Care service inspection report

Skye View Care Centre

Care Home Service Adults

1 Arran Drive
Airdrie
ML6 6NJ

Inspected by: Rose Bradley

Aileen Scobie

Type of inspection: Unannounced

Inspection completed on: 17 January 2014

Contents

Service provided by:

Care In The Community Ltd.

Service provider number:

SP2003002362

Care service number:

CS2009232361

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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	2	Weak
Quality of Environment	2	Weak
Quality of Staffing	2	Weak
Quality of Management and Leadership	2	Weak

What the service does well

Residents who spoke with us said they liked living at the service. We saw that staff attended promptly to residents requests for assistance and did so in a respectful and gentle way. There was a calm and relaxed atmosphere.

The manager and external manager welcomed daily discussions about our findings during the inspection visit. They acted upon the findings to try to improve the service and outcomes for residents.

What the service could do better

Fourteen requirements were made at the last inspection. The progress the service had made toward meeting or partially meeting some of the requirements helped show that systems were being put in place which would help support staff to improve the quality of the service. As a result we saw some improvement in the management of key healthcare areas including medication management, pressure ulcer prevention, nutrition and continence management.

However there are still areas that continue to cause concerns particularly around some aspects of healthcare, the cleanliness of the building, staff competency and developing the leadership of the service to ensure that consistent, safe care is provided to this vulnerable group of residents.

What the service has done since the last inspection

Since the last inspection there has been a change of manager. The new manager had only been in post since November 2013 and at this stage it is too early to measure the impact they will have on leading staff to improve the quality of the service. The new manager was enthusiastic and eager to work with us to improve the quality of the service.

The improvements noted at this inspection had been instigated and driven by the external manager.

Since the last inspection, staff had:

- Continued to provide some form of daily activity to help make residents days more interesting.
- Safer Recruitment procedures and the recording of staff training had improved.
- New pressure relieving mattresses have been purchased.
- Some improvement was noted in medication management, continence care, nutrition and pressure ulcer prevention.

Details of requirements made at the last inspection are contained within the report. In order to support improvement unmet elements from some requirements have been reworded or incorporated into other requirements to give more clarity of expectation and reduce the overall number of requirements. This should support the provider and manager in developing an achievable action plan.

Conclusion

Following the last inspection we advised the provider that failure to achieve improvement at the service would result in the Care Inspectorate taking enforcement action.

At this inspection we saw evidence of some improvement at the service. At feedback the provider demonstrated willingness to work with us and a commitment to continuing to improve the service. The provider demonstrated an awareness of the need to sustain improvement.

However if improvement is not sustained the Care Inspectorate will consider enforcement action.

Who did this inspection

Rose Bradley
Aileen Scobie

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.careinspectorate.com.

This service was previously registered with the Care Commission and transferred its registration to the Care Inspectorate on 1 April 2011.

The Care Inspectorate will award grades for services based on findings of inspections. Grades for this service may change after this inspection if we have to take enforcement action to make the service improve, or if we uphold or partially uphold a complaint that we investigate.

The history of grades which services have been awarded is available on our website. You can find the most up-to-date grades for this service by visiting our website, by calling us on 0845 600 9527 or visiting one of our offices.

Requirements and recommendations
If we are concerned about some aspect of a service, or think it could do more to improve its service, 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 but where failure to do so will not directly result in enforcement.
- A requirement is a statement which sets out what is required of a care service to comply with the Public Services Reforms (Scotland) Act 2010 and Regulations or Orders made under the Act or a condition of registration. Where there are breaches of the Regulations, Orders or conditions, a requirement must be made. Requirements are legally enforceable at the discretion of the Inspectorate."

Skye View Care Centre (referred to in the report as "the service") is registered to provide a service for 26 older people with a diagnosis of dementia and adults under 65 years who have a diagnosis of dementia. The service is owned and managed by Care in the Community Ltd (referred to in the report as the "provider")

During the inspection there were 18 people (referred to in the report as "residents") living in the service.

The service is situated in a quiet residential area of Airdrie. There are local shopping facilities and public transport links nearby.

The accommodation has en-suite bedrooms and two lounges, one on the ground floor and another on the first floor. Both floors have dining areas. The upper floor has accessed via a lift and stairs.

The aims and objectives of this service state:

''We will endeavour to provide a 24 hour holistic care to specialised dementia residents in a supportive and comfortable environment. It is our objective to promote independence and help each resident reach their maximum potential. We will ensure that their wellbeing, privacy and dignity are maintained at all times. We actively promote resident and relative participation in all aspects of our service".

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

Quality of Care and Support - Grade 2 - Weak
Quality of Environment - Grade 2 - Weak
Quality of Staffing - Grade 2 - Weak
Quality of Management and Leadership - Grade 2 - Weak

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 the report after an unannounced inspection that took place at the service on the 7 January 2014 between the hours of 9.45am and 3.30pm, 8 January 2014 between the hours of 10am and 4.30pm and the 10 January 2014 between the hours of 9.45am and 4pm.

The inspection was carried out by Care Inspectorate Inspectors Rose Bradley and Aileen Scobie.

The manager of the service (referred to in the report as the "manager") and the manager from Hogganfield Loch Nursing Home, (referred to in the report as the "external manager") which the provider also owns were made aware of the main areas of concerns at the end of each inspection day.

The outcome of the inspection was formally discussed with the provider at a meeting on the 17 January 2014. The meeting was attended by two directors, the service manager and the external manager and the finance manager.

The focus of this inspection was to make sure that the residents were protected and that their health and welfare needs were met. We did this through measuring progress in meeting the requirements made at the last inspection in August 2013 and assessing the professional care practices in the service.

During this inspection we gathered evidence from various sources, including relevant documentation including residents care plans and staff records. We paid particular attention to the action plan the provider gave us describing how they planned to address the requirements and recommendations made following the inspection of August 2013.

We also had discussions with various people including:

- Manager
- External manager
- Registered nurses who were on duty
- Carers who were on duty
- Finance staff
- New care staff who were undertaking their induction to the service.

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

1. Ensure that auditing and monitoring of cleaning measures are put in place in accordance with Infection Control in Adult Care Homes: Final Standards.
2. Develop and implement cleaning schedules for equipment in the home.
3. Review the domestic staffing to ensure that adequate domestic staff are employed to enable the home's daily and weekly cleaning schedules to be fully implemented.
4. Carry out regular risk assessments of the building environment taking appropriate and timely action to address any risks identified or visible.

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) - Welfare of Users and Regulation 10(2)(a),(b) and (d) - Fitness of premises.

Timescale: to commence within 48 hours and be completed by the 30 October 2013.

What the service did to meet the requirement

This requirement had not been met. This is discussed under Quality Theme 1, Statement 2.

The requirement is: Not Met

The requirement

The provider must continue to develop the audits of accidents and incidents in the service to identify and minimise risks to service users. Where the risk is person specific this must be:

1. Clearly recorded in their care plan.
2. Identify what the risk is.
3. Identify what factors were considered in assessing this risk i.e environmental factors, service users understanding.
4. Identify how the service aims to reduce the risk including the management of unexplained bruising.

