Holy Rosary Care Home
Care Home Service

Holy Rosary Residence
44 Union Street
Greenock
PA16 8DP

Telephone: 01475 722 465

Type of inspection:
Unannounced

Completed on:
21 September 2022

Service provided by:
Little Sisters of the Poor Greenock a Scottish Charitable Incorporated Organisation

Service provider number:
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CS2017362463

About the service

Holy Rosary Care Home is a service for older people situated in a residential area of Greenock. The care home is close to transport links, shops and community services. The service provides nursing and residential care for up to 28 people.

The service provides accommodation on an upper floor in single bedrooms, all with ensuite facilities. There are smaller lounges and dining areas available for residents. Downstairs there is a large dining room, library, tearoom, computer room, shop, physiotherapy room and a chapel. These facilities are shared with the people who live in the flats attached to the care home. There is a large well-tended garden and outside space, but it is not fully secure.

About the inspection

This was an unannounced inspection which took place on 15 September 2022 and 21 September 2022 between 07.00 and 18:30. The inspection was carried out by four inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:
- Spoke with 14 people using the service
- Spoke with 13 families and friends and gathered feedback by email from six others
- Spoke with staff and management
- Observed practice and daily life
- Reviewed documents
- Spoke with visiting professionals.

Key messages

- Staff knew people well and provided care and support in a kind, respectful way.
- Leaders in the service did not work well together and communication was poor.
- Medication was well managed, but some improvement needed for homely remedies and as required medications.
- Nutrition management requires improvement.
- Infection prevention and control practices must improve as puts people at risk.
- Quality assurance systems were not effective.
- Recruitment practices need to improve to ensure staff are recruited safely.
- Lounge areas and other areas in the home are not used to their full potential.
- Residents' personal plans and daily recording were poor and must be improved.
- Staff training was up to date, but staff would benefit from formal supervision.
- Residents were connected with their family and friends through open visiting.

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?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	3 - Adequate
How good is our setting?	3 - Adequate
How well is our care and support planned?	2 - Weak

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

How well do we support people's wellbeing? 2 - Weak

1.3 People's health and wellbeing benefits from their care and support

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve. In addition to areas for improvement and requirements which have come from this inspection, we have restated an area for improvement which had arisen from a recent complaint.

Residents experienced compassionate care. We saw care staff working well in a warm, kind way. Staff knew residents well and their choices were respected. Residents told us how much they enjoyed living in the service. A resident said, 'I've lived here a long time, it's a lovely, comfortable house.'

Medications were well managed and residents were supported to take their medications at the right time. Protocols were in place for some 'as required' medications, however these were not detailed. These are important to support staff decision making when someone has a cognitive impairment. Homely remedy medications were available to support residents on a short term basis, however the recording needs improved, (see area for improvement 1).

Mealtimes are an important part of the day. We observed a mealtime experience which was well managed and meals looked appetising. For those who needed support at mealtimes, staff encouraged them to eat at a comfortable pace. Although choice was available, this was done the day before. It would be nice to see residents with a cognitive impairment benefiting from a visual choice at meal times to help them make knowledge based decisions. Fresh juice and water was available, but served by staff, people couldn't help themselves.

Residents who need a modified diet were not given a choice, as decisions were made by staff. Personal preferences were not considered and we found a lack of detail in documentation to highlight likes and dislikes. Staff were not confident in their knowledge about the different types of modified diets that had been advised by health professionals. Referrals to dieticians and speech therapists were not always evidenced. Nutrition care plans were inconsistent and contributed to the overall risk, (see requirement 1).

Nutritional risk assessments were not accurate and did not reflect potential risk of general deterioration. Food and fluid charts were completed inconsistently and at times significant gaps were noted in recording. Staff were unclear as to who should be having their intakes monitored. The service had a dedicated nutrition champion which was a positive experience. However all staff need to be skilled and trained in supporting nutritional needs. When additional calories to fortify meals was needed, this was not consistently done, (see requirement 1).

