Grove House
Care Home Service Adults
Edenside Road
Kelso
TD5 7BS
Telephone: 01573 223181

Type of inspection: Unannounced
Inspection completed on: 17 November 2014
Contents

Summary 3
1 About the service we inspected 5
2 How we inspected this service 6
3 The inspection 16
4 Other information 38
5 Summary of grades 39
6 Inspection and grading history 39

Service provided by:
Scottish Borders Council

Service provider number:
SP2003001976

Care service number:
CS2003009193

If you wish to contact the Care Inspectorate about this inspection report, please call us on 0345 600 9527 or email us at enquiries@careinspectorate.com
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

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<thead>
<tr>
<th>Area</th>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>Quality of Care and Support</td>
<td>4</td>
<td>Good</td>
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<tr>
<td>Quality of Environment</td>
<td>3</td>
<td>Adequate</td>
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<tr>
<td>Quality of Staffing</td>
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<td>Good</td>
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<tr>
<td>Quality of Management and Leadership</td>
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What the service does well

Grove House care home is part of the local community of Kelso. The staff are welcoming and the atmosphere is relaxed and friendly. The main strength of the service provided at Grove House continues to be the care and sensitivity of the staff. We saw some good examples of care and support being delivered in a manner which was person centred, reflecting the individual choices of residents. We saw that staff were keen to learn and develop their skills.

The home was clean and free from malodours.

All of the residents we spoke with were happy with the care and support they received from the staff. Similarly, there was a high level of satisfaction expressed by families. Staff told us they felt supported in their roles and welcomed the training opportunities being made available.

What the service could do better

During previous visits, we highlighted the need for investment in the internal environment. We noted that this had not been progressed by the provider. Whilst it was evident that the staff did their best to create a personalised and comfortable environment, there were areas of the home which would benefit from up-grading and redecoration.
We noted that the majority of the places in Grove House are currently being occupied by residents who have been assessed as in need of long term care within a residential environment. We saw that there was some occupational therapy input being provided to some short stay residents, but this was limited in the number of hours per week and their contract was temporary. We became aware that the purpose and function of the intermediate care and assessment beds was under review. We will follow this up at our next inspection.

The service would benefit from closer collaboration between the senior staff, in particular ensuring areas of responsibility such as carrying out audits and organising staff meetings are shared between the manager and senior support workers.

What the service has done since the last inspection
We had made a number of requirements and recommendations following our previous inspection. We were aware that the care home manager had been absent for a period of time and this appears to have had an impact on the level of progress made. However, we saw evidence that the areas identified for improvement had been progressed in full or in part. We have repeated those which require further work.

Conclusion
Grove House is a locally valued service and is very much part of the community. The main strength of the service continues to be the quality of care and support delivered by the staff team. Acknowledging that progress has been made in responding to the areas identified for improvement, there remains some work to be done to ensure that requirements and recommendations are met in full by the provider and that the purpose and function of the service is clarified with appropriate resources being made available.
1 About the service we inspected

The Care Inspectorate regulates care services in Scotland. Information about 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.

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 Reform (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.

Grove House is owned and operated by Scottish Borders Council. It is located close to local amenities in Kelso. The service is registered to provide accommodation and care for a maximum of 22 older people: seven beds are registered for intermediate care, two beds for short breaks and two beds for assessment. All of these are on the first floor. The remaining 11 beds are the only long stay beds within the home and are situated on the ground floor. During this inspection there were 18 residents living in Grove House, 10 on the ground floor and eight on the first floor.

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

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

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 0345 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 low intensity inspection. We carry out these inspections when we are satisfied that services are working hard to provide consistently high standards of care.

What we did during the inspection
We wrote this report following an unannounced inspection. This was carried out by one inspector. The inspection took place on 12 November 2014 from 10.15am to 6pm and continued on Thursday 13 November from 8.45am to 5.45pm. We made a final visit on Monday 17 November from 8.30am to 6pm when we also gave feedback to the service manager and the care home manager.

As part of the inspection, we took account of the completed annual return and self assessment forms that we asked the provider to complete and submit to us. We sent 15 Care Standards Questionnaires to the manager to distribute to residents. Four residents sent us completed questionnaires. We also sent 15 Care Standards Questionnaires to the manager to distribute to relatives and carers; nine completed questionnaires were returned to us before the inspection. We also asked the manager to give out 15 questionnaires to staff and we received six completed questionnaires.

During this inspection process, we gathered evidence from various sources including the following:

We spoke with:

- ten residents
- three relatives
- the manager, service manager and care staff
- two visiting professionals.

We looked at:

- residents’ care plans
- minutes of meetings with residents
- minutes of meetings with staff
- activities records
- temperature checks for fridges
- records of Legionella checks
- records of accidents and incidents
- the complaints log
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

Requirement 1.
The provider must make proper provision for the health, welfare and safety of service users by taking action to:

- ensure all care plans for short and long stay residents accurately reflect levels of need and the care and support to be provided. These should link into other sections of the care plans such as review reports and visits from health care professionals to demonstrate that actions are being followed up when issues are identified, for example, significant weight loss. All charts should also be completed as required
- where there are any legal powers in place, these must be documented, evidenced and understood by staff
- where a service user is in receipt of “as required” medication, a protocol must be in their care plan which details the triggers for the administration of this, any alternatives, how often it should be reviewed, the effectiveness of such medication and the maximum dose to be administered within a specified period. The service’s medicines management guidelines should be revised to include a protocol for the administration of “as required” medication
- ensure MAR sheets for those residents whose medication is being administered by the service record details of all prescribed medications and quantities
- ensure MAR sheets accurately record the times or time bands when medications have been administered.