5. Identify what outcomes they have achieved as a result of a suitable risk management plan.

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) - Welfare of Users

Timescale - to commence within 48 hours and be completed by 30 October 2013.

What the service did to meet the requirement

This requirement had been met. This is discussed under Quality Theme 2, Statement 2.

The requirement is: Met - Within Timescales

The requirement

The provider must adhere to the staffing schedule and ensure there are sufficient numbers and skill mix of staff to meet the care needs of service users using 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 15(a) - a regulation about staffing.

Timescale for meeting this requirement: to commence within 24 hours of receipt of this report for completion by 30 October 2013.

What the service did to meet the requirement

This requirement had been partially met. This is discussed under Quality Theme 2, Statement 2.

The requirement is: Not Met

The requirement

The provider must ensure the health and welfare or residents and that there is a medication recording system that is safe, up to date, and accurate. To do this it must ensure:

1. A complete, accurate and consistent auditable record of all medicines entering, administered or destroyed, and leaving the service.

2. That where a regular medicine is not given as prescribed a reason for this is clearly annotated on the Medicines Administration Recording [MAR] chart.
3. That medication including homely remedies is available at the time of administration.
4. Medication is given in line with the service user's lifestyle (for example that night sedation is given when the person wants to go to bed rather than at "drug round" times).
5. Medication which has passed its expiry date must not be available for use.
6. The medication trolley is not left open and unattended and is secured to a wall when not in use.

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) - Welfare of users.

Timescale: to commence within 24 hours of receipt and be completed by the 30 October 2013.

What the service did to meet the requirement

This requirement is partially met. This is discussed under Quality Theme 1, Statement 3 where an amended requirement will be made.

The requirement is: Not Met

The requirement

The service provider must develop care plans for the administration of medication that is prescribed on an "as required" basis. The care plan must be subject to regular review and include:

- when medication started
- who prescribed it
- what condition it is prescribed for
- criteria for administration
- the use of assessment tools such as the Abbey Pain Scale tool.

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) - Welfare of users.

Timescale: to commence with in 24 hours for completion by 30 October 2013.

What the service did to meet the requirement

This requirement had been met. This is discussed under Quality Theme 1, Statement 3.

The requirement is: Met - Within Timescales

The requirement

The asset register must be completed, clearly listing all valuables and assets owned by residents. This must be regularly checked against residents' actual property. Assets must be labelled and identified as the property of the resident to whom they belong. A statement of assets held on the resident's behalf must be provided to the resident or their next of kin and or representative and upon their departure from 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 14 (e) - Facilities in care homes and The Regulation of Care (Requirements as to Care Services) (Scotland)Regulations 2002 (SSI 2002/114) regulation 19(3) (h) - Records.

Timescale: to commence within 24 hours from receipt of this report for completion by 30 October 2013.

What the service did to meet the requirement

This requirement had been met. This is discussed under Quality Theme 1, Statement 2.

The requirement is: Met - Within Timescales

The requirement

The provider must ensure that all service users with continence management problems have an individual continence management plan that takes account of:

1. Staff understanding of residents' continence care needs and how continence is promoted.
2. Accurate fluid intake is recorded if required.
3. Analysis of episodes of incontinence.
4. Links to nutrition, skin integrity and medicines.
5. Normal bowel habits and medication for constipation.
6. Environmental factors that could affect continence promotion.
7. Any other risk factors specific to individual residents needs such as dementia, diabetes and acute illness.

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) - Welfare of users and Regulation 15(a) and (b), (i) and (ii) - Staffing and takes account of NHS Health Improvement Scotland formerly QIS(2009) Best Practice Statements and Scottish Intercollegiate guidelines Network (SIGN) 2005/2006, Nursing and Midwifery Council (NMC) guidelines for record keeping.

Timescale: to commence within 1 week and be completed by 30 October 2013.

What the service did to meet the requirement

This requirement had been partially met. This is discussed under Quality Theme 1, Statement 3 where outstanding elements from the requirement will be incorporated into a requirement about care plans. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly.

The requirement is: Not Met

The requirement

The provider must review service users' eating and drinking care plans and associated care plans such as those for constipation to ensure that all service users' needs are identified. In order to do so the provider must ensure:

1. That dietary intervention is specified, care is implemented, effectively monitored and comprehensively evaluated.
2. Identify service users' eating and drinking needs on admission, formulate a care plan to address these needs and thereafter regularly review.

3. Implement the operational procedures about the action staff must take for service users identified as having weight loss, risk of malnutrition and/or dehydration.
4. Have an audit system which provides an overview of how well it is managing service users' eating, drinking and nutritional care.

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) - Welfare of users and takes account of the National Care Standards, Care Homes for Older People, Standard 13 - Eating Well.

Timescale: to commence within 24 hours and be completed by the 30 October 2013.

What the service did to meet the requirement

This requirement had been partially met. This is discussed under Quality Theme 1, Statement 3 where outstanding elements from the requirement will be incorporated into a requirement about care plans. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly.

The requirement is: Not Met

The requirement

The provider must review and implement changes to the menu to ensure it meets the dietary needs of service users and use best practice standards to help it plan, for example Food in Hospitals national catering and nutrition specification for food and fluid provision in hospitals in Scotland 2008 Scottish Government which is applicable to care homes. Download from www.scotland.gov.uk/Publications/2008/06/24145312/0.

The provider must review and implement and necessary changes to the provision of special diets, in particular high calorie diets and modified food textured diets, to ensure residents receive a balanced and nutritious diet which is appropriate to their individual needs. Residents must be properly consulted about the menus as they are being developed and on an on-going basis, to make sure they cater for residents' preferences and offer choice.

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) - Welfare of users and takes account of: the National Care Standards. Care Homes for Older People, Standard 13 - Eating Well.

Timescale: food modification to commence within 24 hours of receipt of this report and completed by the 30 October 2013.

What the service did to meet the requirement

This requirement had been met. This is discussed under Quality Theme 1, Statement 3.

The requirement is: Met - Within Timescales

The requirement

The provider must implement a planned and consistent approach to: skin assessment and care; pressure ulcer prevention; wound assessment and tissue viability management. In order to achieve this the provider must:

1. Further update the "pressure areas care and management" policy.
2. Implement the policy to ensure it reflects best practice in relation to a planned and consistent approach to care.
3. Ensure all registered nurses and care staff are fully conversant with the policy.
4. Ensure that risk assessment for pressure ulcer prevention is carried out within the timescales stated in the policy guidance.
5. Identify all service users at risk of pressure ulcer development and ensure that they have appropriate plans of care in place and evaluate these plans within agreed timescales.
6. Ensure that relevant health professionals and service users' families are kept informed of any changes in care and progress and that this is documented.
7. Ensure that individual service users who are assessed as requiring therapeutic equipment for pressure ulcer prevention or treatment receive this timeously as part of their care and treatment.
8. Improve wound care documentation to ensure that a clear complete and accurate record of care is kept.

