Forth View Care Centre
Care Home Service

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Methil
Leven
KY8 3DE

Telephone: 01592 716 500

Type of inspection:
Unannounced

Completed on:
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Service provided by:
Balhousie Care Limited

Service provider number:
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Service no:
CS2011302958

About the service

Forth View Care Centre is a purpose-built care home registered to care for up to 45 older people, of which five may be for short breaks and respite and a maximum of 10 adults with physical and sensory impairment in Loch Head Unit.

The home is part of the Balhousie Care Group. The service is located in Methil and can be easily reached using local transport networks from nearby Leven and Kirkcaldy.

Accommodation is provided over two floors. The rooms consist of single en-suite bedrooms with wet room showers. Each floor has a number of seating areas and dining areas to allow residents to make choices about where to spend their time. Small kitchen areas in the lounges are accessible to residents, relatives and visitors to the service.

The garden to the rear of the building is secure and accessible from the dining room on the ground floor. The garden is equipped with a play area for the use of visiting children.

About the inspection

This was a full which took place between 22 and 25 August 2023. The inspection was carried out by three 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 four people using the service and seven of their relatives;
- spoke with 11 staff and management;
- observed practice and daily life;
- reviewed documents; and
- spoke with visiting professionals.

Key messages

- Staff supported people with warmth and compassion.
- Mealtimes were calm and unhurried. People received person-centred support with eating and drinking.
- Leadership and management of the home needed to improve.
- Staff had not completed the training required to meet the full range of people's needs.

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?	3 - Adequate

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

We made an evaluation of weak for this key question. Whilst some strengths could be identified, these were compromised by significant weaknesses. As these weaknesses concerned the welfare and safety of people, we made requirements for improvement.

We saw some examples of warm and compassionate relationships which evidenced values of respect and person-centred approaches. Staff knew people well and supported them in ways that respected their likes and choices. This included supporting people to express their individuality through dress and grooming. This supported people to maintain their sense of identity and self-esteem.

People told us the use of agency care staff had reduced significantly. People were able to build warm and trusting relationships with the staff supporting them. This improved people's outcomes and experiences.

We were concerned to find information about people's care and support needs was recorded on a board in a staff office which was accessed by people using the service. People saw this as an invasion of their privacy. We raised this issue with the provider who took immediate, appropriate action.

Staff were committed and, at times, went above and beyond the remit of their roles to help people get the most out of life. This included fundraising to provide social and leisure opportunities for people. A bar opened in the home recently with beer pumps and optics. This enabled people to spend time with family and friends in a relaxed, social setting. People told us they were pleased about the new facilities.

People were supported to enjoy activities in their local communities including "bingo buddies" and a dementia choir. This improved people's outcomes and experiences. A dedicated activities worker was recruited to support younger people living in the Lochhead unit. People were getting out more, including attending local music festivals and regularly accessing their local shops. This enabled people to reconnect with people from their local communities. Relatives told us this had a positive impact on people's mood.

Whilst social and leisure opportunities had increased, we identified areas for improvement. There was no activities coordinator in post to support the older people living in the home. People were not being supported to spend their time in ways that were meaningful and purposeful for them. This could have a detrimental impact on people's health, safety and wellbeing.

We were concerned that the staff culture in the Lochhead unit was institutional. People told us staff only did "shop runs" on set days of the week. This limited people's access to items they wanted or needed. People believed their needs would not be accommodated outwith the set times. This demonstrated a lack of choice and control for people. We discussed with the provider that people should be supported to purchase their own requirements as part of their care and support. We were concerned that people were subject to restraint and restrictive practice without the appropriate legal framework.

An activities board on the wall in the Lochhead unit had not been updated since June 2023. People needed support to make plans and have things to look forward to. This demonstrated a lack of understanding of the impact of enduring mental health problems on people's wellbeing. Despite the enthusiasm of staff, we were concerned they did not have the knowledge or skills required to meet people's needs. This was because they had not received the appropriate training or support.

Relatives told us they experienced ongoing, significant delays accessing the care home. This increased at weekends. Relatives said they often waited up to 20 minutes to get into the home. Telephones went unanswered for extended periods of time. This caused relatives frustration and concern when they could not contact staff (see area for improvement 1).

