Elmgrove Care Home
Care Home Service

Inverness

Type of inspection:
Unannounced

Completed on:
6 November 2019

Service provided by:
Marchmont Homes Limited

Service provider number:
SP2007009346

Service no:
CS2007161819

About the service

This service has been registered since 2007.

Elmgrove Care Home is registered to provide a care service for up to 27 older people.
The provider is Marchmont Homes Limited.

Elmgrove Care Home is a large two storey house which has been extended. The care home is situated within its own grounds in a quiet residential area near Inverness city centre. All bedrooms provide single occupancy, one of which has en-suite facilities. There are toilet and bathing facilities on the ground and first floors. There is a shower facility on the first floor. There are communal rooms which include two lounges, a conservatory and a dining room and seating areas within the entrance. The first floor accommodation can be accessed via the stairs or passenger lift.

The service has a statement of purpose:
'Marchmont Homes Limited believe in providing the highest quality service possible. We strive for continuing improvement in our service and practice. The provider and manager understand that to provide this service requires caring and compassionate staff who are suitably trained, supervised and supported. The aim of the service is to provide a professional and efficient service to meet the needs of all who live, work and visit our care home.'

There were 25 people using the service at the start of the inspection.

What people told us

- One person who was sitting in the lounge was calling out saying that she was cold.
- Another person told us everything is ok here and that she had enjoyed her meal.
- One person had been shouting out that she was hungry.
- One person commented that it's always the same thing that is on the television and that they didn't get a choice.
- We saw one person who was uncomfortable, their skin was at risk and they were, sitting in a chair with no pressure reducing equipment.
- We spent time observing how people spent their day, including interactions with staff and the impact this had on the quality of their lives. When care staff had time to interact with people, they did this in a kind and caring way. Additional staff were brought in by the Health and Social Care Partnership to help staff to support people and to ensure there were enough staff to ensure people's safety.

The Care Inspectorate attended a relatives' meeting organised by the Health and Social Care Partnership. Some relatives expressed concern about the service's long history of poor performance.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	1 - Unsatisfactory

How good is our leadership?	1 - Unsatisfactory
How good is our staffing?	1 - Unsatisfactory
How good is our setting?	1 - Unsatisfactory
How well is our care and support planned?	1 - Unsatisfactory

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 1 - Unsatisfactory

We found the service's performance was unsatisfactory.

The quality of care had significantly declined. We identified wide ranging, serious failings in the way the care home operated. We concluded that there was a serious risk to the vulnerable older people's life, health and wellbeing.

There had been an escalation of complaints and concerns in the two weeks before the inspection. The Health and Social Care Partnership suspended admissions to the service on 16 October 2019. We met with the Health and Social Care Partnership on 17 October 2019 for a multi-disciplinary meeting which resulted in a Large-Scale Investigation being initiated under adult support and protection legislation.

The service failed to provide the right care to meet people's needs. As a result, people suffered physical harm and emotional distress. This included a person who required one-to-one support and sustained a serious injury while they were upstairs alone in a dark corridor; and a person living with dementia who was injured after leaving the building unnoticed through a faulty fire door on at least two occasions. There was no evidence that preventative assessments were carried to reduce the risk of harm. Accidents and incidents were not reviewed to enable the service to learn from them and prevent them happening again.

We found that insufficient staffing had adversely impacted on other important aspects of people's care, including support with continence needs, skin integrity, hydration, nutrition, moving and assisting, pain management and fire safety. This put people at considerable risk of harm. People had experienced a lack of support when they needed it and a lack of choice and control over their lives. Staff had limited opportunity to spend time or speak with people to support them physically, psychologically or emotionally. For example, people had experienced a lack of choice when they got out of bed or went to bed, when they could have a bath or a shower. The Health and Social Care Partnership responded to the serious risk by supporting the service with short-term additional staffing.

Being able to eat and drink well is essential to keeping well. The provider and manager failed to ensure people received nutritious well-balanced meals that met people's dietary needs. The provider had assumed responsibility for food ordering. Staff expressed concern that they had been told to cook meals using spoilt vegetables and that the provider said not to buy cakes and biscuits as they were 'luxury' items. Food supplies were low, food choices were limited, and the menu was not followed due to a lack of ingredients.

