Newark Care Home
Care Home Service

Southfield Avenue
Port Glasgow
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Type of inspection:
Unannounced

Completed on:
7 October 2025

Service provided by:
SCCL Operations Limited

Service provider number:
SP2014012299

Service no:
CS2014326119

About the service

Newark Care Home is registered to provide care to 61 older people. The service provider is SCCL Operations Limited.

The home is located in Port Glasgow and is within close proximity to local shops and public transport. The accommodation is a purpose built, modern style two-storey building. All of the bedrooms are single occupancy and have ensuite facilities which include a toilet and shower. The home is split into four units named Gleddoch, Finlaystone, Birkmyre and Lithgow. Each unit has its own living room, dining room, bathing facilities and quiet lounge area. There is access to an enclosed garden area directly from the ground floor and the upper floor is accessed by a lift. Parking is available on site.

There were 56 people living in the service at the time of inspection.

About the inspection

This was an unannounced inspection which took place between 29 September 2025 and 3 October 2025, between the hours of 07:30 and 21:00. The inspection was carried out by three inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about the service. This included previous inspection findings, registration information, complaints, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we reviewed documents and observed practice and daily life. We also spoke with:

Thirteen people and two of their families/friends
Sixteen staff and management
One visiting professional.

We also took into account feedback from Care Inspectorate surveys from 15 staff and three visiting professionals.

Key messages

- Interactions with staff and people were warm and friendly, but limited by staff arrangements which did not meet people's needs.
- Medication management needed to improve.
- Mealtime experiences and nutritional support were not well planned.
- Staff were committed to their roles and people using the service, but were under pressure due to workload demands.
- Audits were not used effectively to drive improvement, incident's and adverse events were not reported, investigated or learned from.
- Personal plans were improving, but additional actions were required.

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?	2 - Weak
How good is our setting?	4 - Good
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 we identified some strengths, these were compromised by significant weaknesses.

Staff interactions with people were often warm and friendly, particularly when delivered by regular staff who knew people well. However, these positive relationships were limited by a task-focused approach to care. We observed people waiting long periods for support, including assistance to use the bathroom. This showed that staffing levels and deployment were not sufficient to meet people's needs in a timely and person-centred way. We have discussed this further in the report under the section "How good is our staff team?".

We sampled medication administration records for the previous month and found that a significant number of medications had not been administered as prescribed. This affected some people more than others, with medication that had not been given for several days. Reasons why medication was not given included stock not being available, out of stock, or could not be located. New medication was not consistently counted or checked in when it was delivered to the service from the pharmacy, leading to inaccurate stock balances and delays in reordering. These findings indicated poor medication stock control, record-keeping and governance. The failure to administer prescribed medication compromised people's health and wellbeing. We advised the service that urgent action was required to ensure people had sufficient prescribed medication available to prevent any decline in their physical and emotional health. We also asked the service to provide assurances that the people who had been impacted most by not having their prescribed medications, were safe and well. The provider was responsive to ensure that statutory notifications were made to the relevant bodies. We were assured that the provider's response and subsequent actions taken had reduced any immediate or ongoing risks to people. (See requirement 1)

While observing mealtimes, we found that some people waited extended periods before food was served. There was a lack of planning and coordination, and staff did not always provide appropriate postural support for people eating in bed. This posed a risk to safe swallowing and increased the potential for choking or aspiration. Support and monitoring of people eating in their bedrooms was inconsistent, and staff were not always aware of the associated risks. Staff lacked awareness of people's nutritional support needs, including food fortification and food that required to be modified to support safe swallowing. Information in care plans was sometimes out of date or inconsistently recorded. "Snack stations" which are meant to provide people with snacks between their meals were either poorly stocked or not stocked at all. This meant that people were at risk of not having their nutritional needs met, which could compromise their safety and wellbeing. (See requirement 2)

Activity provision was under pressure due to staff vacancies and absence, leaving one activities worker to manage alone. This meant that people had prolonged periods without any stimulation, which increases the risks of boredom, isolation and reduced wellbeing. We have discussed this further in the report in the section "What the service has done to meet any areas for improvement made at or since the last inspection".

