Lomond View Care Home
Care Home Service

Lomond View Care Home
Falkland
Cupar
KY15 7AR

Telephone: 01337 857 521

Type of inspection:
Unannounced

Completed on:
18 November 2025

Service provided by:
Holmes Care Group Scotland Ltd

Service provider number:
SP2020013480

Service no:
CS2023000108

About the service

Lomond View Care Home is a well established care home for people over the age of 65, situated in the residential area of Falkland, Fife. It is close to local transport links, shops and community services.

Each floor has its own communal sitting and dining areas and a passenger lift. Bedrooms are all ample size and have en-suite toilet and shower facilities. The home benefits from well kept, landscaped surrounding garden areas, with garden seating available for residents' use.

The service is provided by Holmes Care Group Scotland Ltd.

About the inspection

This was an unannounced, follow up inspection which took place on 17 November 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 eight staff and management
- observed practice and daily life
- reviewed documents.

Key messages

We saw improvement to overall clinical care and oversight.

Systems to share information about people's needs had improved.

The staff team continue to know people's needs well.

Quality assurance and audit systems were consistently being carried out and had been effective in supporting improvement.

How people's voices and views are gathered needs further improvement.

How the service reviews people's needs and outcomes could be improved by a more collaborative approach.

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

There were two outstanding requirements relating to this key question. We were satisfied that these had been met. Details can be found in section 'what the service has done to meet any requirements made at or since our last inspection' of this report. The improvements made had a positive impact on outcomes and experiences for people. To reflect these improvements, we have regraded the quality indicators awarded at the previous inspection to 'adequate'.

How good is our leadership? 3 - Adequate

There were two outstanding requirements relating to this key question. We were satisfied that these had been met. Details can be found in section 'what the service has done to meet any requirements made at or since our last inspection' of this report. The improvements made had a positive impact on outcomes and experiences for people. To reflect these improvements, we have regraded the quality indicators awarded at the previous inspection to 'adequate'.

The needs, outcomes and wishes of people living in the service should be the primary drivers for change. We saw some missed opportunities for people's voices to be captured as part of ongoing quality assurance audits. Improving practice in this area would give people a voice in directing their care and ensure that the support given is effective. Area for improvement 1 applies.

The leaders of the service had been successful in driving the quality of clinical care and support in Lomond View. Further work would be beneficial around ensuring that the systems in place to gather, share and review people's health and wellbeing needs are holistic, outcome focussed and clearly record any actions needed. Area for improvement 1 applies.

Areas for improvement

1. To support a culture of responsive and outcome focussed practice, the service should, at a minimum:

a) gather people's views, suggestions, and choices on a regular basis to monitor practice and inform improvement planning.

b) carry out regular collaborative reviews to ensure the best possible outcomes for people, as their needs change.

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

'I am supported to give regular feedback on how I experience my care and support and the organisation uses learning from this to improve' (HSCS 4.8) and 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

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

Requirements

Requirement 1

By 4 November 2025, you must protect the health and welfare of people by ensuring that pain is proactively managed and without delay. To do this, the provider must, at a minimum:

a) develop, implement and regularly review pain assessment tools to ensure signs that people who are in pain are identified and their pain is addressed timeously.

b) ensure that 'as required' protocols and regular treatments consider all cases where pain can be reasonable assumed.

This is in order to comply with Regulations 3, 4,(1)(a) (welfare of users), 5(1), 5(2)(a), 5, (2)(b)(personal plans) and 9, (2)(b) (fitness of employees) 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 based on relevant evidence, guidance and best practice' (HSCS 4.11).

This requirement was made on 3 September 2025.

Action taken on previous requirement

Action had been taken by the service to upskill its staff team on the signs, symptoms, and management of people's pain. We saw regular use of pain assessment tools, where appropriate, to inform proactive management of pain. The leadership team had sought GP input to review management of people's pain, including situations where pain could reasonably be assumed to be a result of other medical conditions, for example pressure wounds. Discussions had also taken place to ensure that pain medications were being administered at the appropriate times, such as prior to any personal care being given. This supports care that is responsive and promotes people's wellbeing.

Supporting care plans and protocols were in place, and people's individual experiences of pain recorded. Care records showed that when people had complained of pain, treatment had been given without delay. We saw good attention to keeping people comfortable and pain free as part of palliative or end of life care. We were assured that the service had improved its attention to pain management and was following best practice guidance.

Met - within timescales

Requirement 2

By 4 November 2025, the provider must ensure that people's health, welfare, and safety needs are met by robust practice that follows best practice guidance. To do this, the provider must, at a minimum:

a) ensure the management team use regular clinical monitoring systems to ensure the care and treatment being provided is in line with people's needs.

b) ensure accurate recording of key information including wound care review and treatment, care handover records and 'as required' medication protocols.

This is in order to comply with Regulations 3, 4,(1)(a) (welfare of users), 5(1), 5(2)(a), 5, (2)(b)(personal plans) and 9, (2)(b) (fitness of employees) 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: '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) and 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

This requirement was made on 3 September 2025.

Action taken on previous requirement

We saw significant improvement to the overall clinical care and oversight being carried out within the service. We saw a series of daily monitoring systems in place to capture people's acute care needs, including any wound care, infections or concerns around food or fluid intake. The senior care team and care staff continued to show a good knowledge of people's needs. Although some relatives expressed concerns that certain agency staff were unfamiliar with their loved ones' needs, they consistently reported being able to approach permanent staff who were knowledgeable and dependable. This helps to ensure that people's needs are met by people that know them well.