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 4 (1) (a) which is a requirement about the welfare of service users.

See also:
"Guidance about medication personal plans, review, monitoring and record keeping in residential care services", Care Inspectorate, 2012.

Timescale: within 4 weeks of the receipt of this report.
What the service did to meet the requirement

From the care plans we sampled during this inspection, it was evident that some progress had been made to take forward this requirement, but further work was required in some areas. We have therefore repeated the requirement. We have discussed this in more detail in Quality Statement 1.3.

The requirement is: Not Met

The requirement

Requirement 2.
The provider must revise its dependency assessment process to reflect the actual numbers of staff who are providing direct care to residents. This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 15 (a) which is a requirement about staffing.

Timescale: within 24 hours of the receipt of this report.

What the service did to meet the requirement

We saw that the provider had made changes to the dependency assessment process. However, we also noted that the available staff hours per week were being recorded at the staffing schedule levels as opposed to the actual staffing available for each day. These may vary due to unplanned absences when staff may not be able to be replaced or only part of their shift has been covered. We have therefore made a revised requirement about dependency assessments to reflect our findings.

The requirement is: Not Met

The requirement

Requirement 3.
The provider must review its policy and procedures on nutrition and ensure that the specification for the meals provision within this service reflects a good understanding of residents’ dietary needs and how these will be met through menu planning and food provision. This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 4 (1) (a) which is a requirement about the health, welfare and safety of service users.

See also: Food in hospitals national catering and nutrition specification for food and fluid provision in hospitals in Scotland 2008, Scottish government download from www.scotland.gov.uk/Publications/2008/06/24145312/0 which is applicable to care homes.

Timescale: within four weeks of the receipt of this report.

**What the service did to meet the requirement**
We became aware that this work was continuing to be progressed, but yet to be completed. This requirement has therefore been repeated.

**The requirement is:** Not Met

**The requirement**
Requirement 4.
The provider must put in place a training programme on the care of people living with dementia to ensure that all staff are confident and competent in this area. In order to ensure the provider train staff to the appropriate standard, it may wish to consider accessing the “Promoting Excellence” materials. In the event that other alternative materials are used, these should be measurable against the “Promoting Excellence” skill levels.
This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 15 (b) (i) which is a requirement about staffing.
Timescale: within 3 months of the receipt of this report.

**What the service did to meet the requirement**
We saw that some progress had been made in this area, with further training planned for 2015. We have discussed this in more detail in Quality Statement 3.3.

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

**What the service has done to meet any recommendations we made at our last inspection**
Recommendation 1.
It is recommended that the service up-dates its leaflet information to ensure that it accurately reflects the current provision and is responsive to the varying levels of resident ability to participate.
National Care Standards. Care Homes for Older People. Standard 11 - expressing your views.
Progress:
We saw that the leaflet had been up-dated since the previous inspection. However, the section referring to short term placements is limited in content and the leaflet does not describe the service currently being provided. We have therefore repeated this recommendation with amended wording to reflect our findings.

Not met.

Recommendation 2.
It is recommended that the care home manager timetables regular staff meetings to ensure that staff are actively involved in the development of the service.
National Care Standards. Care Homes for Older People. Standard 5 - management and staffing arrangements.

Progress:
From the records sampled, we could see that staff meetings were being held more frequently, though there had been a gap when the manager had been absent for a number of weeks. We have therefore repeated this recommendation to ensure that a programme of regular meetings is embedded into routine practice.

Not met.

Recommendation 3.
It is recommended that the service ensures residents’ care plans are reviewed every six months or sooner, in the event that their needs change, with care plans being up-dated accordingly.
National Care Standards. Care Homes for Older People. Standard 6 - support arrangements.

Progress:
Whilst it was evident that some progress had been made to respond to this recommendation, this continued to be work in progress.

Not met.

Recommendation 4.
It is recommended that the provider ensures the decor within the whole home is kept in good order and well maintained.
National Care Standards. Care Homes for Older People. Standard 4 - your environment.
Progress:
It was evident that there had been no redecoration carried out since the previous inspection. We have made a new requirement about the environment to reflect our findings.

Not met.

Recommendation 5.
In order to meet good infection control standards in all areas, it is recommended that the service ensures all "J cloths" are removed from communal toilet/bathing areas and are only used once. The service should also remove all bars of soap from communal toilet areas and replace flip top bins with pedal bins.
National Care Standards. Care Homes for Older People. Standard 4 - your environment.

Progress:
During our observations of the environment, it was evident that the use of "J cloths" had ceased, there were no bars of soap in evidence in communal toilets and flip top bins were being replaced by pedal bins.

This recommendation had been met.

Recommendation 6.
It is recommended that the provider formalises and implements an induction procedure for agency staff who may be engaged in the service.
National Care Standards. Care Homes for Older People. Standard 5 - management and staffing arrangements.

Progress:
We saw that an induction procedure was in use for all new agency staff.

