ASC Orchard Court and Dalguise Care Home Service

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Type of inspection:
Unannounced

Completed on:
28 October 2025

Service provided by:
Advanced Specialist Care Limited

Service provider number:
SP2005007542

Service no:
CS2011298007

About the service

ASC Orchard Court is a care home service which is registered to support up to 24 people with learning disabilities and complex needs. 24 people were using the service during our inspection.

The care home is situated in a rural setting close to a village where people can access public transport to nearby towns and cities.

The service is provided in two separate buildings. People have their own ensuite bedrooms which they can personalise to their own tastes. There are communal lounges, kitchen and dining rooms with smaller lounges for people who prefer quieter spaces.

About the inspection

This was a full, unannounced inspection which took place between 13 and 28 October 2025. The inspection was carried out by two 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 eight people using the service and three of their representatives;
- spoke with 14 staff and management;
- observed practice and daily life;
- reviewed documents;
- spoke with visiting professionals.

Key messages

- People were supported with care and compassion and respect.
- Warm and trusting relationships had formed between people and staff providing support.
- Leadership and quality assurance had improved.
- Staff had access to a wide range of training including in-person support from trainers.
- Levels of restraint and restrictive practice had decreased since the last inspection. Further reductions were ongoing.
- Personal plans were person-centred and strengths based but further detail was needed to ensure consistency.

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?	4 - Good
How good is our leadership?	4 - Good
How good is our staff team?	4 - Good
How good is our setting?	4 - Good
How well is our care and support planned?	4 - Good

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

How well do we support people's wellbeing? 4 - Good

We evaluated this key question as good. Several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

We spent time in communal areas of the home. This meant we could observe interactions between people using the service and staff. Staff supported people with compassion, kindness and respect. People were supported at their pace and were not rushed. People took the time they needed to make choices and decisions. This included choosing activities or outings that they wished to participate in.

Warm and trusting relationships had been built between staff and the people they supported. Humour was used as an effective, supportive tool with people, where appropriate. In these cases, the stress and distress people experienced was reduced.

It was apparent that staff knew people well. Staff picked up on changes to people's presentation or needs quickly. People had access to support from the multi-disciplinary team. This meant concerns about people's physical, emotional or psychological health were responded to appropriately.

People were supported to express their individuality through their, dress, personal grooming, and décor in their bedrooms. This helped people maintain and increase their sense of identity and self-esteem.

People were supported to spend their time in ways that were meaningful and purposeful to them. This had a positive impact on people's wellbeing. People told us about work placements and opportunities they enjoyed in nearby towns and cities. This enabled people to learn new skills and abilities. People could also build relationships with others out with the care home. A varied programme of activities and social opportunities was available throughout the week. This was led by the activities team who were enthusiastic and skilled. Activities took place in the activities room where people came together from the four services on the site. Support was also provided in individual houses in the service. We observed people taking part in activities that were meaningful for them, for example, karaoke, setting up the dining room for meals and participating in meal preparation. Some people did not participate in activities but enjoyed watching and listening to interactions.

The workshop was enjoyed particularly by people who were interested in learning practical tasks. One person told us, "I want to make a shoe rack. I will ask the workshop leader to help". This gave the person a sense of achievement and improved their self-image. People told us they valued talking with the workshop leader about their worries or concerns. They told us, "I like to go to the workshop and talk to the workshop leader. He listens to me". The workshop and activities team worked together on joint programmes such as a scarecrow making competition and a recent fun day event. This support improved people's outcomes.

People told us they enjoyed the food in the home and they were involved in menu planning. Meals were provided from the central kitchen. People using the service were involved in picking up and returning the food trolley with staff. Alternatives were available if people did not want what was on the menu. People were supported to go shopping. They had their own cupboards and space in the fridge and freezer for food and drinks they bought. During the inspection some people chose to cook and eat food they had bought themselves. Staff also supported people to cook meals from scratch. People were able to prepare snacks and drinks independently where appropriate. This maintained and increased people's skills, abilities and independence. This was important in working towards people moving on to less supported environments.