Good links were established with Fife Health and Social Care Partnership's care home liaison nursing team. Regular guidance and support was sought to ensure people's health, safety, and wellbeing. Staff knew people well and this meant they picked up changes in people's needs or health and wellbeing concerns quickly. Prompt responses by staff ensured people had access to all relevant health professionals as appropriate. However, we found improvements that had been made to people's health care and support were not sustained and we identified several areas that required improvement.

Care plans did not contain the information and guidance staff required to provide safe, consistent and effective care and support for people. Whilst care plans were regularly reviewed, there was no evidence of analysis or evaluation of the effectiveness of the care plan. We could not be confident that care plans reflected people's current needs.

We were not assured that risks to people's health, safety, and wellbeing were identified or mitigated. Care plans were not developed to ensure people received safe and consistent bowel care. People were at risk of constipation but a lack of appropriate oversight of records put them at risk of harm.

People living in the home experienced seizures. Care plans did not identify the types of seizures people experienced and all contained the same information, which related only to one type of seizure. There was a risk that some seizure activity could be missed. We noted issues identified in epilepsy care plans almost 12 months ago had not been followed up appropriately. Subsequently, people's health, safety and welfare were at risk.

People living with dementia experienced stress and distress. Care plans to inform staff's practice were not always in place or followed. For example, one person experienced stress and distress in response to hunger. This was clearly recorded in their care plan but was not followed. We were concerned that people received "as required" medication to reduce stress and distress because they were not supported appropriately.

Some people living in the Lochhead unit experienced severe and enduring mental health problems. However, their care plans did not contain the information and guidance staff required to provide effective, person-centred care and support. There was no guidance to enable staff to identify deteriorating mental health and this meant people's health, safety, and wellbeing were at risk. Staff lacked knowledge and understanding of the impact of poor mental health on people's motivation and volition and how to support people successfully.

People were not supported to maintain or increase their independence. People should be supported to shop and cook for themselves, do their own laundry and have opportunities to establish a valued, positive presence in their local communities. This would support people to maintain their self-esteem and sense of identity. People were not supported to take positive, life-enhancing risks and this led to a loss of skills and confidence (see requirement 1).

People's human rights were compromised when they could not make their own choices or decisions, even when they had the capacity to do so. People's access to food and drinks of their choice or vapes were limited. These practices were examples of restraint and restrictive practice that demonstrated a lack of knowledge or understanding of Adults with Incapacity legislation. We signposted the provider to the Mental Welfare Commission guidance "Rights, Risks and Limits to Freedom" for reference (see requirement 2).

Staffing levels were adequate to meet people's care and support needs across the home. However the allocation of staff duties and responsibilities was poorly organised. This meant opportunities to reduce risks such as falls, and provide consistent care were not maximised. This compromised people's outcomes and experiences.

Requirements

1. By 8 December 2023, the provider must protect the health, welfare and safety of those who use the service. In particular, they must ensure that all personal plans support people to maintain and increase skills, abilities and independence. This must include developing a positive risk taking culture. In order to achieve this, the provider must:

a) ensure people using the service and/or their representatives are involved in developing and reviewing their personal plans;
b) ensure people have access to a copy of their personal plan in a format that is accessible to them;
c) ensure personal plans reflect people's current assessed needs with priority given to mental health, stress and distress, epilepsy and bowel care;
d) identify, assess and mitigate risks to people;
e) ensure personal plans detail how people need and wish to be supported to meet their needs; and
f) evaluate personal plans on a regular basis to ensure they remain effective.

This is in order to comply with Regulation 3, 4 (1)(a),(b) and 5 (1), (2)(a),(b),(c),(d) 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 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).

2.
By 8 December 2023, the provider must protect the health, wellbeing, and rights of people using the service. In order to achieve this, the provider must ensure people are not subject to restraint or restrictive practices unless:

a) people's health and safety cannot be protected by any other means and restraint or restrictive practice is used as a last resort;
b) consent to use restraint or restrictive practices is given by welfare guardians or attorneys with appropriate legal powers;
c) a multi-disciplinary team approach determines when restraint and restrictive practice can be used;
d) restraint reduction plans are developed with progress reviewed regularly;
e) the need for and use of restraint and restrictive practice is reviewed on a regular basis; and
f) Mental Welfare Commission good practice guidance "Rights, Risks and Limits to Freedom is available to staff and fully complied with.