This recommendation had been met.

Recommendation 7.
It is recommended that the manager ensures there are planned opportunities for staff discussion and team building. This should include but is not limited to having a timetable for regular and planned staff meetings, the records of which should contain action plans which are followed up at each meeting or sooner if required.
National Care Standards. Care Homes for Older People. Standard 5 - management and staffing arrangements.
Progress:
Whilst it was evident that some progress had been made in this area, further work was needed to ensure that there was a programme in place of regular and planned opportunities for team discussion and team building.

Not met.

Recommendation 8.
It is recommended that the provider ensures all internal audit processes are carried out on a regular and planned basis and include action plans and systems for accessing the views of and providing feedback to those using the service and their families. The service should also consider the use of external auditing and supplement internal systems to include other areas of care and support such as accidents and incidents.
National Care Standards. Care Homes for Older People. Standard 11 - expressing your views.

Progress:
We saw that audits had been carried out of staff supervision files by the care home manager. It was evident that issues raised from these were being taken forward by the manager. We also noted that medication audits had been carried out in June and August 2014 and some audits had been done on some care plans. Acknowledging that some progress had been made in this area, further work is needed to ensure that there is a regular and planned schedule of audits carried out by the senior team and that these are appropriately recorded with actions followed up.

Not 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.

We received a self assessment from the service which generally reflected our findings during this inspection.

Taking the views of people using the care service into account

We received four completed Care Standards Questionnaires from those residents living in Grove House. Feedback received included the following comment:

“I am very comfortable here. Grove House is very pleasant. I like my own room with my pictures and photographs and my possessions. I am well cared for.”

One resident did state they had some concerns about the cleanliness within the home. One resident also raised questions about staff training and the numbers of staff on each shift.

During our inspection we spoke with nine residents. None raised any concerns about their care and support. Two residents told us they felt the staff were kind. From our observations of resident and staff interaction, it was apparent that this was positive and person centred.

Taking carers’ views into account

We received nine completed Care Standards Questionnaires from relatives. All feedback was positive and comments included:

“Find staff very supportive, caring and considerate even when under staffed, having to cover extra shifts or under pressure. We are always made to feel welcome.”

“The service provided is excellent. Residents are so well looked after. This has been really good for my relative who is being so well looked after by all staff. Don’t think they could do any more than they do at the moment”.

“Since my relative has been in Grove House I have felt relaxed as I know they are safe and well looked after.”
“Grove House is a very caring and friendly care home - excellent. My relative is happy and settled there. They are well cared for, comfortable and have the freedom of choice and movement around the home. The home is bright and attractive. I am most impressed by the tender loving care, patience and devotion to the residents’ welfare and comfort shown by all the staff at all times. No matter how busy attending to those in need...the staff have time to talk and listen. They do care and life there is enjoyable and positive.”

One relative raised some concerns about the meals being provided and did not think they were nutritious.

We spoke with three relatives during our inspection visits. There were no concerns raised and all were positive about the quality of the service.
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: 4 - Good

Statement 1
We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Service strengths
We saw that the service was operating to a good level in this area. We measured this by looking at the service’s information leaflets, minutes of meetings with residents and staff. We also looked at records of six month reviews for residents. We could see that some progress was being made in responding to the recommendations for improvement.

We saw that the information leaflet for the service had been up-dated.

We noted that staff meetings had been taking place.

It was evident that the service had been carrying out some six month reviews of residents’ care plans.

We saw that there was a participation strategy for the service. We were also aware that the service was continuing to issue a newsletter, the most recent of which was for the period October and November 2014. This contained information about activities and resident’s birthdays. There was also a quiz. We noted a similar content for back issues for the months of August/September and April/May 2014. These were colourful and well presented.

We looked at the complaints log for the service. There had been no complaints recorded since our last inspection.
We saw that meetings had been taking place with residents in January, February and July 2014. We were advised that the plan was to meet every four to six weeks. We noted a good level of detail being recorded about what had been discussed. A range of issues were being talked about such as choices of activities and menus.

Relatives we spoke with told us they always felt welcome and would know how to complain if there was a concern. They also told us they knew who their relative’s key worker was and had been aware that their relative had asked their key worker specifically to support them in some activities.

**Areas for improvement**

We had made a recommendation following our previous inspection that the service should update its leaflet information to ensure it accurately reflected the current service provision. We saw that the leaflet had been up-dated. However, there was limited information provided about short term placements. As a result of the changes in the use of beds in the service, the leaflet will need to be revised. It will also need to be kept under review as decisions are made about the future provision within Grove House.

We noted that the section on complaints in the leaflet containing information for people moving into a care home should be amended to reflect the fact that people have the right to complain to the Care Inspectorate in the first instance, not just if they are dissatisfied with the response from the provider. This recommendation has therefore been repeated with a slight amendment to the wording to reflect our findings.

See recommendation 1.

We had made a second recommendation that the care home manager should timetable regular staff meetings. Whilst it was evident that some staff meetings had been taking place, these needed to be more regular for all staff to ensure that they are actively involved in discussing how the service is developing. We have repeated this recommendation and amended the wording to reflect our findings from this inspection.

See recommendation 2.