Wound care and treatment records were robust and being completed in line with people's individual wound care plans. This included better use of photography to monitor wound progression. Plans made clear reference to pain management and we saw associated medication protocols were in place, where needed. Clinical oversight of wounds had increased, with daily checks being carried out by the management team to ensure treatment had been given.

The service had implemented a '24-hour care summary' and the care staff told us this had been a helpful resource, improving communication between teams. Staff consistently did not use parts of the '24-hour care summary', including follow-up actions needed to resolve concerns. A daily 'flash' meeting was also still being used to handover essential information. We spoke with the service about how they can better use their information-sharing systems to involve all key staff in daily assessments of need and ensure resources are used more effectively.

We saw some minor gaps in the consistency of resident monthly reviews. Where reviews had been carried out, the content of these had improved and were reflective of that person's experiences of the month, for example, falls, weight loss, mood, and medication. The service was in the initial stages of implementing a new 'resident of the day' review format. We asked the service to consider how they can utilise these formats to ensure that a holistic and consistent assessment of people's changing needs is carried out and that this then directly informs the care and support being given. Area for improvement in section 'How good is our leadership?' applies.

Met - within timescales

Requirement 3

By 4 November 2025, you must ensure that quality assurance systems are being utilised to ensure that the health, safety, and well-being needs of people receiving care are met, and they experience positive outcomes. To do this, the provider must at a minimum:

a) Ensure appropriate and effective leadership of the service.

b) Implement accurate and up-to-date audits for monitoring and checking the quality of the service are in place and ensure that any areas for improvement identified are addressed without delay.

c) Ensure effective clinical oversight is in place to monitor people's health care needs and ensure that the right care and treatment is in place, at the right times.

d) Include feedback from all stakeholders as part of these assurance systems to measure improvement.

This is in order to comply with Regulation 4(1)(a), Regulation 10(2)(a), Regulation 10(2)(b) and Regulation 10(2)(d) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and Sections (7) and (8) of the Health and Care (Staffing) (Scotland) Act 2019.

This requirement was made on 3 September 2025.

Action taken on previous requirement

We saw consistent oversight was in place by the leadership team in Lomond View. Daily manager checks monitored practice and helped to sustain improvement. The leadership team had a good understanding of what was required to drive further improvement and enhance the experiences of the people living in the service. The care staff told us that the manager was approachable, supportive, and had addressed concerns. This promotes an open and honest culture.

Regular audits were being carried out to monitor practice and people's experiences. We saw that focus had been given to key areas for improvement, including effectiveness of clinical care. Attention had also been given to upskilling care staff through training and reflective practice. This follow-up inspection found that significant improvement had been made across all areas of quality assurance, clinical care, and support.

We found limited resident or wider stakeholder input in quality assurance. Although the service held meetings with residents and relatives to gather feedback, attendance was low. The service should seek other ways to consistently gather feedback from people, in ways that are meaningful. This means improvements are shaped by what people need and want. Area for improvement in section 'how good is our leadership?' applies.

Met - within timescales

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 allow for concerns to be addressed, by the right people and without delay, the provider should ensure that staff, visitors, and people living in the service have clear and easily accessible contact information about the leadership team at all levels within the provider group.

This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS), which state that: 'My human rights are central to the organisations that support and care for me' (HSCS 4.1) and '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 3 September 2025.

Action taken since then

Information about the provider, along with contact details, was now accessible from the visitor's entrance of the home. This included information for residents, relatives, and staff on how and to whom, to escalate concerns within the organisation.

Correspondence had been shared with relatives and other stakeholders about the changes to the management arrangements within Lomond View and contact information.

This area for improvement is MET.

Previous area for improvement 2

Support staff should have regular opportunities to give feedback and discuss their learning and development needs. The provider should, at a minimum, use supervision, team meetings, and observations of practice to promote a culture of continuous feedback, development, and support.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states 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) 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 3 September 2025.

Action taken since then

We saw various examples of where learning and development opportunities had been provided to the staff team. This included training and workbooks around pain management and pressure care. The care staff told us that the flash meetings were a useful forum to come together as a team to share information.

The management team evidenced using regular 'mealtime experience' observations to review staff practice.

We saw a lack of progress around supporting staff with regular supervision, team meetings, and individual observations of practice. The service was aware of the progress needed in this area.

This area for improvement is NOT MET.

Previous area for improvement 3

The provider should ensure that people's views, suggestions, and choices are gathered on a regular basis and used to inform any changes, adaptations, or improvements made to the environment.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state that: 'If I live in a care home, I can decide on the decoration, furnishing and layout of my bedroom, including bringing my own furniture and fittings where possible' (HSCS 5.13) and 'I can use an appropriate mix of private and communal areas, including accessible outdoor space, because the premises have been designed or adapted for high quality care and support' (HSCS 5.1).

This area for improvement was made on 3 September 2025.

Action taken since then

We found a lack of progress in this area for improvement. The service should consider ways in which it gathers people's views, wishes and experiences on a regular basis as part of quality assurance checks and changes happening in the service.

This area for improvement is NOT MET.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate

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

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