This is in order to comply with Regulations 3, 4(1)(a)(c), 15(b) of The Social Care and Social Work (Requirements for Care Services) Regulations 2011 (SSI 2011/210)

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

'If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively.' (HSCS 1.3).

Areas for improvement

1. People should be supported to maintain relationships with relatives, friends and others who are important to them. In order to maximise opportunities for contact, the provider should ensure people visiting or telephoning the home receive a prompt response and access to the home.

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

'I am supported to manage my relationships with my family, friends or partner in a way that suits my wellbeing.' (HSCS 2.18).

How good is our leadership? 2 - Weak

We made an evaluation of weak for this key question. Whilst some strengths could be identified, these were compromised by significant weaknesses. As these weaknesses concerned the welfare and safety people, we made a requirement for improvement.

The provider demonstrated creative and responsive approaches to recruitment in the home. The service benefited from the appointment of additional senior carers and new team leader posts were created. Where the need for an additional team leader post in the Lochhead unit was identified, budgets were approved to accommodate this. Two regional nurses were recruited to provide peripatetic support across the provider's homes. This would provide consistent support across the provider's homes from nurses who are familiar with the provider's practices, policies and procedures.

Staff told us members of the leadership team were supportive and they felt confident to discuss professional and personal issues. Staff said the leadership team were very visible across the home and always happy to provide support when required. Staff felt their views and ideas were heard and put into practice where appropriate.

Whilst staff provided positive feedback about their experiences of the leadership team, we had concerns about aspects of management and leadership practice.

The provider developed robust quality assurance processes to ensure the health, safety and wellbeing of people living in the home. However, these were not used effectively to improve people's outcomes, experiences or the service they received.

Management and leadership of the home was disorganised and we had concerns about some of the decision-making. The leadership team did not have oversight of the keys risks in the home and how, or if, these were mitigated.

A range of audits were carried out across the home including daily environmental walkarounds, IPC, maintenance and medication audits. These were carried out by several different staff. This practice reduced the risk of complacency. However, whilst areas for improvement were identified, there was little evidence these were addressed. Maintenance issues were recorded consistently for several months and a recent medication audit identified the potential loss of a significant quantity of medication. We identified inaccuracies in daily walkaround and IPC audit findings. Therefore, we could not be confident that the information in audits was reliable.

The management and oversight of medication needed to improve. Controlled medication was not checked consistently and staff's understanding and practice differed. During the inspection, we identified that a person living in the home had not received their night time medication as it was "out of stock". This issue had been raised at the daily "flash" meeting, but appropriate action was not taken to ensure the prescribed medication was available. We were further concerned to find that protocols to inform staff's practice in the administration of medication prescribed on an "as required" basis were not sufficiently detailed.

We raised concern about the issues we identified with the provider as these issues put people at risk of significant harm (see requirement 1).

Daily "flash" meetings took place between members of the leadership team and lead nursing, kitchen and housekeeping staff. This was to ensure appropriate arrangements were in place to ensure people's health, safety and wellbeing. The information recorded was sparse and very limited and did not identify, monitor or address new and emerging issues and risks in the home. We concluded that the meetings were ineffective in their current format.

People should expect services to demonstrate a culture of continuous improvement. The views of people using the service and/or their guardians or attorneys should drive service improvement. We found practice needed to improve. Quality assurance questionnaires had been distributed to people living in the home, relatives and staff. Very few were completed but where feedback had been provided, there was no evidence of analysis or action plans developed to drive improvements. People were not informed about how their feedback would be used to improve services.

Relatives' meetings took place on a quarterly basis. The meetings were poorly attended. The provider should investigate how attendance could be improved. Relatives told us they did not receive meeting minutes or action plans to address issues raised at meetings.

Relatives told us they did not have regular contact with members of the leadership team and said their only contact was with nurses or senior carers during visits or telephone calls. Relatives were not asked how the service could be improved.

We noted residents' meetings took place across the home. People living in the Lochhead unit raised issues at meetings in April, May and June 2023. There was no evidence their issues were addressed. This demonstrated a lack of respect for people's view, choices and rights. Several people living in the home no longer had legal capacity. We could not find evidence of people being supported to provide feedback or complete questionnaires. The provider should ensure that people receive support from relatives, welfare guardians or attorneys or independent advocates to express their views in ways that are meaningful for them.

We were concerned that people experienced poor outcomes and experiences because management and leadership of the home was inadequate and ineffective. The provider must take steps to reduce risks to people without delay.