We had made a further recommendation following our previous inspection that the service should ensure resident’s care plans are reviewed every six months or sooner if needs change. We looked at records of reviews. Acknowledging that some reviews had been carried out, it was evident that further work was needed to ensure all care plans were being reviewed regularly and that this was consistent across the service. For example, we saw that the six month review monitoring template stated that a resident was due to have a review in September 2014. There was no record of this having taken place. The review form in the file was dated July 2013. This was partially completed, unsigned and undated. For another resident, we noted that their care had
last been reviewed in April 2014. The next review was due to have taken place during October, but there was no record of this. We also noted for one resident that they had been losing weight prior to their care and support being reviewed. There was no record of this issue having been discussed at the review nor what actions had been taken.

See recommendation 3.

Whilst there was a participation strategy in place, the strategy paper did not refer to any possible routes as to how service users or stakeholders could be involved in shaping the service. We would suggest that the provider reviews this in light of changes taking place in the service. We would also suggest that the newsletter could be utilised for canvassing the views of stakeholders. We will follow this up at our next inspection.

It was evident that the staff were engaging residents in activities, some of which were group activities and some of which were personal to individual residents. However, the records of these were minimal for some months and may not reflect what had, in fact, been taking place. We would suggest that the service reviews how it records activities. We will follow this up at the next inspection.

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

**Number of requirements:** 0

**Number of recommendations:** 3

**Recommendations**

1. It is recommended that the service up-dates its leaflet information to ensure that it accurately reflects the service being provided. This should be kept under review as the service changes. Information leaflets should also reflect the right of a complainant to make their complaint direct to the Care Inspectorate in the first instance if this is their choice.
   National Care Standards. Care Homes for Older People. Standard 11 - expressing your views.

2. It is recommended that the care home manager time tables regular staff meetings to ensure that staff are actively involved in the development of the service. These meetings should be recorded with action plans and time tables for actions to be taken forward.
   This recommendation also applies to meetings involving residents.
   National Care Standards. Care Homes for Older People. Standard 5 - management and staffing arrangements.
3. It is recommended that the service ensures resident’s care plans are reviewed every six months or sooner, in the event that their needs change, with actions being taken forward and care plans being updated accordingly. National Care Standards. Care Homes for Older People. Standard 6 – support arrangements.
Statement 2
We enable service users to make individual choices and ensure that every service user can be supported to achieve their potential.

Service strengths
We saw that the service was operating to a very good level in this area. We measured this by observing staff and resident interactions. We also spoke with residents, relatives and visiting professionals.

It was evident that the staff were motivated to support residents in maximising their potential. For example, we noted that one resident had expressed an interest in going swimming at the local swimming baths. This had taken place and the resident had enjoyed this experience. This was a good example of staff maximising the potential of a resident who is normally very dependent on others for support with their activities of daily living.

We observed a staff member assisting a resident with their lunch. We saw that the carer gently encouraged the resident and took their time, going at the resident’s pace. They offered the resident choices, allowing time for the resident to make a decision. They ensured that they were sitting close to the resident with no other distractions. This was a very personalised approach and it was evident from the response of the resident that they had enjoyed this meal time experience and the interaction with the carer.

We observed staff interacting with residents living with dementia. Some staff were very skilled in their approach.

We spoke with some relatives of residents during our inspection visits. All expressed satisfaction with the quality of care and support being provided. Comments included feeling that the service could not have done anything better to improve their relative’s care. They also spoke of staff trying to support their relative in a person centred way in order to retain life skills.

One member of staff said they felt the best thing about their job was that they were enabling residents to stay as independent as possible.

We noted that one resident continued to be regularly supported by a charitable organisation to visit their family. This is very important to the resident’s well being and sense of purpose and belonging.
Areas for improvement

It was evident during our inspection that the staff were trying hard to maximise the potential of individual service users within available resources. We have made a recommendation about staff training being made available to develop skills and expertise in working with people who are living with dementia. This recommendation also applies here, as it is important all staff feel competent and confident in their ability to maximise the potential of those residents who may have limited cognitive capacity and who may also have life choices which are important for them to realise.

Grade awarded for this statement: 5 - Very Good
Number of requirements: 0
Number of recommendations: 0
Statement 3
We ensure that service users’ health and wellbeing needs are met.

Service strengths
We saw that the service was operating to an adequate level in this area. We measured this by sampling resident’s care plans and assessing the progress made in the areas identified for improvement following the previous inspection.

We observed some kind and thoughtful interactions between residents and staff. For example, we saw a member of staff supporting a resident with a visual impairment. The staff member took time and care to explain the changes in floor coverings so that the resident did not misplace their footing.

We noted that some residents who may find it more challenging than others to use the staff call system were wearing a pendant alarm. This made it easier for them to call for staff assistance when needed.

We observed a member of the senior care staff team administering medication. We saw that they carried out this task with care and patience, following best practice. We also noted that MARS had been completed accurately. We looked at records of temperature checks for the mobile drugs trolley, the drugs storage cupboard and fridge. We saw that these were all complete with no gaps.

We saw that some progress had been made in up-dating and reviewing the information recorded in care plans to ensure that these accurately reflected current levels of need. We noted some good levels of detail in respect of personal history information about individual residents. This helped staff to have a better understanding of the resident’s potential life choices and areas where they may need support. We also noted that the service had implemented a new form which detailed when and in what circumstances family or representatives would wish to be contacted.