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) - Welfare of users. Regulation 5(1) - Personal plans. Regulation 15(a) and (b), (i) and (ii) - Staffing.

Timescale: to commence within 24 hours and be completed by 30 October 2013.

What the service did to meet the requirement
This requirement had been partially met. This is discussed under Quality Theme 1, Statement 3 where outstanding elements from the requirement will be incorporated into a requirement about care plans. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly.

The requirement is: Not Met

The requirement
The provider must ensure that each service user has an appropriately detailed care plan to inform care staff about the individual and their specific care needs. Care plans must include but not be limited to service users' social and health care needs including pain management and specialist equipment.

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) - Welfare of users.

Timescale: to be completed by 30 October 2013.

What the service did to meet the requirement
This requirement had not been met. This is discussed under Quality Theme 1, Statement 3.

The requirement is: Not Met

The requirement
All staff must have a suitable Protection of Vulnerable adults (PVG) check performed and returned prior to commencing employment in the care home, in accordance with the provider's policy on recruitment. References requests from the most recent employer must be made.

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 9(1) and 9(2),(a),(b) and (c) - Fitness of employees.

Timescale: to commence within 24 hours and be completed by 30 October 2013.
What the service did to meet the requirement
This requirement had been met. This is discussed under Quality Theme 3, Statement 2.

The requirement is: Met

The requirement
The provider must ensure that all staff new to the service receive an induction to the service. A copy of the induction documentation must be kept on file at 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 15(a) and (b), (i) and (ii) - Staffing.

Timescale: to commence within 24 hours and be completed by 30 October 2013.

What the service did to meet the requirement
This requirement had been met. This is discussed under Quality Theme 3, Statement 3.

The requirement is: Met

The requirement
The provider must carry out regular evaluation of staff training and practice. An up to date record of each staff members training must be kept. This must include but not be restricted to moving and assistance techniques, infection control procedures, tissue viability, wound management, care planning and evaluation, meaningful activities and adult support and protection. All training must be delivered timeously to ensure that residents' needs are met.

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) - Welfare of users and Regulation 15(a) and (b)(i) and (ii)- Staffing and The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI 2011/28) regulation 4 - Notifications.

Timescale: to commence within 1 week and be completed within 30 October 2013.

What the service did to meet the requirement
This requirement had been partially met. An amended requirement will be made under Quality Theme 3, Statement 3.

The requirement is: Not Met

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

Recommendation 1

The provider should ensure that medicines are managed according to recognised best practice. To do this they should ensure that:

1. No stock is used in the treatment of minor ailments which is invasive when suitable alternatives exist.
2. Handwritten narratives on MARs should not use Latin abbreviation, should be dated when changes made and should record who authorised the changes.

This takes account of the National Care Standards, .Care Homes for Older People, Standard 5 - Management and staffing arrangements and Standard 15 - Keeping Well - Medication.

What the service did to implement the recommendation

This recommendation had been partially implemented because element 1 had been actioned and part of element 2.

This is discussed under Quality Theme 1, Statement 3 where an amended recommendation will be made.

Recommendation 2

The provider should ensure that covert medication care plans clearly detail for each medicine how they should be given covertly.

This takes account of the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing arrangements and Standard 15 - Keeping Well - Medication.

What the service did to implement the recommendation

This recommendation had been implemented.

Recommendation 3

Following water outlet temperature checks, records should indicate what remedial action, if any, has been taken to address the water outlets with temperatures outside the recommended safe limits.

This takes account of the National Care Standards, Care Homes for Older People, Standard 4 - Your environment.

What the service did to implement the recommendation

This recommendation had been implemented.

Recommendation 4
The provider should complete all risk assessments of each service user's ability to manage their finances on admission and on an on-going basis. The provider should complete the recording of the measures and authorities that are in place to manage residents' finances in the service users' personal plans.

Noted authority should guide staff expenditure on behalf of service users in accordance with The Adults with Incapacity (Scotland) Act 2000. Code of Practice. For managers of authorised establishments under part 4 of the Act, (6.14,6.13,6.29 and 1.17.5).

This takes account of the National Care Standards, Care Homes for Older people, Standard 9 - Feeling Safe and Secure and Standard 8 - Making Choices.

What the service did to implement the recommendation
This recommendation had been implemented. This is discussed under Quality Theme 1, Statement 2.

Recommendation 5
Each invoice in the sales ledger should note the period to which it relates and each standing order payment (or cash payment where applicable) should be matched to the invoice to which it relates. In this way, any omitted payments would be highlighted when due and could be easily identified and followed up for payment. Likewise any underpayments (due to a failure to change the Standing Order in line with increased assessment of client contribution), would also be identified and the shortfall of payments on each invoice easily identified and explained. These changes would help improve credit control and provider/customer communication.

Residents or their relatives should receive regular statements as a matter of course to keep them informed of the balance on their account and should have the opportunity to discuss any queries with the provider.

This takes account of the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing - keeping records of financial transactions in a way that care inspectors can readily examine

What the service did to implement the recommendation
This recommendation had been implemented. This is discussed under Quality Theme 1, Statement 2.

Recommendation 6
The provider should follow good practice guidance when interviewing prospective staff. This should include ensuring that more than one person is on the interview panel. When staff change roles within the organisation, there should be evidence that employees have been interviewed for the new role and that they have received appropriate training for the position.

This takes account of the National Care Standards. Care Homes for Older People, Standard 5 - Management and Leadership and Safer Recruitment Through Better Recruitment.

What the service did to implement the recommendation
The recommendation had been implemented. This is discussed under Quality Theme 3, Statement 2.

Recommendation 7
The provider should develop and implement an appropriate policy on the use of agency staff/bank staff and make it available to all staff that need access to it.

This takes account of the National Care Standards. Care Homes for Older People, Standard 5 - Management and Leadership.

What the service did to implement the recommendation
The recommendation had been implemented.

Recommendation 8
The provider should identify who is responsible for keeping operational policies and procedures up to date in order to ensure the policies are reviewed regularly and are in line with current good practice guidance. Policies should record the date when theses should be reviewed.

This takes account of the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing.

What the service did to implement the recommendation
The recommendation had been partially implemented. A designated Director had responsibility for updating policies. Because the focus of the inspection was to measure the progress in meeting requirements, this recommendation was not fully explored at this inspection. We will make an amended recommendation under Quality Theme 3, Statement 3.

Recommendation 9
The provider should ensure that regular staff meetings take place to allow all staff the opportunity to contribute to the improvement agenda for the service.

This takes account of the National Care Standards, Care Homes for Older People. Standard 5 - Management and staffing arrangements.

What the service did to implement the recommendation
This recommendation had been partially implemented. This is discussed under Quality Theme 4, Statement 3.

Recommendation 10
The provider should formally update the Care Inspectorate on the progress in the recruitment of a new manager for the service.