Requirements

1. By 8 December 2023, the provider must ensure service users' health, safety and well-being needs are met. In order to achieve this, the provider must ensure that the service is led well and quality assurance for the service is responsive and carried out effectively. In order to achieve this, the provider must:

a) ensure effective leadership and management of the service ensures people's needs, rights, and wishes are met and respected;
b) ensure quality assurance and oversight of the service is responsive and effective. This must include audits to monitor and check the quality of service which are accurate, up-to-date and ensure that analysis and follow-up leads to any necessary action to achieve improvements or change without delay;
c) ensure senior leadership oversight and governance of the service on an interim basis until the provider can evidence effective local leadership and oversight.
c) ensure that people's views, suggestions and choices are gathered on a regular basis and that this information is used to improve people's outcomes and experiences; and
d) ensure a continuous improvement plan evidences that the care and support provided meets the assessed needs of service users and that they experience positive outcomes on an ongoing basis.

This is in order to comply with Regulations 3 and 4(1)(a) 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).

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve.

An organisation wide training needs analysis detailed the skills and knowledge staff required to ensure people received safe, consistent and effective care and support. However, training needs analysis should be service specific to ensure staff have the knowledge and skills required to meet the full range of people's needs.

Staff had access to a wide range of learning and development resources which were delivered online or in person. Professionals from Fife Health and Social Care Partnership provided in person training in areas including supporting people experiencing stress and distress, hand hygiene and donning and doffing PPE.

We were concerned that the gaps in staff's skills and knowledge were not identified or addressed. Staff had not undertaken training in key areas including care planning, epilepsy, diabetes, supporting people who experience severe and enduring mental health problems and restraint and restrictive practice. This put the health, safety, and wellbeing of people at risk and compromised their outcomes and experiences.

The provider previously developed and implemented bespoke training for staff and systems were in place to assess staff's understanding and competency. We were disappointed to find this was not sustained. Staff were enthusiastic and keen to continue to learn and develop. We noted 90% of online mandatory training and and 83% of role specific training had been completed. However, we could not be confident that staff had the skills, knowledge and understanding required to ensure people's health, safety and wellbeing because staff's ability to transfer learning from training into practice was not effectively evaluated (see requirement 1).

Staff told us they received regular supervision with their line manager. Staff valued the opportunity to have protected time with their line manager to discuss practice issues and identify their learning and development needs. Staff annual appraisals were not carried out in accordance with the provider's policy. Feedback about performance is important to recognise strengths and good practice and identify areas for improvement.

Requirements

1. By 8 December 2023, in order that people experience good outcomes, the provider must ensure staff have the knowledge, skills and understanding to meet the needs of people using the service. Priority must be given to mental health, restraint and restrictive practice, stress and distress and epilepsy. In order to achieve this, the provider must:

a) carry out staff training needs analysis on regular basis;
b) ensure the content of training is person-centred to the needs of people using the service;
c) develop and implement systems to ensure learning is transferred into practice; and
d) ensure staff's knowledge, skills and understanding remains current and meets best practice standards.

This is in order to comply with Regulation 15 (b)(i) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210)

This is to ensure care and support is consistent with the 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

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve.

There were opportunities for people living in the Lochhead unit to maintain and increase their independence. This included kitchen and laundry facilities. However, people were not being supported to make use of these facilities.

The unit had recently undergone refurbishment and new furniture and fixtures were expected to arrive imminently. People moving into the unit would have the opportunity to enjoy a fresh, modern and comfortable environment. We were pleased to hear the large room that was previously used as a dining room would remain a multi-purpose communal area for people living in the home and their relatives. This will provide access to the garden for people across the home.

Garden areas around the home had improved. Volunteers from a local community group maintained the gardens and provided opportunities for people who were interested in gardening to get involved. People should be able to access outdoor space independently. The provider should ensure paths and walkways are maintained to enable people to do so safely.

The environment should promote people's independence. However, the door to the Lochhead unit was locked and people living in the unit could not enter or exit independently. People should not be subject to restraint without the appropriate legal framework in place. The provider must address this issue without further delay.

The kitchen in the Lochhead unit was fitted with standard units and appliances. People living in the unit who used wheelchairs were unable participate in cooking or food preparation. We discussed this issue with the provider who took action to investigate solutions to improve access and independence.

