Carlingwark House
Care Home Service

Carlingwark Street
CASTLE DOUGLAS
DG7 1TH

Telephone: 01556 505060

Type of inspection:
Unannounced

Completed on:
31 October 2025

Service provided by:
Park Homes (UK) Limited

Service provider number:
SP2006008483

Service no:
CS2021000288

About the service

Carlingwark House is registered to provide a non-nursing care home service to a maximum of 30 older people over the age of 65 years. The provider is Park Homes (UK) Limited.

The service is located close to Castle Douglas town centre. Local amenities are within walking distance of the home.

The home is a Victorian style building. All bedrooms have en-suite toilet and sink facilities. There are three shared bathing facilities and one shared shower room.

Communal lounges are available throughout the home along with a dining and kitchen area.

The home has two floors serviced by a passenger lift and a staircase. The upper floor is currently not in use. All accommodation is provided on the ground floor of the building. There is an enclosed garden with seating, and a car park is available to visitors.

At the time of the inspection there were 23 people living at the service.

About the inspection

This was an unannounced follow-up inspection which took place on 30 October 2025 between 08:30 and 17:45 hours. Feedback was provided on 31 October 2025. 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, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with 11 people using the service and one relative
- for people unable to express their views, we observed interactions with staff and how they spent their time
- spoke with 13 staff and management
- spoke with three visiting health professionals
- observed practice and daily life; and
- reviewed documents.

Key messages

- While there had been some improvements in personal care, support remained inconsistent.

- Staff were kind and responsive, although proactive identification of care needs requires further development.

- Continence care lacked clarity and consistency, with assessments and plans not always reflecting current needs.

- Meaningful activity was limited, and not embedded in daily routines, reducing opportunities for engagement and stimulation.

- Management oversight had improved, however quality assurance systems were not yet robust or consistently applied.

- Staffing levels were generally sufficient, however deployment did not fully consider environmental layout or feedback from people and staff.

- Environmental upgrades were underway, but key improvements and fire safety actions remained outstanding.

- The service had met one requirement and one area for improvement made at the previous inspection.

- As a result of this inspection we restated four requirements, four areas for improvement and made one new requirement and one new area for improvement.

From this inspection we evaluated this service as:

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

How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate

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

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, where strengths just outweighed weaknesses. Whilst the strengths had a positive impact, key areas need to improve.

Management oversight had improved, however some routine checks and follow up actions were inconsistent. Audits identified issues, yet documentation of outcomes and learning was limited. Strengthening these processes is needed to embed effective quality assurance. (see requirement 1)

We have reported on our findings under the following sections: "What the service has done to meet any requirements made at or since the last inspection." and "What the service has done to meet any areas for improvement made at or since the last inspection."

Requirements

1. By 25 January 2026, the provider must ensure that quality assurance systems are robust and consistently used to identify, act on, and learn from areas of concern. This is to ensure that people experience care that is safe, well managed, and continuously improving.

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

a) Ensure all relevant issues identified through audits and monitoring are accurately recorded.
b) Ensure timely and effective action is taken in response to identified concerns.
c) Clearly document actions taken, outcomes achieved, and any lessons learned.

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 use a service and organisation that are well led and managed." (HSCS 4.23)

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate, where strengths just outweighed weaknesses. Whilst the strengths had a positive impact, key areas need to improve.

The requirement had been met in relation to the provider ensuring the level of staffing on each shift must be adequate to provide the assessed level of support to people at all times. However, ensuring that staffing assessments take into account environmental factors and stakeholder feedback continued to be an area for improvement. (see area for improvement 1)

We have reported on our findings under the following sections: "What the service has done to meet any requirements made at or since the last inspection." and "What the service has done to meet any areas for improvement made at or since the last inspection."

