Kintyre Care Centre
Care Home Service

Shore Street
Campbeltown
PA28 6BT

Telephone: 01586 553615

Type of inspection:
Unannounced

Completed on:
23 October 2025

Service provided by:
Argyll and Bute Council

Service provider number:
SP2003003373

Service no:
CS2023000081

About the service

Kintyre Care Centre is a care home service that provides nursing care for 38 older people, including people living with dementia. The provider is Argyll and Bute Council.

The service is based in Campbeltown, close to shops and local amenities. There are car parking spaces available next to the home.

People have access to a communal lounge and dining facilities on each of the two floors of the home. The accommodation offers single bedrooms with ensuite toilet facilities. Shared bathrooms and shower rooms are available on each floor. There is an enclosed patio area which people can access through the lounge area on the ground floor. There is lift access to the upper floor.

There were 34 people living in Kintyre Care Centre at the time of the inspection.

About the inspection

This was an unannounced follow-up inspection which took place on 21 , 22, and 23 October 2025 between the hours of 09:00 and 18:00. The inspection was carried out by one inspector from the Care Inspectorate.

The inspection focused on the requirements and areas for improvement made during the previous inspection, which took place on 17 April 2025. We evaluated how the service had addressed these to improve outcomes for people. During this follow-up inspection, we increased the evaluation for quality indicator 5.1 to good because the service had made progress by building on key strengths.

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 informally with six people using the service and three of their family.
- Spoke with nine staff and management.
- Observed practice and daily life.
- Reviewed documents.
- Spoke with one visiting professional.

Key messages

We followed up seven requirements and one area for improvement from the last inspection. Improvement was found in six requirements. Further improvement is required to ensure people have positive experiences and outcomes. We made two new requirements and two new areas for improvement.

Improvements had been made to the home décor but several environmental improvements are still outstanding.

Staff had access to a wide range of training but leadership oversight needed to improve, to ensure all staff had completed key learning for their roles.

Leaders had access to improved guidance documents to help promote best practice.

A new nurse call system and fire alarm system had been installed which impacted positively on people's safety and comfort.

Day to day maintenance of the environment was not sufficient, to ensure the building was being maintained to a safe standard.

People's personal plans had been reviewed and reflected their needs, preferences and outcomes.

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
How good is our setting?	2 - Weak
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 good is our leadership? 3 - Adequate

The service had made improvements in this area to meet the requirements made at previous inspections. (see 'What the service has done to meet any requirements we made at or since the last inspection').

The provider was in the process of producing guidance protocols that were suitable for the service type. We reviewed these during inspection. We asked the provider to continue to develop these protocols to ensure these were robust and clear enough to support best practice. (See area for improvement 1).

Areas for improvement

1. To ensure people benefit from a service that is well-led, the provider should develop clear operating procedures for leaders and staff to follow. This should include, but not be limited to, guidance for medication practice, guidance for quality assurance, and guidance for maintenance of the environment.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11).

How good is our staff team? 3 - Adequate

The service had made improvements in this area to meet the requirements made at previous inspections. (see 'What the service has done to meet any requirements we made at or since the last inspection'). While we found improvements in staff supervision, observations of staff practice, and the availability of training, oversight of training compliance was not sufficient to assure us that all staff had the right training and development to keep people safe. (See requirement 1).

Requirements

1. By 31 March 2026, the provider must ensure that people experience a service with suitably trained staff. To do this, the provider must:

a) Develop a comprehensive list of mandatory and additional training for each role.
b) Ensure all staff have completed induction and training relevant to their role.
c) Maintain a record of all staff training, which clearly outlines the training staff have completed and when refresher training is due.

This is to comply with section (8) of the Health and Care (Staffing)(Scotland) Act 2019 (HCSSA).

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

How good is our setting? 2 - Weak

The provider had made some improvements to meet requirements made at previous inspections. (see 'What the service has done to meet any requirements we made at or since the last inspection'). Further improvements are required, to ensure people experience an environment that is safe and well-maintained.