The service had recently started to introduce more meaningful activities. Resident's had the opportunity to be involved in a variety of things such as arts and crafts, reminiscence and musical items. The new activities co-ordinator had been encouraging some residents to come down to the ground floor activities room. Although this was positive for some, we highlighted the importance of ensuring meaningful activities are also available on the main care floor. This would ensure everyone's wellbeing could benefit from these (see area for improvement 2).

1.4 People experience meaningful contact that meets their outcomes, needs and wishes

Residents benefited from a range of meaningful contacts within and out with the home. We received good feedback overall from people who are visiting the home who told us they are supported to visit at any time. We saw a number of visitors in the home and people enjoying spending time together.

Scottish Government Open with Care guidance encourages services to identify up to three named visitors, who can continue to visit their relative in the event of restrictions due to an outbreak. Staff were unclear about who people's named visitors were and this information was not recorded in resident's personal plans. We could not see a clear plan in resident's personal plans to identify how they, as individuals wanted to be supported to stay connected to those important to them.

The service had good WiFi connection to enable people to use the internet. We could not see how staff supported residents to use technology. As the service has a new activities co-ordinator it would be good to see this develop further, with a clear plan in personal plans.

Residents rarely enjoyed sitting together throughout the home as tended to stay in their rooms. This may be linked to the way the service has not created a welcoming lounge space, (see area for improvement in 'How good is our setting?') It would be nice to see further opportunities for residents to develop friendships and maintain relationships. The service could also consider ways to develop how residents are supported to celebrate important events, such as birthdays or sending cards and letters. We could not see in personal plans how resident's were supported to keep in touch with people, or how they could be encouraged to celebrate important life events.

1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure

We evaluated this key question as weak. While some strengths could be identified, these were compromised by significant weaknesses. As these weaknesses concern the welfare of people, we have made a requirement for improvement.

The service was well presented and appeared clean and fresh. However, staff were unclear about what cleaning products they should use and were not always preparing the chlorine solution correctly. Staff were not confident in their knowledge of the Standard Infection Control Precautions as detailed in the Care Home National Infection Prevention Control Manual (NIPCM). Cleaning schedules and tasks were not in line with this guidance. As staff were not cleaning in line with the guidance, this meant it would be difficult to 'step up' their cleaning measures during an outbreak. There was a lack of consistency amongst staff and no clear leadership to ensure staff were working together to an expected standard. The company infection prevention and control policy did not support staff practice in this area, (see requirement 2).

Laundry management was not in line with ARHAI Scotland guidance 'Safe Management of Linen: Standard Infection Prevention & Control and Transmission Based Infection Control Precautions.' Staff were unaware of what guidance to follow which meant people were put at risk of infection. Laundry was not transported or sorted safely which meant the risk of cross contamination was high. We were concerned that staff were unclear about the correct thermal temperatures for washing linen. This meant we could not be assured linen was free from potential infection (see requirement 2).

We observed good practice around hand washing by staff, and the service had recently commenced observation of practice for this. Personal protective equipment (PPE) was readily available and easily accessed by staff, however PPE was not being disposed of into clinical waste bins, (see requirement 2).

We did not have confidence the service was 'outbreak ready' should they experience a further outbreak of an infectious disease, such as Covid-19. There was no staff contingency plan to support staff in the event of an emergency. Leaders were not confident in communicating what steps needed to be in place, (see requirement 2).

We discussed the effectiveness of audits as they had not picked up key areas for improvement. We emphasised the need for staff to be given clear guidance to allow them to develop confidence in the leadership of the service. Quality assurance systems should support improvement and provide a robust structure to drive change, (see requirement in, how good is our leadership?).

Requirements

1. By 20 November 2022, the provider must ensure that food and fluid provision and nutrition management within the home meets the needs of residents.

