, NHS Scotland National Infection Prevention and Control Manual 2013.

Timescale for achieving this requirement: By 29 November 2013.

**Recommendations**

1. The provider should continue to develop its quality assurance systems by finding ways to involve visiting professionals and agencies with a professional interest in the service, through encouraging and supporting them to express their views of the service, and how it can be improved.

   This takes into account the National Care Services 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

## 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 the Care Inspectorate re-grading a Quality Statement within the Quality of Management and Leadership Theme (or for childminders, Quality of Staffing Theme) as unsatisfactory (1). This will result in the Quality Theme being re-graded as unsatisfactory (1).

# 5 Summary of grades

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

# 6 Inspection and grading history

| Date | Type | Gradings | |
|---|---|---|---|
| 26 Oct 2012 | Unannounced | Care and support<br>Environment<br>Staffing<br>Management and Leadership | 3 - Adequate<br>3 - Adequate<br>3 - Adequate<br>3 - Adequate |
| 6 Aug 2012 | Unannounced | Care and support<br>Environment<br>Staffing<br>Management and Leadership | 3 - Adequate<br>2 - Weak<br>3 - Adequate<br>3 - Adequate |
| 23 Mar 2012 | Unannounced | Care and support | 2 - Weak |

| | | | |
|---|---|---|---|
| | | Environment | 2 - Weak |
| | | Staffing | 3 - Adequate |
| | | Management and Leadership | 3 - Adequate |

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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