This takes account of the National Care Standards, Care Homes for Older People, Standards 5 - Management and staffing arrangements

What the service did to implement the recommendation
This recommendation had been implemented. This is discussed under Quality Theme 4, Statement 3.

Recommendation 11
All service users who require a soft diet should have a choice of meals.

This takes account of the National Care Standards, Care Homes for Older People, Standard 13 - Eating well.
What the service did to implement the recommendation.

This recommendation had been implemented. This is discussed under Quality Theme 1, Statement 3.

Recommendation 12
It is recommended that the provider consider alternative menu formats in addition to the written word which could help residents understand the menu on offer.

This takes account of the National Care Standards, Care Homes for Older People, Standard 13 - Eating Well.
What the service did to implement the recommendation
This recommendation had been implemented. This is discussed under Quality Theme 1, Statement 3.

Recommendation 13
The provider should ensure that where other healthcare professionals are involved in the care of an individual this is recorded with any follow up or arrangements that may be required.

This takes account of the National Care Standards, Care Homes for Older People, Standard 14 - Keeping well - healthcare.

What the service did to implement the recommendation
This recommendation had been implemented. This is discussed under Quality Theme 1, Statement 3.

Recommendation 14
The provider should keep a record showing when a resident has participated in an activity of his or her choice. This should include what was achieved because of the resident's participation and how the resident felt.
This takes account of the National Care Standards, Care Homes for Older People. Standard 6 - Support Arrangements and Standard 8 - Making Choices.

What the service did to implement the recommendation
This recommendation had been partially implemented. This is discussed under Quality Theme 1, Statement 3.

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.

Every year we ask the service to complete a self assessment document telling us how the service is performing. During the inspection we check to make sure this assessment is accurate.

The service completed a self assessment before the last inspection in August 2013 and therefore we did not ask the service to complete another before this inspection.

Taking the views of people using the care service into account

We saw all residents during the inspection and spent time in their company, in general conversation.

Some residents were unable to easily verbalise their views of the service or how staff cared for them. In those instances we observed the interaction between staff and residents to form a view. Residents looked comfortable around staff when there was contact. We saw that staff were patient and gentle when engaging with residents.

Residents who were able spoke positively about living at the service and the quality of staff.

Taking carers' views into account

We did not speak with any visitors during the inspection.

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: 2 - Weak

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

The service was adequate at involving both residents and relatives in developing the service.

As the purpose of this inspection was to focus on requirements, recommendations and areas for improvement made at the last inspection this statement was not fully examined at this visit.

We saw that the systems used to help residents/relatives express their views, which we identified at the last inspection, were still evident. These included care reviews, suggestion box, verbal and individual comments and meetings.

We saw that the manager had continued to meet with residents and relatives on a regular basis to gain their views of the service. The manager also met with residents during the day to day management of the service. This offered residents an opportunity to discuss any views and areas of concern.

At the last inspection the service had devised a record of when care reviews were due. At this inspection we saw this system had been implemented to help ensure that care reviews were completed within the legal timescales.

Areas for improvement

At the last inspection we made a recommendation that the provider should make sure that any person using the service and their representative had been offered the opportunity to sign the completed care/personal plan and be offered a copy.

At this inspection in the sample of care plans we examined we did not see this information consistently recorded. Care plans were not always dated. This made it more difficult to measure the level of relatives involvement in care planning or how recent the involvement was. (See recommendation 1).

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 1

Recommendations

1. The provider should continue enabling service users and their representatives to have an opportunity to be involved in developing their care plans. This should include:

   - Where possible, a signature and date as evidence that the service user and their relative or representative had contributed to the care and support plan.
   - Service users and or their representative having an opportunity to receive a copy of their care plan in a format, they understand.
   - Giving service users information pertaining to them about the service which reflects the information given and received by their representatives.

   This takes account of the National Care Standards, Care Homes for Older People, Standard 6 - Support Arrangements, Standard 8 - Making Choices and Standard 1 - Informing and Deciding

Statement 2

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

Service strengths

At this inspection we found that the performance of the service was adequate for this statement.

To assess this statement we took account of the progress made in meeting a requirement and two recommendations about the management of residents' finances which were made at the last two inspections.

We saw that the service had continued to improve the recording of the asset registers and assessing the ability of residents to manage their own finances. As a result the requirement and the recommendations had been met.

The method of identifying which items belonged to the service and which to residents had been improved and ownership was clearly identified on assets registers. The documents were reviewed six monthly to make sure these correspond accurately with belongings.

The risk assessments of residents' ability to manage their finances had all been completed and a system was in place to ensure this was redone six monthly. This has the potential to identify any changing circumstances and as a result will be beneficial to residents.

Systems were in place to record all money received into the service on behalf of residents. Receipts were in place for all expenditure and money received into the service. There were clear records of which relatives wished to be issued with invoices to cover accounts.

This improvement in the financial recordings will help safeguard residents and their personal belongings while living at the service.

Areas for improvement

We saw one instance where a chair owned by a resident was not labelled. As a result possessions did not correspond to the residents possession register. This was an oversight and rectified by the end of the inspection.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 3

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

Service strengths

At the last inspection the Care Inspectorate had significant concerns about some aspects of the health and wellbeing of residents and considered enforcement action if improvement was not made.

Overall there has been improvement since the last inspection and this has reduced the risk to residents. As a result the Care Inspectorate will not take enforcement action. However if the quality of service does not improve or the improvement is not sustained, the Care Inspectorate will again consider enforcement action.

At this inspection whilst we saw improvement and there were areas of strength, there continued to be important weaknesses which caused concern and therefore we have graded this statement as weak.

We acknowledge and welcome the hard work and commitment that staff have made to improve the quality of care and outcomes for residents.

On arrival at the service, residents looked well care for and we saw that staff were attentive to residents care needs.

An external health care professional told us they thought the quality of care was improving.

During this inspection, we assessed the progress made in meeting the requirements made at the last inspection. We looked at the following areas in particular:

- Medication
- Nutrition
- Continence
- Pressure ulcer prevention and tissue viability
- Care plans
- Social needs.

For ease of reference in this Statement, we have reported on the specific healthcare topics under the appropriate heading. In this instance, we have also reported the areas for improvement directly under the specific heading rather than under the areas for improvement section of this Statement. This is to make it easier for the reader to follow.

Medication
To assess progress we looked at medication management. We noted that new systems had been implemented and as a result we saw improvement in the management of medication. This has reduced the risk to residents.

Two requirements and two recommendations were made about the management of medication at the last inspection. The provider had met one requirement and partially met the other requirement. One recommendation had been implemented and the second recommendation partially implemented.