Areas for improvement
We had made a requirement that the provider must improve the recordings within care plans and medication administration records (MARS). We sampled care plans and MARS during our inspection. Whilst it was evident that some progress had been made in responding to this requirement, further improvement was needed. For example, during our visit we sampled topical medication administration records (TMARS) for the application of creams and eye drops. We noted that creams did not always have the date they were opened recorded on the packaging. We also saw that TMARS were not always being completed accurately. For example, one did not record how often the cream should be applied. The most recent record of the cream being applied was 4 September. The date we looked at the record was 12 November 2014. Another TMAR for a different ointment last recorded the administration of this as having been
carried out on 31 December 2013. We noted that this ointment was still in use. It was also evident that some TMARS would benefit from being archived.

We noted that one resident who was prescribed "as required" medication did not have a protocol in their care plan which would support staff to know when to administer this medication, the maximum dosage within a 24 hour period or what results to expect after the medication had been administered. We saw an example of an "as required" protocol being in place for another resident, but this lacked sufficient detail to guide staff and had not been up-dated following a medication review in April 2014. We looked at the provider’s medicines management guidelines which are being compiled in partnership with NHS Borders. These are still in draft and there is no guidance as yet within this document for staff on the management of "as required" medication.

We saw that a resident with a diagnosis of dementia had been seen by the mental health support team. However, there was not an Adults with Incapacity (AWI) certificate in place with a treatment plan to guide staff about the level of capacity the resident had to be involved in decision making about their care and support needs. We also noted that an AWI certificate for another resident was out of date.

We also sampled oral care and food and fluid records. We noted that these were not always being completed for each day. We did speak to the care home manager about one resident whose food and fluid intake should have been monitored given their health care needs at that time. This was immediately dealt with by the manager, though records remained incomplete.

We also saw one example of a resident’s weight not having been recorded since August 2014.

We saw that there were some examples where daily records had not been completed by staff. There appeared to be few recordings made by night staff. Whilst it was evident that staff seemed to have a good understanding of the residents’ needs, their likes and dislikes they appeared to hold a lot of this information in their own heads and it was not being recorded within care plan documentation as required. Also some records were written in the first person and some in the third person. This needed to be consistent across the service.

It was evident that care plans were not always being up-dated as needed. For example, in one instance we noted that the Do Not Attempt to Resuscitate (DNAR) form had been up-dated in August 2014, but the care plan had not been up-dated to indicate that this had been done. There was also an out of date DNAR form in the care plan dated August 2011 which should have been archived. In another resident’s care plan, there were two DNAR forms. One was dated 2012 for the period of one year. A second was also dated 2012 but with “no limit” as the review time frame. It was unclear which form was correct.
We saw a further example where a resident had been seen by their GP in October 2014. There had been a change in medication at that time but this had not been recorded in the general health and medication support plan which was dated September 2014.

We also noted further examples where resident’s care plans and risk assessment had not been up-dated following discharge from hospital, a period of recorded weight loss and changes in mobility and use of equipment. Desired outcomes were not always being clearly recorded.

We noted that some care plans did now contain copies of legal documentation such as Power of Attorney. However, it was not always recorded in the care plan that there was a third party with legal powers involved, nor the extent and limits to these powers.

We identified that the main areas for the service to focus on improving care plans were as follows:

- all care plans must be up-dated as and when needs change and include sufficient levels of detail about personal choice, likes and dislikes as well as desired outcomes
- all charts and daily records - for example - food and fluid intake, TMARS, oral health care - must be completed as required
- protocols for the administration of "as required" medication must be put in place as appropriate
- those residents with limited capacity should be assessed in respect of their ability to be involved in decisions about their care and treatment, and this must be recorded in their care plan
- information about third parties with legal powers must be sufficiently detailed to guide staff as to how and in what circumstances they should be involved in decision making about care and support.

We have therefore repeated this requirement with some amendments to reflect our findings.

See requirement 1.

We had made a further requirement from the previous inspection that the provider must revise its dependency assessment process to reflect the number and skill mix of staff who are providing direct care to residents. We sampled dependency assessments and staff rota s. We saw that the service had done some work to respond to this requirement. However, we noted that within the dependency calculations, the available staff hours per week were being recorded at the staffing schedule level as opposed to actual hours worked. We saw that there were occasions when shifts were being covered for unplanned absences, the hours worked were not always the full
shift. This means that the dependency assessments were unlikely to be accurate. We have therefore repeated this requirement with some amendments to reflect our findings. See requirement 2.

We had made a third requirement that the provider must conclude the review of its policy and procedures on nutrition and ensure that the specification for meal provision reflects a good understanding of the residents’ dietary needs. Whilst it was evident that the provider had been taking this forward with support from the Care Inspectorate’s nutritional advisor, we saw that this work was as yet incomplete. This requirement has therefore been repeated. See requirement 3.