Relevant information about people's nutritional needs, preferences and risks was held in the kitchen. This was reviewed monthly or when people's needs changed. Some people could be at risk of choking. Assessments identified when they needed their food and drinks in modified textures.

Regular health checks were carried out for people in response to their individual needs. This included monitoring people's weight, bowel habits and the condition of their skin. These checks were informed by a range of health-based risk assessments. Concerns could be addressed by in-house nursing staff. Referrals were also made to relevant professionals such as speech and language therapists and community learning disability nurses. These measures supported people's health and safety.

People received safe support with their medication. The management of medication was good with regular audits carried out. We were satisfied that oversight of medication support was robust and accurate.

People were prescribed medication to be administered on an "as required" basis. Protocols were in place to inform the administration of medication. Detailed care plans ensured medication was given consistently and only when staff had tried all other relevant measures. The recording of people's stress and distress reactions was generally good. However, records should be kept in the appropriate section of the personal plan. This is to reduce the risk of errors. The provider should ensure care plans reflect the risk of "as required" psychoactive medication being used as a form of restraint. No one was being supported to self-medicate during the inspection. However, the provider appreciated the importance of enabling this when appropriate.

The use of restraint and restrictive practice had reduced. Staff had undertaken training and, as a result, had improved knowledge and understanding. Work was ongoing to further reduce the restraint and restrictive practice people were subject to. We were confident that the provider and staff were committed to improving people's outcomes and experiences and recognised people's human rights. This work was supported by the in-house positive behaviour support (PBS) specialist. Decisions as to the need for physical intervention or other restrictions was by multi-disciplinary agreement. Central to this were people's relatives or representatives, who had been appointed as Welfare Guardians with specific powers to consent to restrictions, where appropriate. Risks assessments should identify and mitigate the risks of using physical intervention. This is to protect people's health, safety and wellbeing. We observed people experiencing stress and distress. We were concerned that too many staff responded and this increased the risk of escalation and use of physical intervention. We discussed our observations with the provider who planned to share the feedback with the PBS specialist to support staff practice.

PBS plans were in place. These were detailed and person-centred. However, the provider should review the plans so guidance for staff is clear and easy to follow. This is to enable staff to identify when people are becoming stressed and distressed at the earliest opportunity. This should ensure staff can provide appropriate support and reduce the need for the use of physical intervention. Where people are prescribed psychoactive medication, this should be recorded on people's restraint log as this medication can have a sedative effect. Powers to consent to restraint and restrictive practice were mostly recorded in guardianship orders. We discussed specific cases with the provider who took appropriate action. The provider should ensure the powers to consent to the use of restraint and restrictive practice have been granted. These were usually in place. However, we identified some gaps. We were reassured when the provider took immediate, appropriate action in response.

Health based and person-specific risks to people were identified and mitigated. We discussed the importance of developing a positive risk-taking approach. This was needed to enable further reductions in the use of restraint and restrictive practice. For example, people used plastic cutlery and crockery. This was

to reduce the risk of harm or self-harm to people. However, this was an example of blanket restrictions which should be person-centred and used as a last resort. The provider agreed and started to prepare to safely change this practice.

People's relatives and representatives told us they mostly felt involved and informed. There were concerns that they were not always informed of the outcome of health appointments. Generally, representatives felt communication could be improved. They also identified that staff needed more guidance to ensure care and support was consistent. This was to provide structure and routine for people and enable people to have more control over their care and support.

How good is our leadership? 4 - Good

We evaluated this key question as good. Several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

Staff told us the service had improved since the registered manager was appointed. This was further supported by ongoing support from the regional operations manager. Staff said there was a clear improvement plan for the service. They felt more positive about the future.

The management team consisted of nursing staff, the registered manager, deputy manager and team leaders. Staff said there was always a senior member of staff if they needed guidance or support. The manager was visible in different areas of the home at various points throughout the day. This provided opportunities to build relationships with people using the service, and staff.

The deputy manager had formed warm and positive relationships with people using the service. People sought out the deputy for support or a chat. We observed the reassurance their support provided for people. This was facilitated by the provision of compassionate and appropriate physical comfort. Staff told us they felt supported and valued.