To do this, the provider must, at a minimum ensure:

1. Staff have access to 'Eating and drinking well in care: good practice guidance for older people' (Care Inspectorate, 2018) and have a demonstrable understanding of menu planning to meet the needs of all people using the service, including those on modified diets.
2. The menu is planned in advance, taking into account the provision of special diets, in particular, high calorie diets and modified food textured diets, diabetic, to ensure residents receive a balanced and nutritious diet which is appropriate to their individual needs.
3. Residents must have choice and should be properly consulted at the menu development stage and on an ongoing basis.
4. Residents food preferences are established at admission and on an ongoing basis in sufficient detailed to allow staff to, help residents eat healthily, identify the best food to offer residents when they are unwell, choose foods residents like, if they need to increase the number of calories and plan menus.
5. Residents have easy access to drinks and snacks throughout the day.
6. Food and fluids are accurately recoded and staff have a clear understanding of who is to be monitored.
7. Residents nutrition risk is monitored accurately using the Malnutrition Universal Screening Tool (MUST). Weights are recorded and any actions are reflected within personal plans.
8. Referrals to dieticians and speech therapists are recorded and advice is clearly evidenced through personal plans.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I can choose suitably presented and healthy meals and snacks, including fresh fruit and vegetables, and participate in menu planning' (HSCS 1.33). 'My meals and snacks meet my cultural and dietary needs, beliefs and preferences' (HSCS 1.37).

2. By 20 November 2022, the provider must ensure infection, prevention and control procedures support staff in their practice to reduce the transmission of infections, including Covid-19.

To do this, the provider must, at a minimum ensure:

1. Staff are supported to access and understand the principles set out in the Care Home National Infection Prevention Control Manual (NIPCM).
2. All linen is handled, sorted and washed in line with ARHAI Scotland guidance 'Safe Management of Linen: Standard Infection Prevention & Control and Transmission Based Infection Control Precautions' (September 2020).
3. Clinical waste, including PPE is disposed of in a manner that prevents cross contamination i.e. with a foot operated bin with lid.
4. Clear procedures are in place for housekeeping staff showing what constitutes a daily, weekly and deep clean. This includes how cleaning is carried out and what chemicals to be used is in line with guidance in (1). All sanitary wear to be cleaned with 1000ppm chlorine in line with said guidance.
5. Cleaning schedules are sufficiently detailed to evidence cleaning.
6. Chlorine solution is made up in line with manufacturers guidance to ensure 1000ppm.
7. The infection prevention and control policy is updated to reflect relevant guidance noted in (2) and (3).
8. A staff contingency plan is in place.

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

This is 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).

Areas for improvement

1. To support people's wellbeing the manager should ensure as required medication is given appropriately and is effective. This should include, but not limited to, staff to record the outcome of all as required medications given and develop a detailed protocol for all as required medications prescribed. Homely remedy use should also be recorded and records maintained.

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

2. To ensure people experiencing care can enjoy stimulating and meaningful engagement opportunities, the provider should ensure a programme of activity is developed and delivered, which meets with people's needs, preferences and abilities. A record of all activity attended should also be maintained.

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which states 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).

How good is our leadership? 2 - Weak

2.2 Quality assurance and improvement is led well

We made an evaluation of weak for this key question. Whilst some strengths could be identified they were compromised by significant weaknesses. The service had one area for improvement from a recent complaint, however due to our concerns about the leadership of the service we have incorporated this into a requirement for improvement.

Leaders in the service did not demonstrate a clear understanding about what was working well and what improvements were needed. There was a lack of communication between leaders and at times conflict amongst them. There was a lack of clarity about leaders roles and responsibilities between the care and spiritual departments. This meant staff were unclear of who to go to for support and important areas were missed. The service delivery was very disjointed and throughout the inspection we were unable to decipher who was responsible for what areas. Leaders were not working well working together, there were no management meetings, or opportunities for clear, open discussions about the day to day running of the service, (see requirement 2).

Quality assurance should ensure standards of good practice are adhered to and drive change and improvement where necessary. There was no effective quality assurance system in place. A few audits had been completed, however these lacked detail and it was unclear how the audits reflected best practice. There was no clear plan in place to guide when audits should take place. Audits were not reliable and highlighted missed opportunities to effectively and accurately identify issues. Action plans were not always in place and had been ineffective. Audits had been completed on some residents' personal plans, however actions had not been followed up. There was also no service improvement plan in place, (see requirement 1).