We found:

- Where regular medication was not given as prescribed, a reason was clearly annotated on the Medication Administration Recording(MAR)chart. Medication was given in line with residents' lifestyles.
- Stock control systems where much improved which made it easier to track which medication was on the premises and when new stock needed to be ordered. As a result there was no excessive medication stock and no medication had passed its expiry date.
- Care plans and protocols for "when required" medication had been developed. Protocols contained more information to guide staff about when the medication should be given. The protocols were dated and signed and so it was possible to assess how up to date the information was as well as know the identity of the person devising the information.
- Care plans for convert medication clearly detailed how each medicine should be given.
- Latin abbreviations were not used on handwritten narratives on MAR charts.
- The management of homely remedies had improved. Homely remedies are medicines used for minor ailments. The medicine is not prescribed by a GP but bought over the counter at shops. A register had been introduced to record the type of medicine, the balance and when used. The register corresponded with the homely medication which was stored. Homely remedies were stored securely and separately from prescribed medication. The minor aliment procedure had been amended and no longer listed suppositories for the treatment of constipation.
- Corrective action was taken to maintain a safe temperature within the area where medication was stored.
- Adult with Incapacity Section 47 certificates were no longer stored beside the MAR charts.

- The safe storage of medication had improved. As a result the medication trolley was not left unattended when open. Medication to be returned to pharmacy was stored in a locked container.
- All medicine bottles and labels were clean which allowed the instructions to be read. This reduces the risk of error.

Areas for improvement
While we welcome the improvement noted in medication management we still saw examples which caused us concern.

We saw the following:

- While a system had been implemented to improve the management of homely remedies, we saw instances where this was not followed. A tub of topical cream which is used for skin care had been opened for use. There was no record of which registered nurse applied the cream, when or why the cream was applied or to which resident. This limits the possibility of staff accurately assessing the effects of the homely remedy or if further care is required. (See requirement 1).
- While a system had been introduced to improve stock control we still saw an instance where prescribed medication was out of stock. As a result it was not available if needed by the resident. This situation had arisen because of the way the total number of tablets had been carried forward from one cycle to another and information from a duplicate MAR chart not being considered or stored correctly. This had resulted in confusion for staff and increased the risk to residents that their medication would not be available. (See requirement 1).
- Instances where the MAR charts were not signed which made it difficult to know if medication had been administered as prescribed or not. (See requirement 1).
- Instances where handwritten narratives on MAR charts were not dated and did not record who authorised the medicine. (See recommendation 1).
- A tub of topical cream and a bottle of liquid medicine had not been dated when opened for use. This makes it harder for staff to make a judgement about when to order more which potentially can affect the availabilty of residents medicines and stock control. (See recommendation 1).
- A covert medication care plan was not stored in accordance with the provider's guidance. This increased the risk of error when administering the resident's medicines because the appropriate information was not easily available. (See recommendation 1).

Continence
The provider had partially met the requirement made at the last inspection about continence management.

Since the last inspection staff had received training in continence management to help increase their understanding of this aspect of care. We saw that continence care plans had been developed and contained more information around links to nutrition, skin integrity and environmental factors which could affect continence promotion.

Staff were getting better at completing charts which they used to record when continence care was given.

Areas for improvement

There were still areas of continence management that needed to be improved.

We still saw that care plans were not always updated to reflex changes in the management of bowel habits. There was no evidence that the content of charts which staff completed to show the continence care given, were evaluated and analysed to help promote continence and improve residents care.

We have included the outstanding elements of the requirement about continence management into a requirement about care planning. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly. (See requirement 2).

Nutrition

The provider had met the requirement about menus made at the last inspection. A new menu had been introduced to meet residents dietary needs. We observed meals which looked appetising and were well presented. There were two hot meal options as well as several alternatives offered to residents. Residents said they enjoyed the meals. There was not a lot of waste.

The provider had partially met the requirement about nutrition made at the last inspection. We saw that all residents had a care plan which had been formulated based on an assessment of the assistance they needed to help them with eating and drinking. The care plans were reviewed to ensure the plan still met the residents care needs. We saw that food and fluid charts were in use to record the food taken by residents who were at risk of losing weight. We examined a sample of these and found these to be fully completed. Systems were in place directing staff on the action they should take if a resident lost weight. Registered nurses showed awareness of this procedure. We checked a sample of residents' weights and these were either stable or showed residents gaining weight.

The provider had also implemented two recommendations made at the last inspection. We saw that choices were available if a resident had a soft diet and all food choices were also offered verbally and visually to residents. This potentially increased the opportunity for residents to know the food choices available to them.

Area for improvement
We saw that care plans were not always updated when there were changes to the assistance a resident needed. We assessed that work was still needed to ensure that accurate and up to date guidance was available to guide staff on how best to assist residents with eating and drinking.

We have included the outstanding elements of the requirement about nutrition into a requirement about care planning. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly. (See requirement 2).

We observed two meals served in both dining rooms. While we saw positive aspects which would enhance residents dining experience such as a calm atmosphere, no rushing or long waits between courses, there were other aspects which could be improved. We saw a general lack of oversight and coordination of the meal on the upper floor. It was only on the arrival of the external manager that the meal became organised. The manager agreed to address the issues and we will monitor progress at the next inspection.

Pressure ulcer prevention and care/Tissue viability
The provider had partially met the requirement made at the last inspection about tissue viability. We saw the approach to providing planned care was becoming more consistent. Risk assessments had been carried out and residents who were at risk of pressure ulcer development had an appropriate plan of care in place. Therapeutic equipment had been provided for residents who have been assessed as needing this. A policy and procedure was in place to guide staff in ulcer prevention and care.

At the time of inspection all residents' skin was intact and there were no wounds. This helps evidence that prevention techniques used were having a positive outcome for residents.

Areas of improvement
While we welcome the progress made in this area we still had serious concerns. We saw that the care plan and risk assessment of a resident who was a high risk of developing a pressure ulcer had not been updated to reflect changes to how their care was provided. This also demonstrated that staff were not following the providers guidance. The situation was rectified by the external manager before the end of the inspection. However it would be better if the service was able to identify issues such as this through audits and monitoring rather than relying on the inspection to detect.

We have included the outstanding elements of the requirement about pressure ulcer prevention and care into a requirement about care planning. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly. (see requirement 2)

Social needs

Staff continue to make efforts to provide structured activities for residents each day to help provide a more stimulating environment. Staff made efforts to engage with residents in social conversations and this helped create a friendly atmosphere in the sitting room.

New activity care planning was being introduced to reflect each residents individual social needs. A system was in place to record which activity residents participated in each day.

Area for improvement

There continued to be gaps in the recording of activities each resident took part in. There was no evaluation of the effectiveness of the activities so it was difficult to establish if these supported the residents' social needs. Care plans were not always dated so it was difficult to know how up to date the information was. We have taken account of the fact that a new activity care plan system was being introduced to reflect individual residents' social needs.

We have included the outstanding elements of the requirement about social needs into a requirement about care planning. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly. (See requirement 2).

While staff showed good interaction with residents while engaging in one to one activities, they were missing opportunities to improve group activities. For example while a group activity which residents were clearly enjoying was taking place, staff did not think to switch off the Television which could have been distracting to residents. Staff need more support in understanding how to provide meaningful activities and a stimulating environment. This is discussed under Quality Theme 3, Statement 3.