Areas for improvement

1. To ensure staffing arrangements continue to meet people's needs, the provider should ensure that staffing assessments take into account environmental factors such as the layout of the building and communal areas, as well as feedback from people using the service, their representatives, and staff.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My needs are met by the right number of people." (HSCS 3.15) and "People have time to support and care for me and to speak with me." (HSCS 3.16)

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

Requirements

Requirement 1

By 29 October 2025, the provider must ensure that people consistently receive appropriate standards of personal care. This includes support with nail care, oral hygiene, and that any choices and preferences are respected. This is to ensure people's basic care needs are met in a way that protects their health, dignity, and human rights. To do this, the provider must, at a minimum:

a) Ensure personal care is delivered regularly and in line with each person's assessed needs and preferences.
b) Maintain accurate and up-to-date care records that reflect the care provided.
c) Ensure staff can identify when individuals require support with personal care and respond appropriately.
d) Implement effective monitoring and management oversight to ensure care is not missed or delayed.

This is to comply with Regulation 4(1)(a) and 4(1)(b) (Welfare of users) and Regulation 5(1) (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 experience high quality care and support that is right for me" (HSCS 1.19) and "My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected" (HSCS 1.23).

This requirement was made on 19 August 2025.

Action taken on previous requirement

Personal care was being delivered to people, with improvements noted in responsiveness and presentation. Observations confirmed that nail care and oral hygiene support had improved, and people reported receiving help when requested. However, inconsistencies remained in the delivery and documentation of some personal care needs, for example, handwashing and bathing routines. Preferences for bathing or showering were not always met or clearly explained. Clinical oversight had improved, with proactive measures taken for individuals at risk of skin breakdown.

Care records had shown some improvement, particularly in documenting daily care activities. However, gaps persisted in key areas such as handwashing, skin integrity monitoring, and recording refusals or partial care. Recordings revealed inconsistencies, and while senior oversight was active, the recording tools used could have been better aligned to ensure comprehensive and connected documentation. Strengthening the format and consistency of care records would have supported a more accurate reflection of care delivered and helped identify missed or delayed care.

Staff were observed to respond to direct requests for support, and people confirmed they received help when needed. Despite this, there was room for improvement in proactive identification of care needs. Some relatives and management staff reported instances of missed care, suggesting that a shift in culture and procedures might have been necessary to ensure staff consistently anticipated and addressed personal care requirements.

Monitoring systems were in place and used regularly, including daily handovers and audits. However, these systems did not always capture missed care or document follow-up actions effectively. While daily meetings and regular checks were used to agree on actions, the recording of these decisions and their outcomes needed to be more robust. Improvements in documentation, coordination, and responsiveness were required to fully support people's personal care needs.

This requirement has not been met, and we have agreed an extension to 25 January 2026.

Not met

Requirement 2

By 29 October 2025, the provider must ensure that people's continence needs are consistently assessed and supported. In order to ensure that people receive the right care at the right time, and that continence care is delivered in a person-centred and respectful manner. To do this, the provider must, at a minimum:

a) Ensure continence assessments are accurate, up to date, and reflect each person's current needs and preferences.
b) Ensure continence care plans clearly outline how support will be provided, including how continence will be promoted.
c) Ensure staff have the knowledge and skills to support continence care effectively and respectfully.
d) Ensure individuals who are able or prefer to use toilet facilities are supported to do so at the right time.
e) Ensure monitoring systems evidence continence care is delivered consistently and appropriately.

This is to comply with Regulation 4(1)(a) (Welfare of users) and Regulation 5(1) (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 experience high quality care and support that is right for me." (HSCS 1.19) and "My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected." (HSCS 1.23)

This requirement was made on 19 August 2025.

Action taken on previous requirement
The provider had taken steps to assess and support people's continence needs, with some improvements noted. Continence assessments had been completed for individuals, however, they were not consistently comprehensive or reflective of current needs. In several cases, assessments had not been updated following clinical concerns, such as suspected urinary tract infections raised during daily meetings. This indicated a lack of responsiveness in updating care documentation to reflect changes in health status.

Continence personal plans were in place for people, however, the quality and clarity of information varied. In some examples, personal plans lacked essential guidance, such as catheter care instructions, toileting routines, and product use. Inconsistencies suggested that personal plans were not reliably guiding staff practice or promoting person-centred continence care.

