Castle View Nursing Home
Care Home Service

200 Castlegreen Street
Dumbarton
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Telephone: 01389 764 700

Type of inspection:
Unannounced

Completed on:
27 August 2020

Service provided by:
HC-One Limited

Service provider number:
SP2011011682

Service no:
CS2011300851

About the service

Castle View is a purpose-built two storey care home situated in a quiet residential area of Dumbarton.

The home is set within its own grounds with ample parking facilities to the front and spacious secure garden areas surrounding the home. It is close to local amenities and transport.

The service provides nursing care for a maximum of 60 people. This is for 10 people under the age of 65 with physical disabilities and 20 older people with physical frailty on the ground floor. The first floor is a memory care unit for 30 older people living with dementia. The service has one respite bed in their memory care unit dedicated to short stay respite.

There are lounges, dining rooms and adapted bathrooms and showers on each floor as well as two cafe areas. All bedrooms have en suite facilities.

At the time of the inspection, there were 38 people living in the home.

The aim of the provider, HC-One Limited, is to 'have the kindest homes in the UK with the kindest and most professional staff, we are a company founded on the principles of involvement, accountability and partnership'.

This was a focused inspection to evaluate how well people were being supported during the COVID-19 pandemic. We evaluated the service based on key areas that are vital to the support and wellbeing of people experiencing care during the pandemic.

This inspection was carried out by inspectors from the Care Inspectorate and an inspector from Healthcare Improvement Scotland.

What people told us

During this visit, we spent time in both units. We saw residents moving freely within the home, with support from staff, to access an enclosed garden area.

We spoke to some people living in Castle View and observed friendly, individual and group exchanges. Interactions were limited to ensure we observed social distancing.

We saw staff responding to the needs of individuals. When time allowed staff were seen to engage with residents who responded well to staff and appeared relaxed in their company.

Relatives had been unable to access normal visiting arrangements due to COVID-19 restrictions. An exception to this was end-of-life care. Staff were supporting people, where possible, to see relatives with window and garden visits.

The service had access to technology in all areas.

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 good is our care and support during the COVID-19 pandemic?	4 - Good

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

How good is our care and support during the COVID-19 pandemic? 4 - Good

7.1 People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.

There was a supply of alcohol-based hand rub (ABHR) at the entrance to the home. On arrival, essential visitors completed a questionnaire and temperatures were routinely checked and recorded. This was important to provide an early detection of potential COVID-19 symptoms.

Masks were routinely supplied to visitors with ample waste bins for the safe disposal of personal protective equipment (PPE).

We saw warm interactions between the residents and staff with people being supported to maintain their privacy and dignity. Given the restrictions around family visiting during the COVID-19 pandemic, this helped to keep people connected. People we observed appeared contented and happy with their care and support.

Care plans we read took account of people's wishes, including end-of-life care. Decisions about care and treatment were informed by a range of up to date assessment tools. The service told us they had regular supportive visits from the GP. Technology supported access to a range of other health professionals.

The daily clinical overview meeting included for example, infection control, pressure wounds, falls, nutrition, hospital admissions, the use of bed rails and medications. It was clear how assessments and audits informed actions and supported practice. This approach helped to ensure responsive care and support for people. We were encouraged to see improvements in the management of clinical care, accountability and professional governance.

To help keep people safe, risk assessments were in place. Those we read were regularly reviewed. Staff were committed to supporting people to make choices and take informed personal risks.

There were no issues reported with access to, or the supply of medications during the COVID-19 pandemic.

Overall, social distancing was well-managed. We observed some people remained in their rooms and others chose to spend time in communal areas. The service had introduced two sittings for the main mealtimes. This helped to ensure people accessed the correct level of nutritional support. Staff recognised this was an important opportunity for people to experience some companionship.

Additional drinks and snacks boxes were available over a 24-hour period. The opportunity to access food and drinks between meals was important due to the risk of a reduction in residents' weight during the COVID-19 pandemic.

We noted residents' weights continued to be reviewed regularly. There was a clear protocol for the introduction and management of food and fluid charts. These were appropriately detailed to offer an accurate account of an individual's intake and reviewed for compliance. Ongoing actions and referrals were based on good practice guidance.

Residents living in Castle View enjoyed access to activity staff for one to one and small group support. Care staff told us they would also arrange meaningful activities on a spontaneous basis. There were indoor and outdoor areas including themed cafes and a large screen cinema to help support meaningful occupation.

There was a recent failure to submit an important notification to the Care Inspectorate, although we were satisfied this was an isolated instance. We highlighted the importance of potential adult support and protection notifications and shared good practice guidance. This has been included as an area for improvement to be followed up at the next inspection. (See area for improvement 1.)

7.2 Infection prevention and control practices support a safe environment for both people experiencing care and staff.

Items of furniture and equipment were generally satisfactory and of a good quality. Housekeeping and care staff described increases to normal cleaning routines and infection prevention audits were undertaken. This helped to maintain a satisfactory standard of cleanliness during the pandemic. We saw appropriate products were used for cleaning and sanitising.