Care planning

The provider had not met the requirement about care plans which was made at the last inspection. As highlighted throughout this Statement, there were concerns about care plans including quality, content, evaluation and updating the care plans and risk assessments when circumstances change. We saw an instance where a residents' care needs had changed but we could find no supporting care plan. We could not see what options had been considered to ensure the resident was enabled to lead as fulfilling a life as possible at the service. The external manager took action to implement a care plan before the end of the inspection.

An amended requirement will be made to incorporate the issues highlighted in this report. In this way we hope to make it easier for the provider to understand what is required and develop their action plan accordingly. (See requirement 2).

Charts

Staff used various charts to record when care was given for example, personal care, positional changes and continence care. On the whole there was improvement in the content and it reflected more accurately the care staff gave. However we still saw instances where there were gaps in the recording.

There was no evidence that the contents of the charts were monitored to identify when not completed or if anything untoward had been highlighted. Staff need to get better at monitoring the content of charts and evaluating them so that these influence the care given.

We also saw there was a duplication of charts for the same information. This meant staff were recording the same information in more than one place. Duplicated recording increases the risk of error and places an unnecessary burden on staff. The manager agreed to review duplicated charts. (See recommendation 2).

Residents' personal belongings

While checking the cleanliness of the environment we saw residents' hair brushes that were very dirty. This is poor infection control and is not respectful to residents. Hair brushes were replaced which we welcome. However it would be better if the service had identified this issues rather than relying on the inspection process. This is addressed in a requirement made under Quality Theme 2, Statement 2.

We saw toiletries stored in communal bathrooms. We were told that while residents had personal toiletries, additional supplies were held in communal bathrooms for residents use. While this may be helpful for some residents, it raises the risk that these become communal toiletries. Potentially this could reduce residents choice particularly for residents less able to express their views. (See recommendation 3).

Areas for improvement

As stated above, for ease of reference in this Statement, we have reported on the specific healthcare topics under the appropriate heading. In this instance, we have also reported the areas for improvement directly under the specific heading rather than under the areas for improvement section of this Statement.

This is to make it easier for the reader to follow.

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 3

Requirements

1. The provider must ensure that there is a medication recording system that is safe, up to date, and accurate. To do this the provider must ensure:

   1. A complete, accurate and consistent auditable record of all medicines entering, administered or destroyed, and leaving the service.
   2. That where a medicine is administered this is recorded.
   3. That medication is available at the time of administration.

   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) - Welfare of users

   Timescale: to commence within 24 hours of receipt and be completed by the 28 February 2014.

2. The provider must ensure that all written plans include details of how individual resident's needs and preferences are to be met.

   In order to achieve this the provider must:

   1. Expand the details contained in all plans to ensure that all aspects of the care to be provided is recorded including but not limited to pain management, continence care, nutrition, pressure ulcer care and social activities.
   2. Ensure care plans and risk assessments are developed and updated to reflect residents changing care needs.
   3. Ensure that the evaluation of the care plans takes account of the content of other records such as activity records and charts such as positional changes.
   4. Fully develop an audit system to monitor the quality and content of care plans.

   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 5 - Personal plans

   Timescale for completion of this requirement: to commence on receipt of this report for completion by 30 March 2014.

Recommendations

1. The provider should ensure that medicines are managed according to recognised best practice. To do this they should ensure that:

   1. Handwritten narratives on MARs are dated when changes made and record who authorised the changes.
   2. Tubs of topical cream are dated when opened for use.
   3. Covert medication care plans are stored in accordance with the providers' own guidance.

   This takes account of the National Care Standards, .Care Homes for Older People, Standard 5 - Management and staffing arrangements and Standard 15 - Keeping Well - Medication.

2. The Provider should ensure that staff who complete charts used to record care delivery do so consistently and accurately. The content of charts should be evaluated and care planned accordingly.

   This takes account of The National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing arrangements.

3. It is recommended that the provider review the storage of toiletries in communal bathrooms.

   This takes account of The National Care Standards, Care Homes for Older People, Standard 16- Private life.

Quality Theme 2: Quality of Environment

Grade awarded for this theme: 2 - Weak

Statement 1

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

Service strengths

The service was demonstrating adequate practice in areas covered by this Quality Statement.

With residents permission we visited some bedrooms. We saw that residents had been encouraged to furnish their bedrooms with personal belongings, photographs and ornaments. As a result the bedrooms were homely.

We saw that the service was sharing information with relatives about the redecoration and refurbishment programme.

The strengths stated in Quality Theme 1, Statement 1 are also relevant to this Statement.

Areas for improvement

The recommendation noted in Quality Theme 1, Statement 1 is relevant to this Statement.

Grade awarded for this statement: 3 - Adequate

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

Aspects of this statement were unmet in a way that gives cause for concern and therefore we have graded this statement as weak. To assess this statement we took account of the progress made in meeting requirements made at the last inspection and observed the environment.

On arrival at the service we saw that the atmosphere felt calm. There were no obstructions, which made it safe for residents to move freely around the building. Residents' bedrooms had signage to indicate who lived there. This is beneficial to residents as it helps direct them to their private area.

Two domestic staff were on duty and were available in the morning and afternoon. They were seen to work very hard. There was no mal odour in the building.

Staff were present in the sitting areas at all times and were visible to residents. We saw that staff responded quickly to residents requests for assistance.

Staff practice was safe when working with residents'. For example hot drinks were served on tables for safety and staff used safe moving techniques when helping residents move position.

Staff had put systems in place to enhance the safety of the building. Visitors were asked to sign in and out of the building so that staff knew who was in the building at any time. There were maintenance contracts for appliances and equipment to make sure these were fit for purpose.

The provider had implemented the recommendation about recording any remedial action taken to address high hot water temperatures.

The provider has met the requirement made at the last inspection about auditing accidents and incidents at the service. The audit of accidents had been developed to help identify and minimise potential risk to residents. Action taken following accidents was more easily identified.

Since the last inspection repairs had been carried out to the panty drawer fronts and doors.

All of this contributed to making the environment safer for residents.

Areas for improvement

Whilst there were areas of strength, the cleanliness of the environment caused us concern. This was of concern because the issues relate to basis hygiene and infection control. The same issues were raised at the last inspection and addressed at the time. However the provider had not been able to ensure that the cleanliness of the environment was sustained.

We saw that the upstairs pantry area was dirty. This included dirty drawers, cupboards, sink and worktop. Loose razors were stored alongside cutlery. A table lamp and a soup heater were stored on top of the microwave which posed a potential safety risk. There was a lack of attention to cleanliness including dirty hair brushes, baths and toilet bowls which needed cleaned, mops not stored hygienically and the sluice area was dirty. A pillow was on a bathroom floor. (See requirement 1).

Training records showed that staff had received infection control training. However, the hygiene standards staff demonstrated when maintaining a clean environment did not evidence that they were fully competent in implementing effective infection control procedures. This is discussed under Quality Theme 3, Statement 3.