Staff training had commenced, with further sessions planned, however, it was unclear whether the content included essential topics such as catheter care. The lack of clarity around training coverage and the absence of evidence of staff competence in specific areas of continence care raised concerns about the effectiveness of the training programme. Additionally, personal plans did not consistently describe how and when individuals were supported to use toilet facilities, making it difficult to ensure that care was respectful and timely.

Monitoring systems were in place but were not robust enough to evidence that continence care was being delivered consistently. Record keeping across bowel charts, toileting logs, and daily notes was inconsistent, making it difficult to evaluate whether care was meeting people's needs. The lack of clear documentation and descriptive guidance limited staff's ability to monitor outcomes and adjust care accordingly.

This requirement has not been met, and we have agreed an extension to 25 January 2026.

Not met

Requirement 3

By 29 October 2025, the provider must ensure people benefit from meaningful activity and person-centred support. In order to meet their mental, social and physical needs. To do this, the provider must, at a minimum:

a) Develop a personalised programme of activities with each individual that is part of a person centred care plan.
b) Account must be taken of the abilities, life histories and preferences of individuals.
c) Increase opportunity for meaningful interaction in and out with group activities; including access to the community.

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 2011/201).

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 every day, both indoors and outdoors". (HSCS 1.25)

This requirement was made on 19 August 2025.

Action taken on previous requirement

The provider had taken initial steps to improve the delivery of meaningful activity and person-centred support; however, progress remained inconsistent. Activities were being delivered by care staff at times throughout the week while awaiting the induction of a full-time activity coordinator. Seasonal events, such as a Halloween party, had been organised, and some one-to-one interactions had been observed, including knitting and manicures. However, a full programme of activities had not yet been agreed with residents or reflected in personal plans. This had limited visibility and planning and had not supported a personalised approach to activity provision.

Personal plans included life histories and preferences, which was a positive foundation for person-centred planning. However, not all plans were up to date or clearly documented the types of activities individuals enjoyed or would have liked to try. Continued review and development of these plans was needed to ensure they reflected current interests and abilities.

Staff demonstrated awareness of the importance of meaningful interaction; however, they reported that on occasion their time was dominated by personal care tasks, limiting time for engagement. Observations confirmed some meaningful interactions but also highlighted missed opportunities, particularly for people who remained in their rooms or showed signs of distress. There had been no outings from the home, and access to the community was not evident. Coordination of one-to-one time through meetings could have been improved to ensure consistency and inclusion.

Monitoring and recording of meaningful activity were inconsistent. Personal plans lacked sufficient detail to guide staff, and daily notes did not reliably capture when or how individuals were supported to engage. This made it difficult to evaluate whether activities were meeting people's mental, social, and physical needs. The absence of structured planning, visible scheduling, and consistent documentation meant that meaningful activity was not embedded in daily practice. Further action was needed to ensure people benefited from meaningful, person-centred support in line with their rights and preferences.

This requirement has not been met, and we have agreed an extension to 25 January 2026.

Not met

Requirement 4

By 29 October 2025, the provider must ensure that management oversight is effective in identifying and addressing areas for improvement in the service. To do this, the provider must, at a minimum:

a) Implement robust quality assurance systems that identify deficits in care, including meaningful activity, personal care, and staff interaction.
b) Ensure that management presence in the service is regular, purposeful, and used to monitor the quality of care and staff practice.
c) Take timely and effective action in response to identified concerns, with clear records of actions taken, outcomes achieved, and lessons learned.

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 2011/201).

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

This requirement was made on 19 August 2025.

Action taken on previous requirement
The service had made progress in establishing quality assurance systems. There had been a collaborative approach with the partnership, which had led to improvements in oversight and responsiveness.

Management presence within the service had been consistent and purposeful, with the manager actively supporting staff and overseeing key areas of work. The manager's visibility had contributed to improved staff engagement and coordination. However, some routine oversight activities, such as daily walkarounds and flash meetings, were not consistently taking place, particularly at weekends.

Audits had been carried out and had identified areas requiring action, which was a positive step. However, the follow-through on these findings had remained inconsistent. There was limited evidence of outcomes being tracked or lessons learned. This had weakened the effectiveness of the quality assurance process and had limited the service's ability to demonstrate improvement.