Despite these concerns, there were some strengths. A monthly activity plan was in place, including birthday celebrations, church services, and visits from local school children. Residents' meetings were held quarterly, which gave people opportunities to share feedback about the service, and we saw evidence that the manager responded positively to requests, such as purchasing new curtains and televisions for shared areas of the service. This helped ensure that people were involved in decisions about their home.

Fluid monitoring records were completed to a high standard where this support was required for people. Most people met their daily fluid intake targets, and documentation was thorough. This demonstrated a proactive approach to hydration and supported positive health outcomes.

Some people required support to maintain a healthy bowel function, where people required this support, records were not always accurate enough to support timely interventions, including the use of prescribed medication. Some people had extended periods without a recorded bowel movement or gaps in documentation. While some individuals may have been independent with toileting, this was not clearly recorded. We discussed this with leaders to highlight where consideration should be taken on how this can be better supported.

We reviewed the use of clinical health tools. These are designed to help identify when people's health may be deteriorating, to ensure concerns are escalated timeously, and to avoid unnecessary hospital admissions. These were completed sporadically, with a lack of escalation or follow-up when health concerns were highlighted. Although training had been provided to nurses and senior staff around the use of clinical health tools, this was not reflected in practice. This means that conditions that could be managed early may not be well supported, increasing the risk of potential harm. (See area for improvement 1)

Requirements

1. By 9 November 2025, the provider must implement safe and effective medication management systems. This is to ensure people's health and wellbeing is safe and protected. To do this, the provider must, at a minimum:

a) Complete a full audit of medication stock and ensure all prescribed medications are available.
b) Carry out regular counts of medication to ensure prescribed medication and homely remedies are available.
c) Implement robust systems for checking in new medication and maintaining accurate stock balances.
d) Ensure staff competency in medication administration and competence in use of the electronic medication system is regularly observed and recorded.
e) Establish a process for notifying and investigating missed medication doses, and ensure this is consistently followed.

This is to comply with SSI 2011/210 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 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 9 November 2025, the provider must improve mealtime arrangements and ensure effective support is provided with eating and drinking. This is to ensure people are supported well with their nutritional needs and to reduce the risk of potential harm.

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

a) Ensure staff provide timely and coordinated mealtime support, including appropriate postural support for people, particularly people who eat their meals in bed. Risk should be minimised to promote safe swallowing, reducing risks of choking or aspiration.
b) Ensure staff are aware of and follow current guidance on the International Dysphagia Diet Standardisation Initiative framework (IDDSI), food fortification, diets and preferences.
c) Maintain up-to-date care plans that clearly reflect people's nutritional needs and support, and ensure daily records clearly reflect their support.
d) Ensure snack stations are consistently stocked and accessible.
e) Implement systems to monitor and evaluate mealtime experiences and nutritional outcomes.

This is to comply with SSI 2011/210 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: "My meals and snacks meet my cultural and dietary needs, beliefs and preferences". (HSCS 1.37)

Areas for improvement

1. To identify deterioration in people's health and respond appropriately, the provider should ensure clinical monitoring tools such as NEWS and RESTORE2 are used effectively. This should include, ensuring staff are trained and competent in using these tools, and there is clear systems for escalation and follow-up when concerns are identified.

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

How good is our leadership? 2 - Weak

We evaluated this key question as weak. While some systems were in place, they were not used effectively to drive improvement or ensure people's safety and wellbeing.

Feedback about leadership was mixed. Some staff described leaders as proactive, supportive and visible. Others felt leadership was inconsistent, and at times, unsupportive. This inconsistency affected staff morale and confidence.