People's relatives and representatives had more contact with team leaders and senior support workers. Generally feedback was positive but communication needed to improve to ensure they were kept fully up to date. Professionals experienced a leadership team that was open to suggestions and new ideas. Referrals were appropriate and made at the right time. Guidance and support and suggestions were taken on board and implemented. We experienced a leadership team who were striving to improve people's outcomes and experiences. They welcomed feedback and suggestions for improving practice. Our suggestions were considered, and practice changes were planned, where appropriate. This was an example of a learning and improvement culture. This was demonstrated when we asked the provider to review their incident and accident reports. These did not identify or implement measures to reduce the risk of similar incidents reoccurring. This feedback was shared with the provider's senior leadership team and who agreed they would be reviewed.

The provider's quality assurance system consisted of a range of audits and checks which were carried out regularly. These monitored and reviewed people's clinical needs and risks, health and safety processes and care plan audits. The use of physical intervention was monitored and analysed monthly. Trends and patterns were identified and areas for improvement were addressed. Kitchen, maintenance and housekeeping audits reduced the risk of harm to people using the service. The quality assurance system was being reviewed to ensure it reflected the service provided at Orchard Court and Dalguise.

We were assured that the registered manager and the wider leadership team had appropriate oversight of the service. Key risks in the service were identified and mitigated. This was reflected in the service improvement plan which was kept up to date. This was further demonstrated by detailed shift handover processes. Daily short meetings with heads of departments and regular governance meetings took place. Relevant charts and documents were taken to meetings to review and plan any actions necessary. For example, bowel movement recording charts were reviewed to ensure any concerns about constipation were addressed. This ensured people's health, safety, and wellbeing. Action plans were developed to address areas for improvement identified in audits. Whilst we were satisfied that appropriate action had been taken, action plan records were not fully completed. The provider agreed to improve record keeping.

The provider used a range of approaches to gather feedback about people and/or their representative's experience of the service. Residents' meetings took place regularly. They were attended by most people living in the house. Meetings focused mainly on the environment and relationships and what improvements could be made. People could ask for additional meetings if they had any concerns. People were involved in choosing furnishings and décor in their environment. This was important to people as it helped them feel more at home. However, people were often frustrated at the time it could take to get new furniture or decoration carried out.

Relatives and representatives' meetings were arranged on a regular basis, but these were not well attended. The provider should contact relatives and representatives regularly. Contacting people individually may improve engagement and enable feedback about the service to be gathered. Monthly newsletters were sent to people's relatives and representatives. This kept them informed of events, plans, and developments at the home. People using the service should be involved in deciding upon the content of newsletters and putting these together.

Service satisfaction surveys were distributed to people and their representatives annually. There was little response to the surveys. The provider should try to identify reasons for the lack of engagement and try new and alternative approaches.

People should have regular opportunities to review their service and identify areas for improvement. Service improvement cannot take place if people themselves, or their representatives, are not fully involved. People using the service communicated in a wide range of ways. We noted the activities team used a communication tool, Talking Mats. This enabled people to make choices and provide feedback about activities. The provider should use this tool to support people to identify areas for improvement in their services, as appropriate. This would increase people's self-confidence, self-esteem and ensure people's rights were upheld.

How good is our staff team? 4 - Good

We evaluated this key question as good. Several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

The Health and Care (Staffing) (Scotland) Act 2019 was enacted on 1 April 2024. The legislation placed a duty on social care service providers to make appropriate staffing arrangements. This was to ensure the health, welfare and safety of people using services. This included ensuring, at all times, appropriate levels of staff. Staff must also have the required qualifications and training to provide safe, high-quality care. Service providers must support staff wellbeing to ensure people's care and support is not adversely affected.

The provider's bespoke staffing levels assessment tool was used to determine the number of staff required on each shift. This was to ensure people's health, safety and wellbeing. The assessments were based upon people's individual needs and identified both nursing and support staff required. We reviewed monthly monitoring records which indicated consistently positive levels of staffing.