When the cook was on days off or on leave, cover arrangements were inadequate. A risk assessment to ensure safe high-quality food was prepared when there was no cook was not implemented. The provider and manager cooked some of the meals, but care staff were also taken away from their caring duties to cook. This had a negative impact on people's care and placed care staff under increased pressure. The week before the inspection there was no cook for four days. On one occasion a member of staff used their own money to buy a takeaway meal for people's lunch. The Health and Social Care Partnership had to intervene and provide an emergency meal supply to ensure people could get enough to eat.

We concluded that people were at risk of hunger, ill health and malnutrition due to the provider's failure to ensure adequate food supplies and sufficient staff with the necessary qualifications, experience and skills to safely prepare food that met people's dietary needs and preferences.

Any treatment or intervention people experience should be safe and effective. We found significant failings in relation to the assessment, planning and review of people's care and support needs. As a result, care staff often did not know how to safely meet people's needs.

The service had repeatedly failed to notify and involve other health and social work professionals and withheld important information about actual and potential harm. We concluded that people's health and wellbeing needs had been neglected.

People should be recognised as experts in their own experience, needs and wishes and be able to maintain and develop their interests. Although the care staff were kind and caring they did not have time to spend with people. As a result, people spent almost all of their day with no interaction, stimulation and at times no supervision. A member of staff told us that some people were being kept in their rooms until lunchtime and that they had no activities and 'no life'.

Staff said they wanted to do activities with people, but they were unable to do so as there were not enough staff. This also severely limited the opportunity for people to go outdoors or access fresh air. People had continued to benefit from the regular bike outings provided by an external volunteer group. At the last inspection we asked the provider to ensure that people were offered opportunities to take part in regular activities that were meaningful to them regardless of their abilities and needs. The provider had failed to ensure people had these opportunities.

As a result of the serious concerns identified at this inspection, the Care Inspectorate made an application to the sheriff at Inverness Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application was based on the Care Inspectorate's belief that in the absence of an order there would be serious risk to the life, health or wellbeing of persons cared for by the service.

On 22 October 2019, the Care Inspectorate made an application to the Sheriff at Inverness seeking cancellation of the care service's registration under section 65 of the Public Services Reform (Scotland) Act 2010 ("the Act"). The application is based on the Care Inspectorate's belief that in the absence of an order, there would be a serious risk to the life, health or well-being of persons cared for by the service.

As part of the application, the Care Inspectorate also sought an interim order, suspending the registration of the care service under section 65(3) of the Act.

On 25 October 2019 an order was made by the Sheriff at Inverness, suspending the registration of the care service ad interim with effect from Friday 8 November 2019. The effect of this is to suspend the care service's

registration unless or until the court decides otherwise. The care service should not be provided by the provider from 8 November 2019.

How good is our leadership? 1 - Unsatisfactory

We found the service's performance was unsatisfactory.

People should be confident that the service and organisation are well led and managed. The way the service was being managed and led had significantly deteriorated since the last inspection. Staff expressed concern that this posed a risk to the people living and working in the home.

The manager was absent throughout the inspection. Inadequate contingency arrangements were in place to cover the manager's absence. The deputy manager told us she did not know what had been going on in the service as she had not received an update from the manager or provider when she recently returned from three weeks leave. The deputy manager worked hard and staff said she was supportive, however, she did not have enough time to manage the service as she was also responsible for providing care, cooking meals and carrying out maintenance work on a daily basis.

As identified previously, serious incidents had occurred when people were harmed. We found corresponding records were incomplete, inaccurate, provided conflicting information or were missing. The provider and manager had failed to report actual and potential harm to relevant authorities who could have intervened to give advice and support to protect people.

The provider's failure to report increased the risks to people's health, safety and wellbeing. This was particularly concerning given the manager and provider had previously failed to report allegations of harm and had been reminded in 2018 of their legal duty to do so under adult support and protection legislation and the Scottish Social Services Council's Code of Practice for Employers.