Repairs and upgrades to the environment remain outstanding. The provider had been faced with significant financial outlays over the last 18 months, including replacement of the nurse call system and replacement of the fire alarm system. This had impacted on progress with completing environmental improvements, agreed at the time of registration of the service. A previous requirement relating to these improvements was partially met. We asked the provider to review the environmental improvement plan, and provide a realistic timescale for completion of these improvements. This is necessary to ensure the comfort and safety of people using the service. (See requirement 1).

A range of decorative improvements were underway at the time of inspection, including redecoration of corridors and lounges, redecoration of vacant rooms and the creation of a new café area on the upper floor. There were plans for further improvements to the environment.
We suggested that an ongoing environmental audit should be produced, to enable leaders to easily track progress with these improvements and share this with residents and their representatives. (See area for improvement 1).

Requirements

1. By 31 October 2026, to ensure the safety and comfort of people, the provider must complete the outstanding actions from the agreed environmental plan that is part of the conditions of registration.

This is to comply with Regulation 10. (Fitness of premises) 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: 'The premises have been adapted, equipped and furnished to meet my needs and wishes' (HSCS 5.18).

Areas for improvement

1. To ensure people benefit from a homely setting that is clean, safe, and comfortable, the provider should undertake an audit of the environmental improvements that have been completed. The provider should use this to identify and prioritise future environmental improvements which should be set out in an improvement plan. This should be shared with people and their representatives.

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

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

The service had made improvements in this area to meet the requirement made at the previous inspection. (see 'What the service has done to meet any requirements we made at or since the last inspection'). We have therefore re-evaluated this area from adequate to good.

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

Requirements

Requirement 1

By 31 March 2024, the provider must ensure that people experience a service with well trained and informed staff.

This must include, but not be limited to:

a) Ensuring all staff receive induction and training relevant to their role; including dementia care, communication, restraint and restrictive practice, medication and stress and distress training;

b) Regular quality assurance checks, to demonstrate how the training received is being implemented in practice throughout the care service;

c) Regular monitoring of staff practice to provide assurance, that staff practice is consistent with current good practice guidance; and

d) Regular staff supervision, to ensure staff learning and development needs are reviewed and addressed.

This is in order to comply with Regulations 9, (2)(b) (fitness of employees) and 15, (b)(i)(staffing), of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

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

'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 requirement was made on 10 January 2024.

Action taken on previous requirement

This requirement was made in January 2024 and was not met at the time of inspection in July 2024. At the inspection in July 2025, we agreed a further extension.

A range of training had been made available to the service since the previous inspection. This included training in Adult Support and Protection (ASP), falls prevention, wound care and moving and handling. We sampled training records provided by the manager and saw that some staff had completed this training.

A new training spreadsheet was in place which contained clear information about the courses available to staff and how to access them. Observations of staff practice had been implemented, including observations of staff supporting residents with their meals, personal care and general interactions. Responsibility for completing practice observations was shared by the leadership team and a staff member who had completed additional training in this area. Medication competency was also being assessed as part of regular medication audits. The manager was in the process of developing a new competency framework to enhance this. Staff supervision paperwork had been reviewed to make it more meaningful and applicable to the service. Supervision was planned at six-monthly intervals, with department heads responsible for undertaking supervision with their own staff teams. The manager had identified funding opportunities for staff to complete their Scottish Vocational Qualifications (SVQ), and was in the process of prioritising the staff who needed to complete this qualification to meet their registration requirements.

While the new training spreadsheet had been implemented in the service, we found that this did not enable leaders to easily identify who had completed their mandatory training and when. We were unable to confirm that all staff had completed important training such as, moving and handling training which must be regularly updated to ensure staff are practicing safely. The manager of the service took action during the inspection to arrange this training. While we observed good practices in relation to supporting people to eat and drink safely, with good quality guidance being available to all staff, we were unable to confirm that staff had completed mandatory training in relation to swallowing and choking risks. There had been an issue with staff accessing 'Promoting Excellence in Dementia Care' training. The manager was designing a training workshop to ensure all staff had an opportunity to complete this training. This training has not been completed for several years by the staff team, which means staff may not fully understand how to support people living with dementia.