People living in Orchard Court and Dalguise were supported by a consistent staff team. Staff usually worked predominantly in one house but could provide support across the service if this was needed. Allocation sheets were developed for each shift. These were used to allocate individual tasks to staff members. This included the people they would be supporting, and domestic duties. The tool improved people's safety, wellbeing and outcomes as it enabled accountability, consistency and predictability for people using the service.

The provider did not have a formal process to assess and plan the optimum staff skill mix on shifts. However, they identified the factors they considered when planning the rota. This included staff skills, knowledge, experience, abilities and training they had undertaken. The relationships staff had with people using the service and each other were also considered. People's preferences for the gender of their staff were respected wherever possible. We were satisfied that appropriate methods were used to ensure people's health, safety and wellbeing. We asked the provider to develop guidance for staff responsible for rotas to provide consistency and continuity.

Staff's wellbeing was paramount to the provider. Wellbeing support was provided by an external counselling service. Internally, a wellbeing support worker was available within the service. Staff had regular supervision with their line manager which provided opportunities to discuss any aspects of their wellbeing. Staff told us the members of the leadership team were approachable and supportive. They felt confident to seek support with wellbeing and did not have to wait for their planned supervision. Recruitment could be challenging, as is the case across the social care sector. The staff team was currently stable. There were very few vacant posts, and new recruits were almost ready to take up their posts. The induction process had been reviewed and now included attending a three-day induction at the provider's headquarters. This helped staff feel part of a larger organisation and reduced the risk of staff feeling isolated in services. These measures could reduce staff turnover.

A range of learning and development opportunities were available for staff in a variety of formats including online and face-to-face. These addressed mandatory and person specific needs-led training. We identified some gaps in staff learning and development including personality disorder and using visual supports. This training was needed to support the needs of people currently using the service. The provider should carry out a training needs analysis on a regular basis. This is to ensure staff have the knowledge, skills and abilities to meet the full range of people's needs. This should be completed as a priority. (See area for improvement 1).

The manager and deputy manager had oversight of staff's completion of the required learning and development.

Onsite trainers were available to provide training, which included moving and assisting, infection prevention and control (IPC) and dignity in care. They worked alongside staff when they needed more support. Positive behaviour support training was delivered over four days and was refreshed annually. This meant staff practice reflected current best practice. Staff practice and understanding was assessed throughout the course before they were confirmed as competent. Practice observations were also carried out to confirm staff could transfer their learning into practice in person-centred ways. The provider should continue to develop tools and systems to evaluate staff ability to put learning into practice.

Areas for improvement

1. In order that staff can meet the full range of people's care and support needs, the provider should carry out training needs analysis regularly, deliver relevant training and evaluate staff ability to put their learning into practice.

This is to ensure care and support is consistent with the Health and Social Care Standards which state that: "I have confidence in people because they are trained, competent, skilled, are able to reflect on their practice and follow their professional and organisational codes".
(HSCS 3.14).

How good is our setting? 4 - Good

We evaluated this key question as good. Several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

We found the environment in Orchard Court was generally clean. People were supported to keep their bedrooms clean where this was needed. People's standards and preferences were respected as much as possible. People's bedrooms reflected their preferences and choices and reflected their personalities. This ensured people felt at home and in control of their private space.

Communal areas in Orchard Court were very sparsely furnished. There was a lack of homely touches, welcoming décor, or soft furnishings. The complex needs of some people living in Orchard Court could lead to the destruction of furniture and equipment. However, we were concerned that people would not feel at home or have any sense of belonging in this environment. Dining tables and chairs were delivered during the inspection. The furniture was sourced from a provider of strong and robust furniture that would be more difficult to damage. We heard new sofas were on order. People were looking forward to these being delivered. The environment should be improved to reflect people's wishes, choices, and preferences.

Gardens in both Orchard Court and Dalguise were accessed from the lounge via patio doors. We noted the lack of comfortable and attractive garden furniture. There were no flowers, plants or areas where vegetables could be grown. The garden could provide opportunities to enjoy the fresh air and interest gardeners or potential gardeners. However, people using the service only used the garden to smoke or vape. We acknowledged that the weather was cold and wet at times during the inspection. This could have had an impact on people's use of their gardens.