Grade awarded for this statement: 3 - Adequate
Number of requirements: 3
Number of recommendations: 0

Requirements
1. The provider must make proper provision for the health, welfare and safety of service users by taking action to ensure:

- the draft medicines management guidelines are finalised and include guidance for staff on “as required” medication
- all TMARS, oral health care charts, food and fluid charts and daily records are completed accurately and are kept up-to-date by both day and night staff
- care plans are up-dated when there is a change, for example, following a GP visit or hospital stay
- where a service user is in receipt of "as required" medication, a protocol must be in their care plan which details the triggers for the administration of this, any alternatives, how often it should be reviewed, the effectiveness of such medication and the maximum dose to be administered within a specified period
- where residents are known to have cognitive impairment and may have limited capacity to be involved in decisions about their care and treatment, discussion takes place with all relevant parties to record this, which may include the completion of an AWI certificate with a treatment plan
- all information about third parties with legal powers is sufficiently detailed.

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 4 (1) (a) which is a requirement about the welfare of service users.
See also: “Guidance about medication personal plans, review, monitoring and record keeping in residential care services.” Care Inspectorate 2012.
Timescale: within 4 weeks of the receipt of this report.

2. The provider must revise its dependency assessment process to reflect the actual hours worked by staff and ensure that there are sufficient numbers of staff within the service at all times to meet the needs of residents.
This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 15 (a) which is a requirement about staffing.
Timescale: within one week of the receipt of this report.

3. The provider must conclude the review of its policy and procedures on nutrition and ensure that the specification for meals provision within this service reflects a good understanding of residents’ dietary needs and how these will be met through menu planning and food provision.
This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 4 (1) (a) which is a requirement about the health, welfare and safety of service users.
See also:
Food in hospitals national catering and nutrition specification for food and fluid provision in hospitals in Scotland 2008, Scottish Government download from www.scotland.gov.uk/Publications/2008/06/24145312/0 which is applicable to care homes.
Eating well: supporting older people and older people with dementia - practical guide. The Carol Walker Trust 2011 - www.cwt.org.uk.

Timescale: within 6 weeks of the receipt of this report.
Quality Theme 2: Quality of Environment
Grade awarded for this theme: 3 - Adequate

Statement 1
We ensure that service users and carers participate in assessing and improving the quality of the environment within the service.

Service strengths
Comments made in Quality Statement 1.1 are also relevant to this Quality Statement.

We have also applied the grade of 4 "good" awarded in Quality Statement 1.1 to this Statement.

Areas for improvement
The service should refer to the areas for improvement in Quality Statement 1.1 and ensure they implement any action plans required.

Grade awarded for this statement: 4 - Good
Number of requirements: 0
Number of recommendations: 0
**Statement 3**
The environment allows service users to have as positive a quality of life as possible.

**Service strengths**
We assessed the environment during this visit as adequate. We had previously recommended over two inspections that the provider should ensure that the decor within the whole home was kept in good order and well maintained. Whilst the staff were doing their best to maintain a clean and odour free environment and create a homely atmosphere, it was evident that no progress had been made by the provider in improving the decoration within the home. This was particularly noticeable in some bedrooms as well as some communal areas, including toilets.

We had made a recommendation following our previous inspection that the service should ensure all "J cloths" were removed from communal toilet and bathing areas and used only once. We also advised that bars of soap should be removed from communal toilet areas and all flip top bin should be replaced with pedal bins. It was evident that this recommendation had been met.

We saw that resident’s bedrooms were furnished in a personalised way.

We checked a stand aid and noted that this had been serviced by an engineer in October 2014.

We saw that Legionella checks for shower heads were being completed monthly. There was also evidence of external checks for Legionella being carried out by an independent contractor.

**Areas for improvement**
We had made a recommendation following previous inspections that the provider should ensure that the decor within the whole home is kept in good order and well maintained. Whilst it was evident that the staff did their best to create a welcoming and personalised environment, it was clear that there had been no decoration programme taking place. Some areas of the home were tired, with damaged and stained paintwork.

For example, we noted one bedroom on the ground floor where there had been obvious water damage to the ceiling in the en-suite. This would have benefitted from being redecorated.

Some of the easy chairs in the ground floor sitting room were worn and would benefit from being replaced.

We saw that the kitchen larder on the first floor was being used for the storage of dried foods as well as cleaning equipment. This was an infection control hazard.
There was a lack of storage space for moving & handling equipment, which was mainly kept in the first floor corridor when not in use.

We saw that bath temperature records were not being completed.

Breakfast cereals were being decanted into containers with no use by date recorded.

We looked in the linen cupboard on the ground floor. We saw that bed linen was being stored on the floor. This is an infection control hazard.
We have made a new requirement about the internal environment. See requirement 1.

We saw a notice above a resident’s bed containing personal information. This should have been recorded in the resident’s care plan and not on display. We will check that any notices of this kind have been removed at our next inspection.

Grade awarded for this statement: 3 - Adequate
Number of requirements: 1
Number of recommendations: 0

Requirements
1. The provider must ensure that the environment is safe and fit for purpose. In order to do this, the provider must ensure that:

   • a comprehensive audit of the interior of the home is carried out resulting in an action plan with timescales for required repairs and refurbishment. This action plan must be made available to the Care Inspectorate once it has been completed.
   • all measures have been taken to maximise infection control and health & safety.

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 210. Regulation 10, which is a requirement about fitness of premises.

Timescale: within 8 weeks of the receipt of this report.
Quality Theme 3: Quality of Staffing
Grade awarded for this theme: 4 - Good

Statement 1
We ensure that service users and carers participate in assessing and improving the quality of staffing in the service.

Service Strengths
Comments made in Quality Statement 1.1 are also relevant to this Quality Statement.