People should benefit from a culture of continuous improvement, and the organisation should have robust and transparent quality assurance processes. The service's quality assurance arrangements were unsatisfactory. The service was unable to make or sustain improvements. Changes to improve outcomes for people resulted from interventions through inspection and the involvement of other agencies. Since the last inspection, people's experiences had deteriorated again and the risk of harm to people had increased.

We found systems to keep people safe and assure the quality of care were not in place. Staff told us that the provider and manager failed to take prompt and effective action to address environmental faults that were contributory factors when people were injured. This put people at significant risk of harm.

We also found that meal arrangements were unsatisfactory, safe food hygiene practices were not being followed and staff had been recruited without following safe recruitment practices. At the last inspection we asked the provider and manager to have a more proactive approach to monitoring aspects of service delivery with a focus on sustaining and building on improvements. The provider had failed to do this or to sustain or make further improvements.

The provider demonstrated a lack of understanding and concern when we discussed the serious risks people were exposed to as a result of the way the service was being provided. We were very concerned about the lack of insight, understanding, acceptance and ownership of the issues in the home. We experienced resistance and obstruction at times and the same was also experienced by partner agencies.

During the inspection the provider did not provide information when we requested it. For example we asked to see records so we could assess whether staff had been safely recruited and properly trained, that money and valuables held on people's behalf were managed in a safe and transparent way and that environmental checks and risk assessments were being used to minimise risks of harm and keep people safe.

We concluded the provider and manager had failed to lead and manage the service in a safe manner and the risk to people was unacceptable.

As a result of the serious concerns identified at this inspection, the Care Inspectorate made an application to the sheriff at Inverness Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application was based on the Care Inspectorate's belief that in the absence of an order there was a serious risk to the life, health or wellbeing of persons cared for by the service.

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How good is our staff team? 1 - Unsatisfactory

We found the service's performance was unsatisfactory.

Previous improvements to staffing, that enabled staff to provide people with better support, had not been sustained. Staffing levels were frequently insufficient, and were getting increasingly worse, which contributed to people receiving unsatisfactory care. The service did not have a stable staff team. There were staff vacancies, a high turnover of staff and poor staff retention. Staff were stretched, stressed and under resourced.

Although we observed that care staff were caring and compassionate, there were not enough staff to meet people's needs. Staff spoke of managing basic care only and being 'run ragged'. Staff spoke of feeling 'very guilty' because they couldn't provide the care they wanted to and of being 'very worried if there was a fire or something happened' as there were not enough of staff and they didn't know what to do.

Staff told us about recent occasions when inadequate staffing levels meant people were at risk and received poor quality care. For example:
- on one occasion a member of staff was left on night duty on her own with the responsibility of trying to meet the wellbeing and safety needs of the 23 people living in the home;
- on another occasion the second member of staff on night shift went to bed, leaving only one member of staff to care for all the people living in the home;
- on one occasion there were only two staff on in the morning and people did not receive help to wash, dress, eat, drink or go to the toilet when they needed it. On the same day people did not receive a drink in the afternoon, increasing people's risk of becoming dehydrated;
- On another occasion a Health and Social Care Partnership professional who was visiting the care home had to intervene and ensure a person who was crying out for help received food and a drink.

Staff told us the duty rota was not accurate and they often did not know how many people would be on shift or what cover had been organised in response to staff vacancies or sickness. There was a core group of staff who spoke with genuine care and concern for the people who were living in the home. We found staff to be welcoming and friendly and appreciative of our support and presence. We were impressed that they remained

committed to being there for people using the service and wanting to see things improve. However, they shared our lack of confidence that the service would be able to improve this time.

At the last inspection the service was carrying out dependency level assessments to calculate the number of staff hours that were required to meet people's needs. The provider did not make this information available at this inspection. At the last inspection we were told that the service would increase the number of staff on duty as the number of people using the service increased. We found the opposite had happened. Although the number of people using the service had increased, the number of staff had decreased. For example, the manager had decreased the number of staff on duty at night from three to two without consultation with staff or assessing the risk this exposed people to.

The provider and manager failed to honour an admissions agreement with the Health and Social Care Partnership which was in place to ensure the service was able to meet the needs of new people moving in the home. The manager had admitted people to the home outwith the agreement. This put additional pressure on an already under resourced staff team and increased the level of risk for everyone living in the home.