Leaders did not always identify or act on serious medication risks. Missed doses, poor stock control and gaps in documentation were not escalated or investigated to identify wider issues. These incidents were treated in isolation, rather than as part of a planned and focused approach. This showed weak oversight and ineffective quality assurance. There was no evidence of learning from errors or assurance that improvements were being made. When incidents are treated in isolation, systemic issues go unaddressed, increasing the likelihood of repeated mistakes, which can have a significant impact on people. (See requirement 1)

Staffing levels and deployment were not monitored or adjusted to meet people's needs. There was no dynamic planning to ensure safe care delivery. This impacted people's experiences and outcomes. We have discussed this further in the report under the section "How good is our staff team?"

Audits were carried out across key areas, but they lacked sustained focus, follow-up and accountability. The findings from many of the audits completed reflected some of the concerns we identified during the inspection. These included medication audits, which showed gaps in the accuracy of medication records. Nutritional audits highlighted poor care planning arrangements, and meal time audits showed where inconsistent standards of care and support were provided. Although it was positive that audits had highlighted where improvements were needed, actions required were often delayed or not fully actioned, limiting their effectiveness.

Leaders had carried out a recent analysis of people who had experienced falls in the service, which was detailed and showed good insight into trends and contributing factors. We saw decisions being made around medication changes and additional monitoring where needed. We were aware that the service had recent input from external health professionals, including Physiotherapist, and the Care Home Liaison Nursing Team, to support improvements in falls management. This demonstrated that leaders were able to take a proactive and focused approach to promote improvements in people's health and wellbeing.

Monthly reports of people supported with wound care, infections, weight loss and accident and incidents were collected and discussed locally and with external managers. However, as we were unable to see any detailed minutes of these meetings it was unclear how this data was used to provide effective support to the service. There was no structured analysis to track reoccurring issues such as infections, weight loss, or wound management. This means that leaders may fail to implement early interventions that could stop problems from escalating and support better health outcomes for people. (See requirement 1)

The service used an electronic system to monitor quality assurance and governance. However, the system was complex and multi-layered, and didn't provide a clear and trackable overview of wider service improvements. This may have prevented leaders from having clear oversight of where improvements were required to ensure a sustained focus on continuous development. (See area for improvement 1)

Requirements

1. By 7 December 2025, the provider must use effective governance and quality assurance systems to identify, respond to, and learn from adverse events and risk of harm. This is to ensure people's safety and wellbeing. To do this, the provider must, at a minimum:

a) Ensure that adverse events, including medication errors, are consistently escalated and investigated to identify patterns and risks.
b) Analyse audit findings and clinical governance data to identify where changes can be made that improve people's care and experiences.
c) Ensure there are clear procedures for reporting and learning from adverse events.
d) Ensure notifications are made timeously to relevant bodies, including; the local authority, adult protection teams, and Care inspectorate in accordance with Care Inspectorate's "Guidance on records you must keep and notifications you must make, March 2025".

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 care and support is consistent with the Health and Social Care Standards (HSCS), which that "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities" (HSCS 3.20).

Areas for improvement

1. To support continuous improvement and effective oversight, the provider should develop and implement a structured service improvement plan that is Specific, Measurable, Achievable, Relevant and Time-Bound (SMART). This should include identifying recurring issues from internal and external audits and stakeholder feedback, ensuring the plan is accessible and used to inform provider-level support.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "I use a service and organisation that are well led and managed" (HSCS 4.23).

How good is our staff team? 2 - Weak

We evaluated this key question as weak. Staffing arrangements did not consistently meet people's needs or support positive outcomes.

The current staffing model does not align with the Health and Care (Staffing) (Scotland) Act 2019. Leaders did not demonstrate a clear understanding of the Act or how to apply it to ensure safe and effective staffing.

Staffing levels were determined using a numerical method to calculate people's level of dependency aligned to their support needs. Staff arrangements did not take into account peak times in the day such as morning or mealtimes where people may require a higher level of support. Nor did this take into consideration the time needed for staff to attend daily meetings throughout the day, or carry out non-direct care duties. There was no evidence of dynamic planning or flexible deployment of staff to ensure people received support at the right time, from the right people. As a result, people waited too long for support, including help to use the toilet and delayed responses for help via the internal nurse call system. This compromised people's dignity and wellbeing. This also links to some of the issues identified in the section of the report "How well do we support people's wellbeing?", in particular around inconsistent practice at mealtimes, choking risks, and staff having the right knowledge and time to support people with their nutritional needs.