We found that there was a positive attitude to training in the service. Leaders were keen for staff to have opportunities to attend training relevant to their roles, and staff understood the importance of keeping their skills and knowledge up to date. Recording and tracking of training still needed to improve and it is essential that there is clarity about the core training required for each role. Managers should have clear information about which staff members have completed training and when this needs to be refreshed. This is important to ensure staff have the right skills and knowledge to care for people safely.

Parts B, C, and D of this requirement were met. We could see that the service had made progress with improving the training and supervision opportunities available to staff. It is essential that leaders can easily track staff training to keep people safe. We have therefore made a new requirement relating to staff training under quality indicator 3.2 (Staff have the right knowledge, competence and development to care for and support people).

Met - outwith timescales

Requirement 2

By 31 March 2024, the provider must operate within their registration conditions and meet the registration environmental improvement plan that is outstanding.

This must include, but not be limited to:

a) Have 38 residents as a maximum number, and use the specified numbered rooms 17 and 37 only for short-term respite stays; and

b) Complete outstanding actions from the agreed environmental plan, that is part of the

conditions of registration.

This is to comply with Regulation 14. (d) (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 care and support is consistent with the Health and Social Care Standards (HSCS) which states:

'The premises have been adapted, equipped and furnished to meet my needs and wishes' (HSCS 5.18).

This requirement was made on 10 January 2024.

Action taken on previous requirement

This requirement was made in January 2024 and was not met at the time of inspection in July 2024. We previously agreed an extension to this requirement based on an updated action plan from the provider.

The service had already re-purposed rooms 17 and 37 for short-term stays. The service now accommodates a maximum of 38 residents.

A number of environmental improvements had taken place, including replacement of some windows in the home. The manager of the service was maintaining and updating the action plan regularly with support from the provider.

The building was wind and watertight. There were a number of ongoing maintenance issues which were being addressed by the provider.

The provider had been faced with significant financial outlays over the past 18 months, including the full replacement of the nurse call and fire safety systems in the service. This had impacted on the ability of the provider to complete elements of the environmental action plan.

Part A of this requirement was met. The actions agreed in the environmental improvement plan (Part B) had not been fully completed. We have therefore made a new requirement under quality indicator 4.1 (People benefit from high quality facilities). We asked the provider to review the environmental improvement plan and to provide a realistic timescale for completion of the outstanding improvements.

Met - outwith timescales

Requirement 3

By 31 March 2025, the provider must ensure adequate governance of the service.

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

a) Ensure policies and procedures are in place which are appropriate for the service type. This includes, but should not be limited to, an appropriate medication policy and maintenance policy. Policies should be regularly reviewed and updated as required;

b) Ensure a process is in place for clinical supervision of the manager of the service;

c) Ensure a clear process is in place for oversight of local quality assurance processes; and

d) Ensure the manager of the service is included in governance procedures and informed of the outcome of external audits or reports.

This is to comply with Regulation 3 (Principles) 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 states:

'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 4 September 2024.

Action taken on previous requirement

Clinical supervision of the home manager had been assigned to the lead nurse for the provider. Quality assurance audits continued to be completed effectively by the manager and a new quality assurance guidance document had been produced by the provider. Senior leaders in the provider organisation were responsible for oversight of quality assurance and providing guidance to the service.

There was no medication policy for the service but the provider had produced an updated guidance document which outlined key responsibilities, training expectations and links to best practice guidance. The provider is in the process of producing a comprehensive medication policy and we were able to review a draft of this policy. We were confident that safe medication processes were in place in the service with sufficient oversight by external professionals, including the Health and Social Care Partnership (HSCP) pharmacist. Regular medication audits were taking place and there were no identified issues with medication practice which were impacting people's safety or wellbeing.