There were clear signs reminding staff of the recommended techniques for hand washing. Staff we spoke to were familiar with the correct guidance for putting on and taking off PPE. Both management and staff showed a good understanding of infection control practices and social distancing. The service had appointed two infection control leads. We did ask the service to introduce additional signage to support respiratory hygiene for residents and staff.

We observed PPE was mainly disposed of into clinical waste streams. The service ensured waste bins had lids and a non-touch or pedal bin foot operation. The number of visible waste bins meant it was easier for visitors and staff to dispose of used PPE at the point of care.

Colour coded laundry trolleys were available in all areas with a laundry chute on the first floor. This helped staff follow guidance on the segregation and safe management of linen. Staff we spoke to were able to describe the correct process for laundering their uniforms. Separate changing facilities were available for staff and they kept personal belongings in lockers.

There were effective systems to help manage legionella testing, building maintenance and repairs. Work was underway to renew fire doors along with a programme of redecoration. These reflected actions in the home's improvement plan.

The service was now COVID-19 free. Infection control audits had been maintained to ensure staff were confident, competent, and remained aware of ongoing risks. The approach to overall quality assurance was enhanced with regular staff competency observations. This provided information around the overall cleanliness and infection control.

Overall, the storage of supplies and PPE was well-managed. We reminded the service to ensure all staff remained aware of the cleaning regime for shared equipment to reduce the risks of contact transmission. One mattress had signs of damage and this was removed from use. Some less frequently used areas such as the stairwells, the underside of some tables and the male staff room needed some additional attention to detail.

7.3 Staffing arrangements are responsive to the changing needs of people experiencing care.

We reviewed rotas and saw the service had ample staff working to meet people's preferences and needs. Staffing arrangements were good and could be adjusted to meet people's changing needs. The service was regularly using a staffing dependency tool to inform staffing. This was important to reassure people enough staff were available for the wellbeing and safety of residents.

The service had developed a staffing contingency plan. There was some capacity to offer additional hours, if there was, for example, increased staff absences because of COVID-19. We saw a commitment to support an approach of 'core staffing' in each unit. This helped to develop relationship-based care to support better outcomes for people and reduce the risk of transmission in the event of a further outbreak.

Staff were knowledgeable about COVID-19 symptoms and demonstrated good practice in the use of PPE and hand hygiene. Training for infection control had been recently repeated. We saw over 91% of staff were currently compliant with infection control training.

Management continued to review the effectiveness of infection control training and COVID-19 guidance in practice with regular staff competency observations. This was to ensure infection control training and knowledge was consolidated and embedded into practice.

We saw staff engaged positively with residents. Activity and care staff were available to create opportunities for meaningful occupation in unusual circumstances. Staff recognised the risks of increased loneliness due to isolation during the COVID-19 pandemic. We were encouraged to see the service was continually reviewing their approach to engagement.

The service was part of a larger care group. We saw some areas where variations in the interpretation of guidance was not always helpful. This included, for example, questions around the use of full PPE during the dining experience, cleaning products and waste management. We discussed these areas with Healthcare Improvement Scotland colleagues to provide further direction and clarity to the service.

We were pleased to see the service had already appointed two staff to lead ongoing infection control training. This was to help provide structure and evaluate the impact of overall infection control.

Keyworker roles were more visible and helped staff understand the needs and preferences of individual residents. Nursing assistants undertaking extended tasks were now registered as supervisors and had completed additional training. Overall, staff told us they felt well supported and had opportunities to discuss any concerns.

A previous area for improvement included the introduction of a programme of supervision for staff. Management advised this had not been fully implemented. We have included this as an area for improvement. (See area for improvement 2.)

Areas for improvement

1. The service should ensure people continue to be protected from harm, neglect and abuse. This must include ongoing Adult Support and Protection training for all staff. Putting in place a system for the oversight of any accidents/incidents and appropriate actions to reduce risk, including timeous referral to external bodies such as the Care Inspectorate and the Health and Social Care Partnership.

This is in order to ensure care and support is consistent with the Health and Social Care Standards which state:

'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities.' (HSCS 3.20)

'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 of harm.' (HSCS 3.21)

'I am listened to and taken seriously if I have a concern about the protection and safety of myself or others, with appropriate assessments and referrals made.' (HSCS 3.22)

2. Staff should have access to regular supervision and appraisal. Examples of actions required to progress this area should include;

(a) combining observations of staff competency, supervision and appraisal into the new 'supervision and appraisal' process,
(b) developing supervision further to afford people using the service the opportunity to share their opinion about the support they receive. from staff.

This is to ensure care and support is consistent with the Health and Social Care Standards which state:

'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)

Detailed evaluations

How good is our care and support during the COVID-19 pandemic?	4 - Good
7.1 People's health and well being are supported and safeguarded during the COVID-19 pandemic	4 - Good
7.2 Infection control practices support a safe environment for people experiencing care and staff	4 - Good
7.3 Staffing arrangements are responsive to the changing needs of people experiencing care	4 - Good

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