We have also applied the grade of 4 "good" awarded in Quality Statement 1.1 to this Statement.

Areas for improvement
The service should refer to the areas for improvement in Quality Statement 1.1 and ensure they implement any action plans required.

Grade awarded for this statement: 4 - Good
Number of requirements: 0
Number of recommendations: 0
Statement 2
We are confident that our staff have been recruited, and inducted, in a safe and robust manner to protect service users and staff.

Service strengths
We saw that the service performed to a good level in this area. We looked at the induction procedure for agency staff.

We had made a recommendation following our previous inspection that the provider should formalise and implement an induction procedure for agency staff who may be engaged in the service. We saw that this had been compiled and was in use. This recommendation had been met.

Areas for improvement
During this inspection, we limited our scrutiny of recruitment and induction to following up on the recommendation made following the previous inspection.

Grade awarded for this statement: 4 - Good
Number of requirements: 0
Number of recommendations: 0
Statement 3
We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Service strengths
We saw that the service was operating to a good level in this area. We measured this by looking at training records, minutes of staff meetings and staff supervision files. We also spoke with staff.

We had made a requirement following our previous inspection that the provider must put in place a training programme on the care of people living with dementia to ensure that all staff are confident and competent in this area. During our inspection we looked at the staff training matrix. We saw that four staff had attended six dementia skilled practice workshops, each lasting two hours. One staff member we spoke to who had attended these felt they had gained a lot from this experience. We observed that their practice with residents was skilled and sensitive to their needs. We also looked at the training undertaken by some staff in other subjects. This included: data protection, equality and diversity, moving and handling up-dates, an introduction to food hygiene, the protection of vulnerable adults and medicines management. We noted that Grove House staff will also be participating in a bespoke training programme for care homes, which will include adult support and protection in care home settings, dementia informed practice and the national care standards and principles for care home settings. This is scheduled to take place in August 2015. We saw that staff were registering with the Scottish Social Services Council (SSSC) as required.

Staff told us they felt that they were provided with a good level of training.

We had made a recommendation following our previous inspection that the manager should ensure there are planned opportunities for staff discussion and team building. This was to ensure that the staff team is able to develop and strengthen its leadership skills. Whilst there had been some meetings taking place and staff told us that they felt able to speak up at these forums, it was evident that the absence of the manager for a number of weeks had impacted on the number of occasions staff had met.

We sampled staff supervision files. We noted that some contained a reasonable level of detail about what was discussed, with the actions to be taken forward. We noted one record which had a good level of detail. We saw that there had been discussion about practice and reflection on what the carer had done well. We also saw examples of supervision records where the supervisor was discussing areas of practice which needed to be improved.
Staff told us they enjoyed their job. They also told us that there is a good staff team in Grove House and felt supported. One staff member told us that they gain most job satisfaction from their interactions with the residents, though morale had been affected for some by the decrease in the number of service users admitted for rehabilitation with the plan of returning home.

Staff we spoke with were clear they would report any concerns about unacceptable practice should these occur.

**Areas for improvement**

Though a small number of staff had attended dementia skilled practice workshops, we were advised that these were unlikely to be replicated going forward. We became aware that the provider was arranging a bespoke training programme which included dementia informed practice. We will check at the next inspection that this has taken place and that the standard of training is in line with the “Promoting Excellence” framework.

Whilst we would acknowledge that there had been some staff meetings taking place, these were not always happening on a planned and regular basis.

For example, we saw that there were minutes of senior staff meetings which had taken place in January, February and March 2014. There were no records of any meetings thereafter, with the exception of one typed note which was undated. It was evident that the team had been discussing the previous Care Inspectorate report and the areas for improvement to be addressed.

The most recent records of night staff and domestic staff meetings taking place were dated September 2013. We noted that there had been meetings with the staff working on the first floor in January and October 2014. The last meeting recorded meeting with ground floor staff was September 2012. We would suggest that notes of meetings would benefit from including action plans with timescales.

We have therefore repeated this recommendation to ensure that the practice of staff meeting on a planned and regular basis is embedded into the operational routine. See recommendation 1.

We looked at some staff supervision files. We saw that some contained details of personal issues and some recorded a minimal level of detail. The service should ensure that these are recorded in such a way that respects confidentiality. We noted that some supervision sessions had not taken place, though no reason was given for this. The lack of frequency of supervision was borne out in our conversations with staff, one of whom told us they had last had a supervision session six months previously.
We have commented in Quality Statement 4.4 that the care home manager had audited staff supervision files and it was evident that they had identified areas for improvement regarding how supervision was being carried out. We will monitor how the manager has taken this matter forward with the senior team and what improvements have been implemented in the provision of staff supervision at the next inspection.

We noted that there were times when residents’ care plans were left on the desk in the first floor office which was also open. Staff need to ensure that they consistently manage resident confidentiality by ensuring that personal records are always stored away when no one is working in the office.

**Grade awarded for this statement:** 4 - Good
**Number of requirements:** 0
**Number of recommendations:** 1

**Recommendations**

1. It is recommended that the manager ensures there are planned opportunities for staff discussion and team building. This should include but is not limited to having a timetable for regular and planned staff meetings, the records of which should contain action plans which are followed up at each meeting or sooner if required. National Care Standards. Care Homes for Older People. Standard 5 - management and staffing arrangements.
Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 4 - Good

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
Comments made in Quality Statement 1.1 are also relevant to this Quality Statement.