People should have confidence in staff because they are trained, competent and skilled. Staff had received inadequate training and did not have the necessary knowledge and skills to provide safe care. For example, staff had not been trained to assess people's needs on admission, how to evacuate people if there was a fire or prepare food safely. Staff who were new to care and/or their role had not received the level of support they required. Staff were promoted internally to more senior posts without an induction or with a poor quality induction.

The provider and manager failed to provide staff with the support they required to follow the Scottish Social Services Council Code of Practice for social service workers. The provider failed to provide a detailed training plan, clear training records of staff learning and development or evidence of staff supervision and monitoring of skills and competencies for their roles.

We saw a willingness from some staff to cover roles for which they were neither employed nor trained. We saw care staff having to work in the kitchen on days where the service was already short of care staff. The stress this caused for individual staff and on the operation of the service was clear. Although well intended such practices were not safe nor acceptable.

At the last inspection we identified that some staff were not registered on the correct part of the Scottish Social Services Council register for the role they were employed for. The provider and manager had failed to take action to ensure staff were correctly registered.

People should be confident that staff who support and care for them have been safely recruited. The provider did not give us access to staff recruitment files despite repeated requests to make this information available. We established some staff had been employed without the necessary checks being carried out. The provider was not able to demonstrate that safe recruitment practices had been followed for the two staff who took up post during the inspection.

We had serious concerns about the stability of the whole team. The provider's failure to ensure staff had the necessary knowledge, skills and support to provide safe care posed a serious risk to people's life, health and wellbeing. We had no confidence that the provider had the knowledge, skills, resources or motivation to improve.

As a result of the serious concerns identified at this inspection, the Care Inspectorate made an application to the sheriff at Inverness Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application was based on the Care Inspectorate's belief that in

the absence of an order there was a serious risk to the life, health or wellbeing of persons cared for by the service.

As part of the application, the Care Inspectorate also sought an interim order, suspending the registration of the care service under section 65(3) of the Act.

On 25 October 2019 an order was made by the Sheriff at Inverness, suspending the registration of the care service ad interim with effect from Friday 8 November 2019. The effect of this was to suspend the care service's registration unless or until the court decides otherwise. The care service should not be provided by the provider from 8 November 2019.

How good is our setting? 1 - Unsatisfactory

We found the service's performance was unsatisfactory.

People's environment should be safe, secure and well maintained. On the first day of the inspection we asked Fire Scotland to urgently carry out a visit to the service as we were concerned that fire safety arrangements were unsatisfactory. Fire Scotland identified a serious fire safety risk, particularly overnight for people living upstairs who required assistance to evacuate in the event of a fire. The provider refused to follow advice from the fire officer to immediately reduce the risk. As a result the Health and Social Care Partnership intervened and arranged for additional staffing to be put in place overnight. The provider saw the additional staff, who were there to help keep people safe, as unnecessary.

We had serious concerns that people's life, health and wellbeing were at risk due to the service's ineffective approach to health and safety. Arrangements for ongoing maintenance of the environment were unsatisfactory. A maintenance person was not employed to carry out routine checks and day to day repairs. We found environmental checks were not carried out routinely and the system for reporting of faults and repairs was unsatisfactory. We were not able to evidence environmental risk assessments were in place and up to date.

There was a lack of monitoring by the provider and manager to make sure the environment was safe and in a good state of repair. The records we were able to see, for example the maintenance book and accident book, demonstrated the provider and manager were not meeting their responsibilities with regards to the health, safety and well-being of people using the service. People had come to harm as a result. When people were at risk of harm or experienced actual harm the provider and manager did not take appropriate action to protect them or prevent further harm.

There were some areas of the grounds that had recently been tidied up. People's access to the outdoors was very limited and there was no safe enclosed area for people to use. This impacted on people's choice to have an active life and to regularly access fresh air.
There were areas of the home that looked worn and in need of redecoration, for example there was torn flooring in some bedrooms and in the conservatory. At previous inspections, the provider had told us about plans to improve the environment however they had not been carried out.