Staff consistently reported feeling under pressure. Many said morale was low and the workload was overwhelming. Staff feared making mistakes and felt they had to follow schedules rigidly, even when this didn't meet people's needs.

We observed staff who were busy but often this was task focused, where they had little time for meaningful interaction with people to promote stimulation. Staff told us they missed spending time with people and wanted more opportunities to connect and build relationships with people. Staff turnover was high, particularly in nursing and senior roles. This led to a reliance on agency staff, who were not properly inducted or familiar with people's support needs, which had the potential to put people at risk. This affected continuity of care for people and increased pressure on permanent staff. (See requirement 1)

Training compliance for mandatory training was generally high, this included, Adult Support and Protection, Infection and Prevention Control (IPC), Moving and Handling, Fire Safety and a range of other essential areas. Observations of staff practice were carried out to ensure staff were able to follow best practice in relation to IPC and administration of medication. However, it was unclear whether medication competencies focused on staff competence and understanding of the electronic medication system, where a number of significant errors were identified.

There was a lack of follow up with staff who had been involved in recent medication errors to support improved practice and learning. We saw evidence of a lack of accountability across different staff levels. For example, staff did not report issues when medication stock was unavailable, nor did they take steps to seek remedial action. This highlighted weaknesses in the service's culture of responsibility and learning, increasing the risk of repeated errors. Without follow-up or learning and accountability, the same mistakes are likely to happen again, putting people at risk of harm. (See requirement 2)

Staff experiences of supervision and appraisal were inconsistent. Although we saw that for most staff, supervisions had taken place, the lack of consistent support from an assigned supervisor limited its effectiveness to support staff with both their professional and personal development. We discussed with leaders how staff wellbeing could be better promoted via team building opportunities and reflective learning sessions. This increases opportunities for shared learning, collaboration, and promotion of a positive team culture. (See requirement 2)

Despite these concerns, staff expressed a strong commitment to their roles, people using the service and a desire to see the service improve.

Requirements

1. By 4 January 2026, the provider must improve staffing arrangements and ensure staff are appropriately inducted and deployed. This is to ensure people receive safe, effective, and person-centred care. To do this, the provider must, at a minimum:

a) Ensure staffing levels and deployment are responsive to people's assessed needs, including peak times in the day and non-direct care duties.
b) Demonstrate understanding and application of the Health and Care (Staffing) (Scotland) Act 2019 to support safe staffing decisions.
c) Ensure agency and new staff receive a robust induction to support continuity of care.
d) Implement systems to monitor staffing pressures and take action to support staff wellbeing and morale.

This is to comply with Regulation 4(1)(a) (welfare of service users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/ 210 and Sections (7)(1)(a) and (b) (Ensure appropriate staffing) of the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA).

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

2. By 4 January 2026, the provider must strengthen accountability and support staff to reflect on and improve their practice. This is to ensure the risk of errors and performance issues are reduced and promote a culture of learning. To do this, the provider must, at a minimum:

a) Ensure staff involved in incidents, including medication errors and adverse events receive appropriate follow-up and support to improve practice.
b) Ensure staff have an understanding of their roles and responsibilities across all staff levels for reporting and resolving issues, this includes concerns that may cause harm to people.
c) Provide staff with regular opportunities for support through consistent supervision and reflective learning.

This is to comply with Regulation 4(1)(a) (welfare of service users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services).