We have also applied the grade of 4 "good" awarded in Quality Statement 1.1 to this Statement.

Areas for improvement
The service should refer to the areas for improvement in Quality Statement 1.1 and ensure they implement any action plans required.

Grade awarded for this statement: 4 - Good
Number of requirements: 0
Number of recommendations: 0
Statement 4

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

Service strengths

We saw that the service was operating to a good level in this area. We measured this by reviewing the audit processes in place.

We had made a recommendation following our previous inspection that the provider should ensure all internal audit processes are carried out on a regular basis. These processes should include action plans and systems for accessing the views and providing feedback to those using the service and their families.

We saw that medication audits had been carried out in June and August 2014. We also noted that a medication audit had been carried out in February 2014 by the care home manager and the local pharmacy. Some actions had been suggested for improvement, but on the whole the outcomes were good from this exercise.

We saw that the senior team had been auditing care plans.

We also noted that monthly checklists had been put in place from May 2014. These included checking areas such as MARS as well as accident records, care plans, fridge temperature records and the general environment.

We noted that there had been a catering survey carried out and that there had been five responses from residents on the ground floor.

We saw that an audit had been carried out of staff supervision files during September and October 2014 by the care home manager. Some actions were recorded following this audit.

We saw that a monthly falls monitoring form was being completed as was a monthly falls overview form.

Areas for improvement

We would suggest that it may be useful to the senior staff team to add an action column to the monthly checklist system now in use. It would therefore be easy to see what needs done and whether it has been taken forward.

Whilst it was evident that a catering survey had been carried out and the results had been set out in a bar chart, it was unclear what actions (if any) had been taken forward following on from this exercise. We also noted that eight residents living on the first floor of Grove House had responded to a catering survey but this information was undated. These responses appeared to be positive about the quality of catering supplied.
We noted that actions to be taken forward from the staff supervision audit had been identified. However, it was unclear how these were being taken forward, by whom and within what timescales. For example, the care home manager had identified that some supervision sessions for some staff were not taking place as frequently as required in line with the service’s policy.

We would suggest that the service may wish to consider reviewing the monthly falls monitoring and overview forms. It may be that these can be combined into one form to reduce duplication of recording.

Whilst acknowledging that the service had begun to audit care plans, we noted that some of these were undated. It was also unclear who was responsible for checking that points for action had been followed up. We would suggest it may be helpful to have a regular cycle of audits so as to identify gaps in care plan recording and follow these up quickly.

We have made a new recommendation about auditing processes. See recommendation 1.

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

**Number of requirements:** 0

**Number of recommendations:** 1

**Recommendations**

1. It is recommended that the senior team reviews all internal and external audit processes and ensures that all are carried out regularly and are appropriately recorded with action plans. There should be an effective system in place to ensure that all areas for improvement are taken forward to demonstrate improved outcomes for residents.

   National Care Standards. Care Homes for Older People. Standard 11 - expressing your views.
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
It was evident during our inspection that the service in Grove House was responding to local need for long stay care. This meant that the beds were not all being used for the purpose they had been registered with the Care Inspectorate. We also became aware that the physiotherapy support to the intermediate care unit had ceased. The occupational therapy input was limited to one practitioner for three days per week, allocated across two care homes. At the time of this inspection, this was a temporary arrangement. The weekly multi disciplinary meetings held to discuss plans for residents moving on had been reinstated. However, we noted that only a limited number of short stay beds were being used for the purpose of rehabilitation, assessment or intermediate care. Some residents admitted to the intermediate care beds appeared to be waiting for a period of months on long stay care in a 24 hour care setting. For some residents, this was unsettling and at times distressing given the length of time it was taking to resolve their individual situations. It was also challenging for staff who had been trained to support residents to rehabilitate, but who were working in the main with service users who were awaiting long stay care and who needed higher levels of support.

We were advised by the provider that discussions were underway about the future purpose and function of the service. We will monitor this at future inspections.

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 - 4 - Good**

| Statement 1 | 4 - Good |
| Statement 2 | 5 - Very Good |
| Statement 3 | 3 - Adequate |

**Quality of Environment - 3 - Adequate**

| Statement 1 | 4 - Good |
| Statement 3 | 3 - Adequate |

**Quality of Staffing - 4 - Good**

| Statement 1 | 4 - Good |
| Statement 2 | 4 - Good |
| Statement 3 | 4 - Good |

**Quality of Management and Leadership - 4 - Good**

| Statement 1 | 4 - Good |
| Statement 4 | 4 - Good |

## 6 Inspection and grading history

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<thead>
<tr>
<th>Date</th>
<th>Type</th>
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<td>Unannounced</td>
<td>Care and support 4 - Good</td>
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<tr>
<td></td>
<td></td>
<td>Environment 4 - Good</td>
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<td>Staffing 4 - Good</td>
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<td></td>
<td></td>
<td>Management and Leadership 4 - Good</td>
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<td>17 Jan 2013</td>
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<td>Care and support 2 - Weak</td>
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<td></td>
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Telephone: 0345 600 9527
Email: enquiries@careinspectorate.com
Web: www.careinspectorate.com