We acknowledge that the manager addressed these issues when discussed with her. However it would be better if environmental audits were used more effectively to improve the environment and not be dependent on the inspection to identify such matters. This is discussed under Quality Theme 4, Statement 3.

At the last inspection we noted the laundry area was badly in need of decoration and had loose floor tiles that could potentially be dangerous to staff. The outside area around the laundry was overgrown and with an uneven path. We were told the laundry area was earmarked for redecoration and upgrading. We will visit the laundry area at the next inspection to monitor progress.

The provider had not fully met the requirement about complying with the staffing schedule made following the last inspection. We examined the staff duty rota and found it was difficult to follow and the information was confusing. As a result it was hard to identify which staff and how many were on duty at a particular time. This was mainly related to night duty where on several occasions in October and November 2013, the rota recorded only three staff on duty. If this were the case the provider would be in breach of the conditions of registration. We checked a sample of pay roll information and this indicated the correct number of staff were on duty. The external manager and manager amended the rota to make sure it clearly recorded which staff were on duty and their designation. This should help evidence the staffing levels within the service. We saw no evidence of staff shortages while at the service.

We saw occasions in November 2013 when a senior carer was not on duty. This is in breach of the condition of registration. As a result the necessary skill mix was not available to meet residents care needs. This was an issue at the last inspection and we had been assured it would not happen again. Further assurances were given at this inspection. We saw that additional senior staff had been employed and the amended duty rota confirmed this. As a result there is no reason why a senior carer would not be on duty. (See requirement 2).

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 0

Requirements

1. The provider must ensure that the physical environment and equipment is kept clean, hygienic, and free from offensive smells. In order to do this the provider must:

   1. Ensure that auditing and monitoring of cleaning measures are put in place in accordance with Infection Control in Adult Care Homes: Final Standards.
   2. Develop and implement cleaning schedules for equipment in the home.
   3. Review the domestic staffing to ensure that adequate domestic staff are employed to enable the home's daily and weekly cleaning schedules to be fully implemented.
   4. Carry out regular risk assessments of the building environment taking appropriate and timely action to address any risks identified or visible.

   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) - Welfare of Users and Regulation 10(2)(a),(b) and (d) - Fitness of premises.

   Timescale: to commence within 48 hours and be completed by the 28 February 2014.

2. The provider must adhere to the staffing schedule and ensure there is a sufficient skill mix of staff to meet the care needs of service users using 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 15(a) - a regulation about staffing.

Timescale for meeting this requirement: to commence within 24 hours of receipt of this report for completion by 30 January 2014.

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 2 - Weak

Statement 1

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

Service Strengths

The service was demonstrating adequate practice in areas covered by this Quality Statement.

The strengths stated in Quality Theme 1, Statement 1 are also relevant to this Statement.

Areas for improvement

The recommendation noted in Quality Theme 1, Statement 1 is relevant to this Statement.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 2

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

Service strengths

The service was demonstrating adequate practice in areas covered by this Statement. This is an overall improvement in performance since the last inspection. To assess this statement we took account of the progress made in meeting requirements and recommendations made at the last inspection.

We examined three files of the most recently employed staff. All staff had a file which was securely stored with restricted access to ensure staff confidentiality. The files were well maintained and easily navigated.

All files had an application form or a CV, job description, two references one of which was from the current or most recent employer and an offer of post.

The provider had implemented the recommendation made at the last inspection and records showed that two people were on the interview panel.

The provider had implemented the recommendation made at the last inspection and a policy on the use of agency staff was available.

Nursing and Midwifery checks were carried out prior to nursing staff commencing employment.

The provider had met the requirement about all staff having an induction to the service. A copy of the induction was held in each staff member's file and was fully completed.

The provider had met the requirement about staff having a suitable Protection of Vulnerable Adults (PVG) check prior to employment.

Areas for improvement

We still saw one instance where a domestic staff member was employed before a PVG had been received. This was supported by a risk assessment based on the staff members' most recent PVG. We will continue to monitor this at future inspections.

The risk assessment which was completed in the absence of an up to date PVG stated the staff member's own copy of the PVG had been seen. The provider should consider keeping a record of the reference number in case it is needed.

We saw one instance where the referee contacted differed from that on the application form. There was no record in the file for the reason. While there was no concern around the referee contacted it would be better if a record was maintained of the rationale behind this.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 3

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

Service strengths

Whilst there were areas of strength, there were important weaknesses which caused concern and therefore we have graded this statement as weak. To assess this statement we took account of the progress made in meeting the requirement and recommendation made at the last inspection and observed staff practice.

We have taken a fair and balanced approach to grading this statement. We recognised that staff were enthusiastic about working at the service and were eager to provide good care to residents. We acknowledge that training was provided to staff and some improvement was noted in how care was given. Registered nurses and carers who spoke with us were able to describe residents care needs.

The provider had partially met the requirement about staff training which was made at the last inspection. To assess this we looked at staff training records. Each staff member had an up to date record of all training received, which made it easier to see what training had been provided and when refresher training was due.

Training included - wound care, continence care, falls management, medication, nutrition, infection control moving and handling, adult support and protection and dementia awareness. The community psychiatric nurse had provided training in managing stress and distress.

Following training sessions, each staff member completes an evaluation of the training content. The evaluations were collated to measure how effective the training was and if any changes were needed. This was well documented.

The new manager had commenced one to one support and supervision for all staff. This would allow staff the opportunity to discuss their practice and professional development. A team meeting had been held where gaps in practice were discussed and expected standards at the service explained. The gaps in practice discussed reflected some of the issues we discuss in this report, for example, cleanliness but had not resulted in improvement.

During the inspection, staff were cooperative, polite and professional. They remain keen to provide good care and were seen to be respectful to residents and each other.

The provider confirmed its awareness that all new staff must be registered with the SSSC within 6 months of employment and this was underway.

Areas for improvement

We acknowledged that the staff group, collectively, had a lot of skills, knowledge and experience. We acknowledge that the provision of staff training means the service is now better placed to improve staff practice and therefore the outcomes for residents.

However, there were aspects of care practice that must be addressed to minimise risks to people. The provider needs to consider how staff practice has influenced the poor quality of care identified under Quality Theme 1 and hygiene issues under Quality Theme 2 and judge staff competency. (See requirement 1).

Since the last inspection a new manager has commenced in post. An external manager from another of the provider's services was providing management support. The effect of management changes on a staff team should not be underestimated. Several new staff members had also commenced in post and staff need support to adapt to change. Team working within the home is a crucial factor in ensuring that residents' physical, social and emotional needs are met.

While team meetings were held these were not often. Given the changes within the management and staff team and the standard of staff practice identified in this report, it is clear staff need support to improve their practice. Team meetings would be one way of providing support and guidance and increase consistent care practice. (See recommendation 1).

Gaps in staff practice which were discussed at team meetings, had not improved by the time of the inspection and reflect some of the issues we discuss in this report, for example, cleanliness. Oversight of staff practice is discussed under Quality Theme 4, Statement 3.