The leadership team had limited oversight in some areas and at times failed to communicate important changes to each other. Leaders were not proactive at ensuring quality care was in place. This had created difficulties in the team and meant staff did not have the knowledge of best practice to support change. An example was in the infection prevention and control audit which had been completed. Staff undertaking any audit should know the benchmark to assess the practice against. While a number of policies and procedures were in place to support staff, some had not been updated to reflect current practice used in Scotland.

There was a lack of analysis of accidents and incidents which meant there was limited efforts to learn from these. The service collated records of falls, however there were significant gaps and delays in updating residents records to ensure all staff knew what measures were in place to support people. We were concerned about the lack of clinical oversight of health outcomes, which could include monthly audits and analysis of areas such as; nutrition, pressure care and wounds. Poor communication amongst the leadership team and lack of recording had meant certain staff were not always aware of important information shared by external professionals in a timely manner.

Requirements

1.
By 8 January 2023, the provider must ensure that effective quality assurance systems are in place that are underpinned by a culture of continuous improvement. A service improvement plan must support the development of the service which is informed by outcomes from audits, feedback from stakeholders and other quality assurance activities which are linked to best practice.

This is to comply with Regulation 3 (Principles) and 4 (1) (a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

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

2. By 8 January 2023, the provider must ensure that people experience a service which is well led and managed. Roles and responsibilities for care and spiritual leaders in the service are clearly established. The culture ensures the service is delivered by leaders who are responsive and demonstrate open, proactive communication.

This is to comply with Regulation 3 (Principles) and 4 (1) (a) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My care and support is consistent and stable because people work together well' (HSCS 3.19).

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate. While strengths had a positive impact, key areas need more work to ensure staff have the right knowledge, competence and development opportunities to care for and support people.

Staff were warm and compassionate when interacting with residents. Positive relationships were evident and staff knew residents well. We received positive comments about staff from both residents and relatives.

The families and representatives of residents told us that they were confident in the staff and they were satisfied that they were appropriately trained and skilled. This was important to people who said it offered them reassurance that their relative was well cared for. We found that staff were mostly up to date with the mandatory/core training however records showed that in some areas it was overdue. It is important that training is kept up to date to ensure the competence and confidence of staff while supporting their ongoing professional development.

Records showed that staff were either registered or in the process of registering with the relevant professional bodies of the Nursing Midwifery Council or the Scottish Social Services Council. This is important as registration ensures that staff work to a recognised code which sets out standards and expectations in their practice.

In discussion with staff, it was clear that formal supervision had not taken place for some time. They felt they could speak with peers and managers if they had any concerns, however they did not receive regular, formal supervision to discuss personal development and training needs, (see area for improvement 1).

We sampled recruitment files for newer staff members. There were expected records in place such as application forms, identification checks, interview questionnaires and offer letters. However we did not find that the current recruitment process and records followed best practice guidance Safer Recruitment through Better Recruitment. We noted some references had not been sought from the candidates most recent employer and references could not be verified as had come from personal email addresses. Immediate action was taken to address this during the inspection. We were advised that members of the senior care team would not always be involved in the recruitment of care staff. It is important that members of the senior care team interview possible candidates so they have the opportunity to assess their suitability to care for older adults and assess their compatibility and skills they can bring to the whole care team. This

practice does not ensure that all staff have been recruited, interviewed and vetted following good practice, (see requirement 1).

Requirements

1. By 20 November 2022, the provider must ensure that staff have the necessary recruitment checks completed prior to their start date.

To demonstrate this, the provider must:

1. Review the policy and procedure for recruiting staff safely, referenced to the best practice guidance Safer Recruitment through Better Recruitment from the Scottish Social Services Council (SSSC) and Care Inspectorate.
2. Adhere to best practice regarding the safe recruitment of staff.
3. Obtain appropriate references prior to recruitment at all times, and include most recent employer if indicated.
4. Ensure that all assessment paperwork for a potential candidate, such as interview questionnaires, are completed fully and signed.
5. Ensure that the registered manager has oversight of all staff recruitment procedures prior to employment.