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

How good is our setting? 4 - Good

We evaluated this indicator as good, where strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

We observed varied standards of cleanliness across the service during the inspection. On the first day, the environment was not well maintained, but this improved over the following days. Absences in domestic staff had led to a reliance on agency workers, some of whom were unfamiliar with the home's cleaning systems and infection prevention and control (IPC) procedures. Cleaning logs were completed and submitted to management for review. However, some areas appeared either not cleaned or not cleaned to a high standard. This may have been due to unfamiliarity with the environment or unclear expectations, particularly among agency domestic staff. Inconsistent cleaning practices and lack of clarity around roles increased the risk of cross contamination, compromising people's safety and wellbeing. We have discussed this further under the section of the report "What the service has done to meet any areas for improvement we made at or since the last inspection".

Personal protective equipment was available throughout the home and most staff used it correctly, in line with national guidance. This supported safe infection prevention and control practices.

Maintenance and regular servicing records were well-managed. The maintenance manager maintained oversight and conducted regular checks, with audits and actions recorded. This supported safety and operational efficiency across the service.

Environmental audits had identified areas of the home that required refurbishment, such as worn paintwork and tired furnishings. Actions were underway to address these, and people were actively involved in choosing colours and designs. This promoted inclusion and a sense of ownership, helping people feel valued and involved in decisions about their living environment.

A dementia design audit which had been carried out in the service, scored well overall. Improvements were identified to support better wayfinding for people with cognitive impairments. We saw people moving freely and safely around the home, including outdoor areas. This supported people's independence and wellbeing.

A system was in place to monitor how efficiently staff responded to nurse call alerts. We saw that emergency alerts were responded to promptly. This helped ensure that people received urgent support without delay, reducing the risk of harm. However, other alerts for help and assistance were not as well responded to. (See "How good is our staff team?", section of the report)

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

We evaluated this key question as adequate where strengths only just outweighed weaknesses.

Some care plans were highly individualised and reflected people's preferences, interests, and family input.

Staff had used this information well to personalise care. Bedroom doors included helpful summaries of what mattered to people, such as their favourite music, faith, and family connections. For example, one person's plan included rich detail about their life history, likes and dislikes, and support needs. We saw this being supported in practice, with staff responding respectfully when they asked for help.

Not all plans were person-centred. Some care plans for people who were living in the service for a short-term, temporary period lacked detail about how they preferred their care and did not include all relevant risk management plans. This raised concerns about whether staff had the right information or skills to support some people safely. It is essential that sufficient information is available to support people safely, regardless of whether they are permanent or temporary residents. Essential information to direct people's care and support should be sought prior to their admission to the service. (See area for improvement 1)

Other care plans included duplicated or outdated information across different sections. This increased the risk of staff following incorrect guidance, particularly for new or unfamiliar staff. Leaders recognised that this was an area of improvement and were supporting staff to reduce unnecessarily duplication of information.

People's future wishes and towards the end of their life were clearly recorded for most people. In some cases, discussions had not yet taken place due to the distress this had caused family, but the service planned to revisit this sensitively. Risk information, such as where people may leave the service and become lost and confused, were clearly flagged at the front of their care plans, helping staff respond appropriately.

Care plans were reviewed monthly and formal review meetings took place every six months, with input from families and professionals. This helped ensure that support was tailored to individual needs. We saw evidence of involvement from speech and language therapists, GPs, occupational therapists, and mental health teams in people's care. This meant the service recognised the importance of seeking expert advice to meet people's needs.

Overall, we found that time and investment into care planning had supported improvement in this area. However, staffing pressures were impacting the quality and consistency of care delivery.

Areas for improvement

1. To ensure safe and person-centred care, the provider should improve pre-admission assessments to capture key health and wellbeing information and inform care planning.
This should include developing care plans that reflect individual risks and support needs, and assessing whether staff have the necessary skills and information to provide effective support.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state: "I am confident that the right people are fully informed about my past, including my health and care experience, and any impact this has on me." (HSCS 3.4)

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 that people's assessed needs are safely met, the provider should ensure staffing levels are kept under regular review. This is to ensure that people are supported by the right number of skilled, trained and knowledgeable staff to provide their support. This should include, but is not limited to; when occupancy levels increase in the service or when people's needs change.