Improvements had been made; however, gaps remained in sustaining oversight, ensuring consistent monitoring, and evidencing action taken. Further work was needed to strengthen internal leadership, embed quality assurance practices, and ensure that improvements were maintained over time.

This requirement is no longer in place and a new reworded requirement has been made under "How good is our leadership?"

Not met

Requirement 5

By 29 October 2025, to ensure the safety, health, dignity and wellbeing of people experiencing care, the level of staffing on each shift must be adequate to provide the assessed level of support to people at all times. To do this, the provider must, at a minimum:

a) Ensure there are sufficient staff on duty who are competent and who are meeting the physical and social support needs of people using the service;
b) Ensure staff are deployed appropriately to ensure that people receive assistance with their care needs at times that meet their needs and preferences;
c) Undertake a thorough evaluation of all the current needs of people who use the service and use the findings to ensure that there are sufficient staff on duty; and
d) Evidence that assessed staffing levels have considered the layout of the building, communal areas and include feedback from people, their representatives and staff.

This is in order to comply with section 7(1)(a) & (b) and (2) of the Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My needs are met by the right number of people" (HSCS 3.15) and "People have time to support and care for me and to speak with me." (HSCS 3.16)

This requirement was made on 19 August 2025.

Action taken on previous requirement
Staffing levels during the inspection were found to be generally sufficient to meet the assessed needs of the residents. Staff reported feeling able to meet people's needs, although some expressed concern about future capacity should dependency levels increase or occupancy rises. Observations confirmed that staff were actively supporting people throughout the day. Staff training compliance was high, with additional training such as continence care underway. Positive peer feedback and practice observations were noted, contributing to a culture of learning and development.

Staff deployment was largely effective, with call alerts responded to promptly and weekly audits confirming timely assistance. People using the service reported they received support when needed or requested. However, during periods of distress, particularly in communal areas, staff presence was not always consistent. This suggested that while deployment was generally appropriate, further coordination was needed to ensure staff were available at critical times and in key areas of the home.

The service used a dependency tool to assess and monitor residents' needs, and personal plans reviewed during the inspection appeared accurate and aligned with observed support. The manager ensured that assessments were updated when changes occurred, and there was evidence of ongoing review. This supported a responsive approach to staffing based on current needs. However, while staffing levels were informed by dependency assessments, there was no evidence that the layout of the building, use of communal areas, or feedback from residents, relatives, or staff had been considered in determining staffing arrangements.

This requirement has been met. An Area for improvement has been made under "How good is our staff team?" in ensuring that staffing assessments take into account environmental factors and stakeholder feedback.

Met - within timescales

Requirement 6

By 29 October 2025, the provider must ensure that the environment is consistently maintained to a standard that promotes safety, comfort, and wellbeing for people using the service. To do this, the provider must, at a minimum:

a) Complete outstanding environmental upgrades and ensuring they are reflected in the service's environmental improvement plan;
b) Addressing maintenance issues promptly, including upkeep and repairs to internal and external areas;
c) Improving wayfinding and bedroom signage to support orientation;
d) Ensuring lighting is adequate and safe throughout the premises; and
e) Fire safety recommendations are planned and addressed promptly

This is to comply with Regulation 4 (1) (a) (b) (Welfare of service users) and 14 (b) (Facilities in Care Homes) 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, "I experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment." (HSCS 5.22)

This requirement was made on 19 August 2025.

Action taken on previous requirement

The provider had made partial progress in improving the environment to promote safety, comfort, and wellbeing for people using the service. Some upgrades had been completed, including corridor painting, and external maintenance work was observed during the inspection, such as window cleaning and garden upkeep. However, some environmental improvements remained outstanding, including door painting and the presentation of some garden furniture. These were noted in the service's environmental improvement plan, which still contained incomplete actions.

Maintenance systems were generally in place and functioning. Equipment replacements had been made with necessary work being actioned. Prompt attention to such issues had helped maintain a safe and comfortable environment, although continued oversight remained essential to ensure standards were upheld consistently.

Wayfinding and signage had been partially addressed, with temporary signage in place at the time of inspection. The provider advised that permanent signage would be installed once door painting was complete.