During the inspection new staff were undertaking their induction to the service. They told us they felt well supported. We saw that they were given time to meet residents and get to know the daily routine before they started working directly with residents. However there was a lack of structure to this and new staff were left for periods without any direction. There needs to be better managerial oversight of induction and outcomes. The manager agreed to address this. We will monitor progress at future inspections.

A recommendation was made at the last inspection about identifying the responsible person for reviewing policies. Because the focus of this inspection was to measure the progress made in meeting the requirements made at the last inspection, the content of polices was not examined. However there is an identified person responsible for reviewing policies and we will amend the recommendation accordingly. (See recommendation 2).

Grade awarded for this statement: 2 - Weak

Number of requirements: 1

Number of recommendations: 2

Requirements

1. The provider must carry out regular evaluation of staff practice to ensure they are competent to carry out their role and responsibilities.

   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) - Welfare of users and Regulation 15(a) and (b)(i) and (ii)- Staffing and The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI 2011/28) regulation 4 - Notifications.

   Timescale: to commence within 1 week and be completed within 30 March 2014.

Recommendations

1. The provider should review the regularity of staff meetings to make sure these are held often enough to allow staff the opportunity to contribute to the improvement agenda for the service.

   This takes account of the National Care Standards, Care Homes for Older People. Standard 5 - Management and staffing.

2. The provider should ensure that operational policies and procedures are reviewed regularly and are in line with current good practice guidance. Policies should record the date when theses should be reviewed.

   This takes account of the National Care Standards, Care Homes for Older People, Standard 5 - Management and staffing.

Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 2 - Weak

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 service was demonstrating adequate practice in areas covered by this Quality Statement.

The strengths stated in Quality Theme 1, Statement 1 are relevant to this Statement.

Areas for improvement

The recommendation noted in Quality Theme 1, Statement 1 is also relevant to this Statement.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 3

To encourage good quality care, we promote leadership values throughout the workforce.

Service strengths

Whilst there were areas of strength, there were important weaknesses which caused concern and therefore we have graded this statement as weak. To assess this statement we took account of the progress made in meeting the requirements and recommendations made at the last inspection.

An external manager had been supporting the service development which had resulted in the positive improvements noted in this report.

As recommended at the last inspection the provider had formally advised us about the new manager's appointment.

The new manager was 100% supernumerary. This should help them find the time to develop the service and support staff during the improvement programme.

As agreed at the last inspection the provider had notified us of events which it is legally obliged to.

As discussed at the last inspection the provider had submitted an application to vary the conditions of registration to reflect the hours staff work.

All of the above help show the providers' cooperation in working with us to develop the service.

We saw that the new manager spent time working directly with staff and assisting residents with their care. We thought this would help the manager get to know residents and staff better as well as monitoring the quality of the service provided.

Staff remain enthusiastic about working at the service.

Areas for improvement

As stated in the last two reports, since Skye View Care Centre was first registered as a care service and as a dedicated unit for people with a diagnosis of dementia the grades awarded for all four Quality Themes have been Adequate (3) or lower. Areas for improvement highlighted at this inspection include areas that have been the subject of requirements and recommendations at previous inspections.

While we acknowledge that the provider and management team is working in a positive way to improve the quality of the service, there is weak leadership at the service which has resulted in limited improvement. Lack of a consistent manager at the service has contributed to this.

The new manager has only been in post since November 2013. It is too early to assess how effective the new manager will be in leading the team, although they demonstrated positive values and eagerness to improve outcomes for residents, which is encouraging.

The service needs strong, consistent leadership to address all the areas for improvement highlighted in this report and the improvement needs to be sustained. There needs to be better daily managerial overview of the daily running of the service, staff practice and the deployment of staff. To do this the new manager will need the providers support.

The improvements noted in the report have been instigated and driven by the external manager who has been supporting the service development. This support cannot be long term as the manager must support her own service to prevent any delay in its development. The provider needs to consider alternative ways of supporting the new manager to develop the service.

Although we found evidence that the provider had taken positive steps to put a framework of quality assurance systems and processes in place, these had not been used in an effective way that would significantly improve the quality of the service. Examples of this are identified under Quality Theme 1, Quality Theme 2 and Quality Theme 3. (See requirement 1).

While sampling a resident's files we found a letter of complaint which was filed with optical information. There was no record of how this complaint had been addressed although verbal information was provided to us. (See requirement 2).

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 0

Requirements

1. The provider must review the system of audit in the service.
   In order to achieve this, the provider must:

   - Ensure that the system takes into account staff practice and care delivery.

- Ensure that records clearly show that action has been taken when areas for improvement are needed.

This is to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) - regulation 3 - Principles.

Timescale for meeting this requirement : to commence on receipt of this report and for completion by 30 March 2014.

2. The provider must ensure that its complaints procedure is followed and that the outcome of any investigation is recorded. The provider must ensure that all staff are aware of the complaints procedure.

This is to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) - regulation 18 - Complaints.

Timescale for meeting this requirement : to commence on receipt of this report and for completion by 28 February 2014.

4 Other information

Complaints

No complaints have been upheld, or partially upheld, since the last inspection.

Enforcements

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

Additional Information

No additional information was identified at this inspection.

Action Plan

Failure to submit an appropriate action plan within the required timescale, including any agreed extension, where requirements and recommendations have been made, will result in 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 - 2 - Weak	
Statement 1	3 - Adequate
Statement 2	3 - Adequate
Statement 3	2 - Weak
Quality of Environment - 2 - Weak	
Statement 1	3 - Adequate
Statement 2	2 - Weak
Quality of Staffing - 2 - Weak	
Statement 1	3 - Adequate
Statement 2	3 - Adequate
Statement 3	2 - Weak
Quality of Management and Leadership - 2 - Weak	
Statement 1	3 - Adequate
Statement 3	2 - Weak

6 Inspection and grading history

Date	Type	Gradings	
7 Aug 2013	Unannounced	Care and support Environment Staffing Management and Leadership	1 - Unsatisfactory 2 - Weak 2 - Weak 2 - Weak
22 Oct 2012	Unannounced	Care and support Environment Staffing Management and Leadership	1 - Unsatisfactory 2 - Weak 2 - Weak 2 - Weak
9 Nov 2011	Unannounced	Care and support	3 - Adequate

		Environment Staffing Management and Leadership	3 - Adequate 2 - Weak 3 - Adequate
26 May 2011	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 3 - Adequate 3 - Adequate 3 - Adequate
4 Nov 2010	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 3 - Adequate 3 - Adequate 2 - Weak
8 Jun 2010	Announced	Care and support Environment Staffing Management and Leadership	3 - Adequate 3 - Adequate 2 - Weak 2 - Weak

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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Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànain eile ma nithear iarrtas.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

ی ہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے-

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

هذا المنشور متوافر عند الطلب بتنسيقات وبلغات أخرى.

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Na życzenie niniejsza publikacja dostępna jest także w innych formatach oraz językach.

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