The environment in Dalguise was much more homely and cosy with soft furnishings and curtains. People told us they enjoyed spending time in the lounge. Dalguise had a separate dining room. People could eat their meals at a table in the lounge or in their bedrooms. However, most people preferred to use the dining room which was pleasant and welcoming.

The environment was clean, fresh, and tidy. People were supported to participate in maintaining the environment. We noted an odour in one person's bedroom and there were no curtains or blinds in another person's bedroom. These issues put people's privacy, dignity, and comfort at risk. We raised this issue with the manager who took prompt action to address the concerns.

Service user meetings took place on a regular basis. This provided a forum for feedback about the environment. People were involved in choosing furnishings and décor in their environment. People often felt

frustrated with the length of time improvements took to implement.

A dedicated maintenance team was responsible for repairs and maintenance in the home. They were also responsible for carrying out health and safety audits and checks. Maintenance staff described positive change since the appointment of the registered manager. Maintenance, repairs and quality assurance processes were more organised and had a clearer direction. They welcomed the printed schedules of work that were now used.

All utility system checks such as gas, electricity and water were in order and up to date. The environmental walk around carried out by maintenance staff was comprehensive. This looked at all areas of the environment and sought feedback from people using the service, and visitors. Staff were also asked to provide feedback about their experience of the environment. IPC audits were carried out by housekeeping staff to reduce the risk and spread of infection. Monthly health and safety meetings took place with members of the leadership team. These measures ensured the health, safety and wellbeing of people using the service, visitors and staff.

How well is our care and support planned? 4 - Good

We evaluated this key question as good. Several strengths impacted positively on outcomes for people and clearly outweighed areas for improvement.

People's personal plans were person-centred and strengths based. Personal plans presented a very positive picture of people, their abilities, strengths and needs. People and their representatives should be involved in developing and reviewing their personal plans. People were currently not involved in the personal planning process. These were developed in an electronic format which people and their representatives could not access. However, work had begun to develop paper copies of personal plans. People using the service were involved in the review process. They were able to decide what information they wished their personal plans to contain. They may not want a copy of the entire personal plan but prefer specific sections. This may encourage people's engagement. The provider should develop opportunities for people's representatives to access their personal plans.

Individual care plans were developed to support people's assessed needs. These focused on the things people could do rather than what they could not do. This approach maintained and increased people's independence, skills and abilities in areas such as using public transport. This was good preparation for people wishing to move to less supported services.

Some care plans needed more detail and information to ensure people received consistent, safe and effective care and support. This included, for example, positive behaviour support plans. We suggested the provider should review these plans to ensure guidance for staff was clear and directive. This was particularly important where people experienced stress or distress and could potentially put themselves or others at risk.

Care plans were reviewed monthly. The provider should ensure reviews provide evidence of evaluation of the care plans to include what was and was not working and areas for improvement. Feedback from the person and/or their representatives should also be included.

The provider had developed a log of the restraint and restrictions people were subject to. We asked that people have individual restraint logs with regular reviews carried out. Restrictions should be in place for as

short a time as possible. Restraint reduction plans should be developed to build people's coping strategies and reduce and eliminate restrictions where possible. The provider should develop a positive risk-taking approach to enable people to develop the necessary skills, abilities, confidence and self-belief.

Staff in the activities team were using Talking Mats. This was a communication tool used to enable people to make choices and decisions. The provider should ensure person-specific communication tools, such as social stories, are used to increase people's knowledge, understanding and control of their support.

People's care and support packages were reviewed at least six monthly and more regularly in response to changing needs. Relevant professionals were invited to attend along with people's representatives. This ensured people's care and support continued to reflect their current needs and abilities.

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?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement is led well	4 - Good

How good is our staff team?	4 - Good
3.3 Staffing arrangements are right and staff work well together	4 - Good

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

How well is our care and support planned?	4 - Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	4 - Good

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