The provider shared a copy of their maintenance policy which outlined responsibilities and escalation protocols, relating to the upkeep and safety of the building.

The provider should continue to develop local operating procedures to ensure sufficient oversight of key areas of practice, including maintenance checks. We have made a new area for improvement under quality indicator 2.2 (Quality assurance and improvement is led well) to ensure these procedures are developed.

Met - outwith timescales

Requirement 4

By 30 November 2024, the provider must ensure that the environment is safe and free from offensive odours.

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

a) Undertake an environmental audit to identify where improvements are required in the environment;

b) Produce an environmental action plan based on SMART principles (Specific, Measurable, Achievable, Realistic, and Time-based) that identifies the actions to be taken to improve the environment;

c) Take action to eliminate the odour in the Davaar unit;

d) Take action to eliminate the risk from electric heaters in communal shower rooms;

e) Ensure people who use the service and their representatives have been consulted about environmental improvements and include their views in the action plan; and

f) Ensure timescales for improvements are communicated with people using the service and their representatives.

This is to comply with Regulation 10(2)(d) (Fitness of Premises) 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 states:

'My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells' (HSCS 5.20).

This requirement was made on 25 July 2024.

Action taken on previous requirement

There were no unpleasant odours in the Davaar Unit or throughout the home. Carpets had been replaced with vinyl flooring in several areas which had improved the appearance and cleanliness of the environment. Heaters in the shared shower rooms had been replaced.

The service has an environmental action plan which is regularly updated and displayed with the registration certificate. A range of improvements were underway at the time of inspection, including redecoration of corridors and lounges, redecoration of vacant rooms and creation of a new cafe area on the upper floor. This will provide additional small-group living spaces for residents and families.

The manager of the service had a clear plan for ongoing environmental upgrades. We suggested that an ongoing environmental audit should be produced, to enable leaders to easily track progress with these improvements and share this with residents and their representatives.

We have made a new area for improvement under quality indicator 4.1 (People benefit from high quality facilities), to ensure the environmental audit and action plan continues to progress.

Met - outwith timescales

Requirement 5

By 28 July 2025, the provider must ensure there are adequate systems in place to keep people safe.

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

a) Provide a clear action plan and timescale for a safe and effective replacement for the nurse call system;
b) Provide a clear action plan and timescale for the repair of the internal and external fire doors;
c) Ensure that the temporary assistive technology used to mitigate the failure of these systems is suitable for people's needs and based on clear and regularly updated risk assessment;
d) Ensure adequate staffing numbers so that people get a timely response when their nurse call or alarm is activated; and
e) Ensure staff have a safe means of accessing support from colleagues while the nurse call system is out of service.

This is to comply with Regulation 10(1) and 10(2)(b) (Fitness of Premises) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

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

'My environment is secure and safe' (HSCS 5.19).

This requirement was made on 17 April 2025.

Action taken on previous requirement

A new nurse call system had been installed which was fully operational. The new nurse call system allowed for monitoring of response times. We reviewed response times over the past few months and could see that these were generally quick which provided assurance in relation to availability of staff and responsiveness. All staff had undertaken training in operation of the new nurse call system. The new system allowed for a door alarm on every room which could be used depending on the assessed needs of the person in each room. This provided an additional safety measure for those who needed it.

A new fire alarm system had been installed in the service. All doors were operating safely and releasing on activation of the alarm. The fire alarm system was linked to a central alarm monitoring system, which ensured any errors or activations would be followed up quickly. Key staff had undertaken training in the operation of the fire system and all staff had been involved in fire drills, to ensure knowledge of the action to be taken if the fire alarm activates.

Met - within timescales

Requirement 6

By 28 July 2025, to keep people safe, the provider must ensure there are adequate systems in place for maintenance of the environment.