This is to comply with Regulation 9(2)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

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

Areas for improvement

1. The service should develop a clear plan to ensure all staff have the opportunity to have formal supervision. This should give staff the opportunity to discuss their practice with a supervisor or manager responsible for their department. Any training needs should be identified through discussion and reflection.

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) 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).

How good is our setting? 3 - Adequate

4.2: The setting promotes people's independence

We evaluated this key question as adequate. While strengths had a positive impact, key areas need to improve to ensure residents benefit from the environment. We have also incorporated an area for improvement from a recent complaint into a new area for improvement.

The home was clean and comfortable. Residents' rooms were personalised to their taste and residents told us they were happy and comfortable in their rooms. All bedrooms had ensuite facilities which promoted

dignity and independence. There were two dining/living areas on the residential floor that could be accessed. It was positive to see residents had the opportunity to chose to have their main meals in the dining room situated on the ground floor.

Residents could choose to spend time in their rooms however if they chose to socialise with others there was no welcoming lounge area that was being used on a regular basis. The Heather Centre was being used as a seating area, but there was little privacy and the area could get busy, as it was a thoroughfare to other parts of the home. Despite having a number of facilities throughout the home such as lounges, tea room, shops, computer and activities room, the environment was not being fully used for the benefit of residents. There are a number of areas that were not being maximised, particularly downstairs, (see area for improvement 1).

The service had completed the Kings Fund environmental audit, 'Is your care home dementia friendly?' Key areas had been identified for improvement such as ensuring suitable signage was more prominent to support orientation. An action plan was still to be developed to support the service in their improvements, (see area for improvement 2).

Attractive garden areas are provided around the service, however the outdoor space is not secure. This meant residents were not able to walk freely in safety. Seated areas were also available which were used be residents and their families. This gave people the opportunity to benefit from the fresh air in an area that was well-kept and welcoming. Residents also benefited from being able to visit the chapel area. This could also be accessed from a balcony on the care floor for those who needed more support. Although some feedback was that staff did not encourage this consistently.

The building maintenance was kept to a high standard, safety checks were in place as expected and were well managed. An area which was not included in the safety checks was the maintenance of bed rails. Although these were serviced annually, regular checks were not routinely in place. The service should develop a rolling programme to ensure that bedrail checks are in place, (see area for improvement 3).

Areas for improvement

1. The service should develop the whole setting for the benefit if residents. A central, comfortable lounge should be established. The areas downstairs should be used to enhance the lives of residents in a more natural way.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells' (HSCS 5.18).

2. The service should develop a plan of action from the Kings Fund environmental audit, 'Is your care home dementia friendly?' with suitable timescales.

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

3. The service should develop a rolling programme to ensure that bedrail checks are in place.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am able to access a range of good quality equipment and furnishings to meet my needs, wishes and choices '(HSCS 5.21).

How well is our care and support planned? 2 - Weak

5.1 Assessment and personal planning reflects people's outcomes and wishes

We evaluated this key question as weak, as while some strengths could be identified, these were compromised by significant weaknesses. As these concerned the welfare and safety of people, we have made a requirement for improvement. We have also restated an area for improvement that had been made following a recent complaint. The service will need more time to clarify families expectations around communication, (see area for improvement 1).

The standard of care and support planning was inconsistent and not supported by strong leadership, staff competence and quality assurance processes. Although staff knew residents well, care and support was provided from head knowledge, rather than informed by a plan of care. Every resident should have a personal plan which clearly sets out and details their current care and support needs. This will guide staff on how best to manage those needs, but also ensure consistent care is provided in a way that respects their personal choices, preferences and wishes. Personal plans we sampled on the electronic iCare system lacked detail, had significant gaps and in some cases were not in place, (see requirement 1).

Risk assessments were not reflective of current needs and for those in place, they did not inform personal plans. This meant we could not be assured care and support was based on best practice. There was a lack of consistency in using the iCare system, while some staff lacked confidence and knowledge in using the system. This meant it was difficult to track and ascertain what support people needed, or who had been involved in certain decisions about resident's care. This included falls management, nutrition, pressure care and palliative care. Personal plans do not reflect up to date good practice guidance. Due to the significant gaps and inaccuracies this meant we could not be confident in the assessment of residents care or involvement of other external professionals which put people at risk, (see requirement 1).