This is to ensure care and support is consistent with Health and Social Care Standards which state "My needs are met by the right number of people" (HSCS 3.19) and "I experience stability in my care and support from people who know my needs, choices and wishes, even if there are changes in the service or organisation" (HSCS 4.15).

This area for improvement was made on 20 February 2025.

Action taken since then

Staffing arrangements were not aligned with the Health and Care (Staffing) (Scotland) Act 2019. The service did not carry out a robust assessment of staffing needs. These did not take account of peak times in the day, staff meetings, administrative duties, or the differing roles and responsibilities of staff. For example, nurses were included in whole staff time hours despite not delivering direct care, and senior staff had responsibilities that did not involve direct support. This meant that staffing levels did not reflect the actual care needs of people using the service.

This area for improvement is no longer in place and has been incorporated into a new requirement under key question "How good is our staff team?".

Previous area for improvement 2

To ensure that people are kept safe, the provider should have effective monitoring and cleaning systems in place to prevent cross contamination. This includes, but is not limited to, ensuring that kitchen equipment used to serve food is cleaned to a high standard.

This is to ensure care and support is consistent with Health and Social Care Standard "I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment" (HSCS 5.22).

This area for improvement was made on 24 October 2024.

Action taken since then

We found gaps in cleaning schedules, particularly in pantry areas. During our inspection, we observed that pantries were not cleaned following meal service. Surfaces had visible food residue and had not been wiped down, which posed a risk to infection prevention and control (IPC). Agency domestic staff had not received an induction to the service. As a result, they were unaware of cleaning regimes, good IPC practice, and the importance of using personal protective equipment (PPE). We observed poor practice, including failure to follow PPE guidance, which increased the risk of cross-contamination. We did not see sufficient progress in this area.

This area for improvement has not been met.

Previous area for improvement 3

The management team should improve the overall dining experience by ensuring quality assurance audits are used to lead improvement. People should be offered hot drinks after meals if this is their preference and staff should ensure a positive dining experience is offered to those who choose to eat their meals in their own room.

This is to ensure care and support is consistent with Health and Social Care Standard 1.19: "My care and support meets my needs and is right for me". This area for improvement was made on 12 August 2024 following a complaints inspection.

This area for improvement was made on 12 August 2024.

Action taken since then

Although the service had carried out audits of mealtime experiences, these had not led to sufficient improvements in practice. We observed similar issues during inspection, including poor organisation by staff during mealtimes. Some people waited extended periods for their meals, with some people telling us they had been up early and had to wait hours for breakfast. Mealtime observations were inconsistent; while some people were offered choice through show plates, others were not. On one occasion, one person was served breakfast twice, and it was unclear how staff were monitoring what people had been offered or eaten. This raised concerns about how well people's nutritional needs were being supported.

This area for improvement is no longer in place and has been incorporated into a new requirement under key question "How well do we support people's wellbeing?"

Previous area for improvement 4

The service should ensure that activities are a planned part of everyone's daily care. All staff should see this as an important part of their role, getting to know people's likes and interests and improving the range of opportunities for engagement to meet individual need, both inside and outside of the service.

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 following a complaints inspection on 12 August 2024.

This area for improvement was made on 12 August 2024.

Action taken since then

We heard that vacancies and staff sickness within the activities team had led to a reduction in meaningful activity for people. During the inspection, we observed people spending prolonged periods with little or no engagement. While some planned activities did take place and were well attended, opportunities were limited. People had little or no opportunity to access the wider community. The service shared a vehicle with three other sister homes, and ongoing issues with staff being able to drive the minibus continued to restrict access.

It was positive to see that a new activities worker had recently been recruited. They were actively introducing new ideas from previous experience, including working with a local library to facilitate poetry reading sessions and a book loaning service. This demonstrated a commitment to improving outcomes for people. However, we were not satisfied that sufficient progress had been made in this area.

This area for improvement has not been met.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

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	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?	2 - Weak
3.3 Staffing arrangements are right and staff work well together	2 - Weak

How good is our setting?	4 - Good
4.1 People experience high quality facilities	4 - Good

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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