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

a) Ensure that daily, weekly, and monthly maintenance tasks are clearly outlined and based on up-to-date best practice guidance;
b) Ensure there is a clear policy or protocol for staff to follow when completing maintenance tasks. This should include clear guidance on recording and when to highlight and escalate concerns;
c) Ensure adequate oversight of maintenance tasks to identify priority areas for follow-up. Follow-up actions should be recorded with clear timescales for completion; and
d) Ensure sufficient staffing in the service to complete the identified maintenance tasks in line with organisational requirements.

This is to comply with Regulation 10(1) and 10(2)(b) (Fitness of Premises) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

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

'My environment is secure and safe'. (HSCS 5.19)

This requirement was made on 17 April 2025.

Action taken on previous requirement

The provider shared the organisation's buildings maintenance policy. This outlined levels of responsibility and escalation processes when repairs and upgrades are required.

The provider had also produced a new guidance document to support the service with implementing safe maintenance checks and quality assurance processes for maintenance. Some maintenance checks were taking place, including water temperature checks, water run-off, and fire door safety checks. Where issues had been identified, these had been followed up and rectified. Fire drills were being completed regularly and records showed that these had been well managed, with all staff, including night staff attending a fire drill in the last 6 months. External contractors were in place for key maintenance tasks such as electrical safety, fire alarm maintenance, LOLER / equipment checks, and gas safety checks.

Many of the standard day to day maintenance checks for the service had not been completed since June 2025. This was due to staffing issues in the maintenance team. The manager was being assisted by a senior carer to complete critical maintenance checks, and we were informed of daily, weekly and monthly 'visual checks' taking place, to ensure the general safety of the building. Many of these checks were not being recorded so there was no evidence of any concerns being recorded or any follow-up actions being taken. There was no plan in place to reinstate the regular, documented maintenance checks. This created a significant risk to people's safety and wellbeing. We asked the provider to complete a full audit of maintenance processes and paperwork and to produce an action plan to reinstate maintenance checks in line with current best practice.

This requirement was not met. We have agreed an extension until 24 January 2026.

Not met

Requirement 7

By 28 July 2025, to ensure people's care and support needs are fully considered, the provider must implement a system for completing six monthly care reviews. To do this, the provider must, at a minimum:

a) Schedule six monthly reviews for all people using the service;
b) Ensure people, their representatives and key professionals are invited to contribute to these reviews;
c) Ensure people's personal plans are updated to include any changes identified at the review. The updated personal plan should be made available to the person and/or their representative, if requested; and
d) Ensure any actions agreed at the review are recorded, planned and followed-up.

This is to comply with Regulation 5(2) (Personal Plans) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states: 'I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change' (HSCS 1.12).

This requirement was made on 17 April 2025.

Action taken on previous requirement
The service had implemented a new tracker for six monthly reviews. Reviews had been scheduled and were up to date. We sampled review paperwork and found it to be of a high standard with evidence of involvement of people, their representatives and external professionals. Personal plans had been updated to reflect decisions made at reviews.

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 keep people safe, the service should ensure that staffing numbers, skills and deployment reflect the needs of the people using the service at all times of the day and night. Decisions about staffing should be transparent and based on the principles 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 states:

'My needs are met by the right number of people' (HSCS 3.15).

This area for improvement was made on 25 July 2024.

Action taken since then

The manager uses a dependency assessment tool to support decision making about staffing numbers and deployment. Leaders and staff knew people well and were able to confidently describe people's needs, health issues and recent changes. Communication about changing needs was good at daily hand-over and 'flash meetings', which helped to support decision making about deployment of staff.

Leaders had reviewed the overall staffing of the service, including skills mix, age/experience level, gender, and mix of local and overseas staff, to ensure an appropriate mix of skills and experience, and opportunities for peer learning and development of less experienced staff. A new eight week rota had been developed to support continuity and work / life balance for staff. This had been shared with the staff team and their views had been sought to develop a rota that works well for the needs of people and staff. An ongoing review process is in place to ensure the new rota is working well.

This area for improvement is 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
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate

How good is our setting?	2 - Weak
4.1 People experience high quality facilities	2 - Weak

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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