As a result of the serious concerns identified at this inspection, the Care Inspectorate made an application to the sheriff at Inverness Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application was based on the Care Inspectorate's belief that in the absence of an order there was a serious risk to the life, health or wellbeing of persons cared for by the service.

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How well is our care and support planned? 1 - Unsatisfactory

We found the service's performance was unsatisfactory.

People's care plans should be right for them because they set out how their needs will be met, as well as their wishes and choices. People should be fully involved in assessing their emotional, psychological, and physical needs at an early stage, regularly and when their needs change. We found significant failings in relation to inadequate and missing assessments, plans and reviews. The service had failed to assess people's needs and develop care plans to ensure they received the right care to promote their safety and protect them from harm.

We were very concerned that there was no development of care plans for people where there were areas of very high risk. For example, a person who was at very high risk of developing pressure ulcers had an unsatisfactory assessment and care plan and their skin had deteriorated and broken down. There was no care plan in place to guide staff on how best to support a person when they were experiencing stress and distress. There was no risk assessment and plan in place for a person who staff had to prevent from inserting cutlery into an electrical socket. Risk assessments were not carried out before people were admitted into rooms upstairs and needed a high level of supervision and support. We concluded that the provider and manager had neglected to ensure that people were provided with the support and care they required.

We had previously identified serious concerns about the poor standard of people's assessments, care plans and reviews. This was addressed as part of the improvement notice we served in 2018 and the service had made some improvements as a result. We highlighted at the last inspection that it was important that staff, including agency staff, could refer to people's care plans for the information they required to effectively deliver care and support. We had asked the service to develop more outcome focussed care plans with people and ensure that reviews were more evaluative to ensure people's care was right for them. The provider had failed to sustain improvements and there had been a significant decline that posed a serious risk to people's life, health and wellbeing.

As a result of the serious concerns identified at this inspection, the Care Inspectorate made an application to the sheriff at Inverness Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application was based on the Care Inspectorate's belief that in the absence of an order there was a serious risk to the life, health or wellbeing of persons cared for by the service.

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

Requirements

Requirement 1

By 31 May 2019, the provider must ensure that where people need support with their medication they receive this at the right time, safely and effectively.

In order to do this the provider must:
a) ensure the care and support people experience with medication and treatment is based on relevant evidence, guidance and best practice.
b) ensure arrangements are in place to monitor administration and recording practices and to take prompt and appropriate action where any issues are identified in relation to this.
c) ensure that information relating to people's medication, related assessments and the circumstances in which it should be given are recorded in people's care plans. This information should be regularly reviewed updated where there are any changes to people's care or well being needs.
d) ensure suitable arrangements are in place and are followed so that medication is being used within date and is kept at the correct temperature

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that, 'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24)

This is also in order to comply with The Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), Regulation 4(1)(a) Welfare of Service users.

This requirement was made on 2 May 2019.

Action taken on previous requirement
We visited the service on 07 June 2019 and could see there had been an improvement in practice and the monitoring of practice to ensure that where people needed support with their medication, they received this at the right time, safely and effectively. At this time the requirement was met. The provider was notified by letter.

Already noted in this report are the failings in the care of the people which have happened as result of improvements not being sustained and the poor management and leadership of the service by the provider and manager.

Not met

Requirement 2

The provider must ensure that people experiencing care can be confident that people who support them have been appropriately and safely recruited.

By 20 September 2019 the provider must improve safe recruitment practices for staff employed to work within the service. In order to achieve this to the following.

a) Carrying out all appropriate recruitment checks in order to comply with current safer recruitment guidelines.
b) Maintaining records that clearly demonstrate how and when this was carried out.
c) Ensuring that staff undergo full safer recruitment checks prior to working in an unsupervised capacity with people receiving care.
d) Ensuring that service quality assurance systems provide clear oversight and assurance that all checks have been fully completed and highlight any necessary actions required to be taken to complete this process.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which states that, 'I am confident that people who support and care for me have3 been appropriately and safely recruited.' (HSCS 4.24)

This is also in order to comply with The Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210), Regulation 9 (1) and(2) Fitness of Employees.

This requirement was made on 2 May 2019.