We highlighted particular concern around people's end of life care planning. People should have an anticipatory care plan (ACP) in place that reflects their wishes and where appropriate, those of their representatives. Although we received positive feedback from families about the support staff were providing, there should be a clear record so all staff are familiar with people's preferences for palliative and end of life care, (see requirement 1).

Daily recording also lacked detail, information was basic and it was difficult to ascertain at times what care and support had been provided. There were significant gaps in recording. The iCare system was not always updated following certain tasks, which meant some entries had been recorded late, or missed. Daily recording should be outcome focused and provide a clear narrative of how someone has spent their day, (see requirement 1).

Care reviews were not carried out in line with legislation. Reviews must be carried out every six-months, or if there is a significant change. Reviews were not completed consistently and there was no evidence how residents or those important to them had been included in the process. This meant they did not have the opportunity to ensure their care and support was in line with their current needs and wishes, (see requirement 1).

Requirements

1. By 20 November 2022, the provider must ensure that each person's personal plan and daily recording reflects their current individual care and support needs. Personal plans must reflect individual choices and wishes, consider people's views and provide a clear plan to meet outcomes.

This is to comply with Regulation 5 (1) and (2) (a) (b) (ii) and (iii) (Personal Plans) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change (HSCS 1.12). 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

Areas for improvement

1. To ensure families/representatives are kept informed about the care and wellbeing of their relative, the provider should clarify contact details, as well as the expectations around when, and in what circumstances, they would wish to be contacted.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS): 'If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account' (HSCS 2.12).

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

To ensure people's needs are met safely and well, clear leadership should be established on each shift, with staff tasks and responsibilities appropriately allocated.

This is to ensure care and support is consistent with Health and Social Care Standard 4.17: If I am supported and cared for by a team or more than one organisation, this is well co- ordinated so that I experience consistency and continuity.

This area for improvement was made on 20 May 2022.

Action taken since then

This area for improvement had been made following a complaint, however this area for improvement has now become a requirement, (see 'how good is our leadership?).

Previous area for improvement 2

To ensure people experiencing care can enjoy stimulating and meaningful engagement opportunities, the provider should ensure a programme of activity is developed and delivered, which meets with people's needs, preferences and abilities. A record of all activity attended should also be maintained.

This is to ensure care and support is consistent with Health and Social Care Standard 1.25: 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.

This area for improvement was made on 20 May 2022.

Action taken since then

This area for improvement had been made following a complaint. The service had recently employed a further activities worker who had begun to establish a programme of activity. As this is still at its early stages and further development is planned, we have restated this area for improvement, (see 'how well do we support people's wellbeing?).

Previous area for improvement 3

The provider should ensure, that all people experiencing care benefit from access to comfortable and inviting lounges.

This is to ensure care and support is consistent with Health and Social Care Standard 5.18: My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells.

This area for improvement was made on 20 May 2022.

Action taken since then

This area for improvement had been made following a complaint, however this area for improvement has been rewritten to reflect our findings during the inspection, (see 'how good is our setting?).

Previous area for improvement 4

To ensure families/representatives are kept informed about the care and wellbeing of their relative, the provider should clarify contact details, as well as the expectations around when, and in what circumstances, they would wish to be contacted.

This is to ensure care and support is consistent with Health and Social Care Standard 2.12: If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account.

This area for improvement was made on 20 May 2022.

Action taken since then

This area for improvement had been made following a complaint, however the service needs more time to develop this area. We have restated this area for improvement, (see how well is our care and support planned?).

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?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate
1.4 People experience meaningful contact that meets their outcomes, needs and wishes	3 - Adequate
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate

How good is our setting?	3 - Adequate
4.2 The setting promotes people's independence	3 - Adequate

How well is our care and support planned?	2 - Weak
5.1 Assessment and personal planning reflects people's outcomes and wishes	2 - Weak

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