We noted the first floor balcony had been refurbished and was decorated with hanging baskets. This was the only direct access to outdoor space for people living on the upper floor of the home. However, people could not currently access the balcony as risks had not been assessed or mitigated. The provider assured us this would be resolved promptly.

Dementia friendly environments are crucial to maximise outcomes and experiences for people living with dementia. We noted areas that should be improved to support the maintenance of continence and reduce stress and distress including wayfinding, lighting and use of colour and contrast. We referred the provider to the Kings Fund's Enhancing the Healing Environment (EHE) self-audit tool https://www.kingsfund.org.uk/sites/default/files/field/field_pdf/is-your-care-home-dementia-friendly-ehe-tool-kingsfund-mar13.pdf.

On day one of the inspection, we found the kitchen in the Lochhead unit was unclean and the fridge/freezer was faulty. The garden area was strewn with cigarette ends. This put people's health, safety and wellbeing at risk. We raised these concerns with the provider who took immediate action to address the issues. The provider should ensure the improvements are sustained.

How well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate. While the strengths had a positive impact, key areas need to improve.

The provider used an online care planning system. Care plans were comprehensive, covering the range of people's needs. Staff were provided with hand held devices through which they could access care plans. This enabled staff to record the care and support they provided for people on an ongoing basis and reduced the risk of information being forgotten.

The standard of people's care plans was inconsistent. Some care plans reflected people's needs, likes, wishes and choices and how people liked to be supported. Generally, care plans were person-centred and presented a positive "picture" of people. The provider had previously invested time and resources in improving care plans and some of the improvements remained. However, we were concerned that the standard of care plans was deteriorating.

People or their representatives, on their behalf, should be involved in developing and reviewing their care plan. There was no evidence that this took place. Where welfare guardians or attorneys had been appointed to make decisions on behalf of people living in the home, they said they were not consulted about care plans. People did not have access to their care plans. This meant people's right to make their own decisions and choices about their care and support were not respected.

Care plans focused on people's health care needs needs with little reference to people's social, emotional and psychological needs. This demonstrated a lack of understanding of the importance of meaningful and purposeful engagement in maintaining health and wellbeing. Appropriate care plans should be developed to support people to maintain their sense of identity, self esteem and motivation.

Risk assessments were in a tick box, generic format and did not evidence measures taken to mitigate risks. Key risks were not identified including relapsing mental health and delirium, which is a medical emergency.

Language used in plans did not consistently evidence a culture of respect and demonstrated an institutional culture. For example, people were described as "complying with medication".
We saw language used in care plans that was accusatory, inaccurate and confidential. People's right to privacy, respect and dignity were compromised (see area for improvement 1).

Please see the "How well do we support people's wellbeing" section of this report for further details of our evaluations. We have also made a requirement.

Areas for improvement

1. In order to improve people's outcomes and experiences, the provider should review and where necessary, amend personal plans to ensure information is person-centred, accurate and recognises and promotes people's dignity and rights to privacy and confidentiality. Personal plans should be reviewed regularly as part of quality assurance processes.

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

'I experience care and support where all people are respected and valued.' (HSCS 4.3).

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

Requirements

Requirement 1

The provider must, by 24 April 2023, ensure that people using the younger person's service experience improved outcomes by spending their time in ways that are meaningful and purposeful for them. In order to achieve this, the provider must:

a) develop, implement and regularly review care plans to support people maintain and increase their skills, abilities and independence; and
b) ensure there are sufficient staff to meet the physical, emotional, leisure and social support needs of people using the service and to ensure people can access outside space, activities and interests when they want to.

This is in order to comply with Regulation 15(a) - (Staffing) 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 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 requirement was made on 20 February 2023.

Action taken on previous requirement
This requirement was not met. We have have amended and reworded this requirement. Please see the "How well do we support people's wellbeing" section of this report.

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

In order to ensure the health, safety, and wellbeing of people using the service, staff and managers should undertake training in effective communication and record-keeping. The provider should use existing systems or develop new systems to assess the staff's competency.

This is to ensure that care and support is consistent with the 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).

This area for improvement was made on 20 February 2023.

Action taken since then

This area for improvement was not met. A requirement has been made. Please see the "How good is our leadership" section of this 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?	2 - Weak
1.1 People experience compassion, dignity and respect	3 - Adequate
1.2 People get the most out of life	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	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?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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