Action taken on previous requirement
Requirement not met

Not met

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The provider should improve the overall management of falls and incidents through better recording, analysis, appropriate follow up action and review.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that, 'I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk.' (HSCS 3.21)

This area for improvement was made on 2 May 2019.

Action taken since then
Please refer to the findings of the inspection noted in the main report.

Previous area for improvement 2

The provider should ensure that people are offered opportunities to take part in regular activities that are meaningful to them regardless of their abilities and needs.

In order to do this the service should:
a) use the information about people's past and present interests and wishes to develop their personal plan. This should support people with activity that is meaningful to them in their day to day life and which clearly details how their recreational, social, creative, physical and learning needs will be met;
b) ensure this is regularly reviewed to see if people's needs are being met and improved outcomes for people are being achieved
c) develop a general activity plan which people can be supported take part in if they choose to.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that, 'I can choose to have an active life and participate in a range of recreational, social. creative, physical and learning activities every day, both indoors and outdoors.' (HSCS 1.25)

This area for improvement was made on 2 May 2019.

Action taken since then
Please refer to the findings of the inspection noted in the main report.

Previous area for improvement 3

The provider should have a system in place to ensure the policies and procedures that support quality care and positive outcomes are followed.

This includes but is not exclusive to:
a) Infection control
b) Kitchen cleaning and Cooksafe house rules
c) Positive learning from complaints and feedback
d) Safe recruitment of staff.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that, 'I use a service and organisation that are well led and managed.' (HSCS 4.23)

This area for improvement was made on 2 May 2019.

Action taken since then
Please refer to the findings of the inspection noted in the main report.

Previous area for improvement 4

The provider should have system to ensure that as far as possible, people are provided with the right care they need at the right time and they experience positive outcomes. The system must be focused on improving outcomes for people and ensuring that where there are indications of poor care provision, prompt action is taken to address this.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that,' benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.' (HSCS 4.19)

This area for improvement was made on 2 May 2019.

Action taken since then
Please refer to the findings of the inspection noted in the main report.

Previous area for improvement 5

The provider and management should have appropriate arrangements in place to monitor and ensure staff are registered with the Scottish Social Services Council (SSSC) and are on the correct part of the register for the role they are employed for.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that, 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes.' (HSCS 3.14)

This area for improvement was made on 2 May 2019.

Action taken since then
Please refer to the findings of the inspection noted in the main report.

Previous area for improvement 6

The service should assess the environment, plan and implement improvements that will promote people's well being, enable people's independence and empower them to be in control of their life as much as they can be. The plan should have clear and reasonable timescales to enhance the environment for people who live at the home.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that, 'The premises have been adapted, equipped and furnished to meet my needs and wishes.' (HSCS 5.16)

This area for improvement was made on 2 May 2019.

Action taken since then
Please refer to the findings of the inspection noted in the main report.

Previous area for improvement 7

The service should develop more outcome focussed care plans with people and ensure that reviews are more evaluative to ensure people's care is right for them.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state that, 'My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected.' (HSCS 1.23)

This area for improvement was made on 2 May 2019.

Action taken since then
Please refer to the findings of the inspection noted in the main report.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	1 - Unsatisfactory
1.1 People experience compassion, dignity and respect	1 - Unsatisfactory
1.2 People get the most out of life	1 - Unsatisfactory
1.3 People's health benefits from their care and support	1 - Unsatisfactory

How good is our leadership?	1 - Unsatisfactory
2.2 Quality assurance and improvement is led well	1 - Unsatisfactory
2.3 Staff are led well	1 - Unsatisfactory

How good is our staff team?	1 - Unsatisfactory
3.1 Staff have been recruited well	1 - Unsatisfactory
3.2 Staff have the right knowledge, competence and development to care for and support people	1 - Unsatisfactory
3.3 Staffing levels and mix meet people's needs, with staff working well together	1 - Unsatisfactory

How good is our setting?	1 - Unsatisfactory
4.1 People experience high quality facilities	1 - Unsatisfactory

How well is our care and support planned?	1 - Unsatisfactory

5.1 Assessment and care planning reflects people's planning needs and wishes	1 - Unsatisfactory

To find out more

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অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

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