There was no clear evidence that fire safety recommendations had been addressed in a timely manner. Discussions during the inspection indicated that feedback was still awaited to confirm which actions had been completed and which remained outstanding. Given the importance of fire safety, delays in implementing recommendations posed a potential risk. Reassurance was given during feedback that action was being taken to address the outstanding fire safety recommendations. This ensures the environment is consistently maintained to a standard that supported people's safety, comfort, and wellbeing.

This requirement has not been met, and we have agreed an extension to 25 January 2026.

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

To support people's health and wellbeing, kitchen staff should have access to the most up-to-date information about individuals' nutritional needs and preferences.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state: "My care and support meets my needs and is right for me." (HSCS 1.19)

This area for improvement was made on 19 August 2025.

Action taken since then

Kitchen staff demonstrated a clear understanding of residents' nutritional needs and preferences, which were effectively communicated through printed dietary sheets, a whiteboard, and daily flash meetings. These systems ensured timely updates and coordination between care and kitchen teams, with residents reporting improved communication and satisfaction with how their dietary needs were being met.

This area for improvement has been met.

Previous area for improvement 2

To support effective quality assurance and continuous improvement, the provider should ensure that all relevant issues identified during audits are consistently and accurately recorded. This should include, but not be limited to, ensuring that actions and outcomes are clearly documented.

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)

This area for improvement was made on 19 August 2025.

Action taken since then

Quality assurance systems were in place and audits were being completed, however, not all identified issues were consistently recorded, and there was limited evidence of follow-up actions or outcomes. During feedback, it was noted that while audits had highlighted areas for improvement, these were not always documented within action plans or tracked to completion. This limited the service's ability to demonstrate continuous improvement.

This area for Improvement is no longer in place and has been incorporated into a new requirement under "How good is our leadership?"

Previous area for improvement 3

To support meaningful involvement, the provider should improve how people experiencing care, relatives, and staff share their views and experiences. This should include exploring preferred ways to give feedback, increasing opportunities for engagement, and using observation to understand people's experiences and the home environment.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state: "I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership." (HSCS 4.7) and "I experience high quality care and support based on relevant evidence, guidance and best practice." (HSCS 4.11)

This area for improvement was made on 19 August 2025.

Action taken since then

Surveys had been distributed to gather feedback from people experiencing care, relatives, and staff, but no responses had been received, and meetings held did not evidence meaningful contribution or follow-up. There was no indication that people had been involved in decisions relating to the environment. The provider should continue to explore preferred ways for individuals to share their views and experiences, and improve how feedback is captured and used to support meaningful involvement in service development.

This area for improvement has not been met.

Previous area for improvement 4

To support staff wellbeing and development, the provider should ensure all staff receive regular supervision and opportunities to attend team meetings.

This should include maintaining accurate supervision records, offering reflective discussions, and creating forums for staff to share ideas, raise concerns, and support each other.

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)

This area for improvement was made on 19 August 2025.

Action taken since then

While recent team meetings had taken place, supervision frequency did not meet the service's policy expectations. Opportunities for reflective discussion and peer support were limited. The provider should improve how supervision and team meetings are planned, recorded, and used to support staff wellbeing, development, and continuous improvement.

This area for improvement has not been met.

Previous area for improvement 5

The provider should ensure that all personal plans contain clear, individualised strategies that reflect each person's needs, preferences, and routines. This includes consistent detail on how to support people during episodes of stress or distress, and how to promote independence in daily life.

This is to ensure care and support is consistent with 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)

This area for improvement was made on 19 August 2025.

Action taken since then

Personal plans reviewed for managing stress and distress were inconsistent and lacked clear, individualised strategies for staff to follow. Some plans included vague instructions without practical examples, while others showed emerging approaches but lacked structure and consistency. Terminology varied across documents, making it unclear where staff should refer for guidance. Additionally, plans did not consistently detail how staff support individuals to remain independent in daily life. A more unified and personalised approach is needed to ensure personal plans reflect each person's needs, preferences, and routines.

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 good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our staff team?	3 - Adequate
3.1 Staff have been recruited well	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	3 - Adequate

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