Finavon Court - Forfar
Care Home Service

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Type of inspection:
Unannounced

Completed on:
21 November 2025

Service provided by:
HC-One Limited

Service provider number:
SP2011011682

Service no:
CS2011300707

About the service

Finavon Court - Forfar is a 60 bedded care home, which is owned and operated by HC-One Limited. The service provides nursing care for older people who have care needs related to dementia and other similar conditions. Care is also provided for up to ten people under the age of 65 years with care needs related to, for example, learning disabilities.

The service is located in the Angus town of Forfar. The service aims to provide care which promotes choice, dignity, and safety.

About the inspection

This was an unannounced follow-up inspection carried out by two inspectors from the Care Inspectorate. The on-site inspection took place on 16 and 17 November 2025, and we continued the inspection remotely on 18 November 2025.

The purpose of this inspection was to follow up on four requirements and five areas for improvement made at the previous inspection. We evaluated the progress the service had made to improve outcomes for people.

To prepare for the inspection, we reviewed information about the service, including previous inspection findings, registration details, complaints information, intelligence gathered throughout the year, and documentation submitted by the service.
In making our evaluations, we:

- Spoke with 13 people using the service and 10 of their families and representatives
- Spoke with staff and the management team
- Spoke with two visiting professionals involved in supporting the service
- Observed practice and daily life
- Reviewed relevant documents and records

Key messages

- We re-evaluated Key Question 1 from weak to adequate due to progress in several areas, but further improvements are needed.
- We extended the requirement for health and wellbeing because gaps in recording remained, particularly in hygiene charts and nutritional recording.
- People experienced warm, positive interactions with staff, contributing to a supportive care environment.
- Oversight of weight monitoring and pressure care had improved, ensuring safer outcomes for people.
- Wound care had improved, with records well documented and care delivered safely.
- People benefited from significant improvements to the environment.
- Recording and monitoring of nutritional support improved in some areas, but overall consistency was still required.

From this inspection we evaluated this service as:

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

How well do we support people's wellbeing?	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

We evaluated this key question as adequate. This was an improvement from weak at the previous inspection because several important strengths now positively impacted outcomes for people and outweighed remaining weaknesses.

Improvements included the management team having better oversight of how they monitored people's weight, and ensured that people had appropriate pressure relieving equipment in place. Audits and alerts were embedded in daily practice. Referrals to professionals were made promptly, and staff demonstrated knowledge of guidance. This supported better outcomes for people and ensured they had access to appropriate health care and support.

However, inconsistencies in people's personal care records and food and fluid charts remained, meaning the requirement was only partially met. Although we identified one person at risk of poor outcomes, we raised this promptly with the management team. They responded by implementing an action plan that addressed the issue and reduced the risk of recurrence. This meant the person's health and wellbeing was safeguarded.

While progress was evident, improvements were not yet fully embedded, and some weaknesses continued to present risk. (See Requirement 1 in 'What the service has done to meet any requirements made at or since the last inspection')

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

Requirements

Requirement 1

By 05 November 2025, the provider must ensure that people's health and wellbeing needs are identified, monitored and met in a timely and effective way to protect their health, wellbeing and safety.

To do this, the provider must, as a minimum ensure that:

a) People's health care and hygiene recording charts and assessments are completed accurately, and that these are reviewed at appropriate intervals to support ongoing evaluation and assessment of people's current and changing needs.

b) Ensure that pressure relieving equipment is in place, reviewed regularly and kept up-to-date, and that associated repositioning support is carried out at frequencies stated in support plans.

c) Ensure that food and fluid balance charts are accurate and inform of actual intake consumed, and weight loss concerns promptly escalated to senior staff and peripatetic professional staff and representatives.

d) Ensure that where concerns have been identified regarding weight loss, that support plans clearly set out frequencies of weight checks, and that concerns escalated promptly to peripatetic professionals and people's representatives.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 4(1)(a) Welfare of users and Regulation 5(2).

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

'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty'. (HSCS 3.18).

This requirement was made on 3 September 2025.

Action taken on previous requirement

We followed up on this requirement and found variation in the quality of personal plans and records. Some were detailed and clear, while others lacked essential information to guide staff. Records did not always show when personal care was offered, refused, or re-offered. Weekly records did not always match daily notes on the electronic system, making it difficult to confirm when care and support was provided. Most people were well presented, but two people's presentation fell below the expected standard, compromising dignity. This was raised with the manager and improved by day two of the inspection.

Many care plans had been updated, and we observed staff putting these into practice, which was positive. However, some plans were incomplete and there was evidence people's preferences were not always being upheld. For example, one care plan did not record that repeated offers of personal care could lead to the person feeling distressed. Another stated a shower should be offered daily, but records often showed "body wash" instead. These gaps increased the risk of people experiencing distress and compromised personalised care. Inaccurate records also made it harder to evidence that preferences were respected.

We noted some improvements in leaders' oversight of food and fluid charts, with alerts introduced and hydration discussed at staff handovers. However, we identified a serious concern in relation to nutritional support. Concerns were raised about whether people were receiving the right food and fluids, and our review confirmed significant gaps for an entire day for one person. Aside from a drink at breakfast, there were no further recordings until later in the afternoon. Records showed a meal was recorded as offered, but this was not observed, and alternatives were not provided. There were also missed opportunities for staff to support at mealtimes. Staff told us they wanted to help more but described the mealtime service as "chaotic". This meant there were missed opportunities to meet people's nutritional needs (**see Area for Improvement 3 in "What the service has done to meet any area for improvement made at or since the last inspection"**). The manager acted immediately, discussed this with staff, and implemented a plan to reduce risks. They provided a detailed response and undertook an investigation, and we were satisfied they would take adequate action to improve this. While this was positive, it shows improvements were reactive rather than embedded.

Recording and monitoring of nutritional support had improved in some areas, but remained inconsistent overall, which compromised clinical oversight and increased risk. While alerts and handover discussions were in place, gaps in documentation meant nutritional needs were not always fully met. For example, for a person receiving end-of-life care, staff were not recording whether food or fluids had been offered. In another case, a person with a fluid target had intake recorded inaccurately. These gaps made it difficult to assess needs and ensure timely interventions, despite some progress in oversight.

Positive practice was evident in other areas. People who required pressure-relieving equipment had this in place, and leaders carried out regular checks and walkarounds. Airflow mattress checks were recorded, and repositioning support was delivered at the correct frequency. These measures helped protect people from pressure damage and maintained comfort.

Where concerns about weight loss were identified, support plans set out clear monitoring, referrals were made promptly, and the service used the dietician portal effectively. Staff told us this supported their work. The manager had improved oversight of weights, and regular audits were in place. These actions helped protect people's health and wellbeing by ensuring weight loss was identified early and addressed promptly,

This requirement was partially met. While some improvements were evident such as increased oversight of weight loss, improved information at handovers and pressure care, significant gaps remained, and improvements were not yet fully embedded. We have extended the timescale to allow the provider to address these issues and reduce risks for people.

This requirement has not been met and we have agreed an extension until 31 January 2026.

Not met

Requirement 2

By 05 November, In order to ensure that wound care is provided in a planned and safe way, the provider must ensure as a minimum:

a) That all wound care documentation includes clear information regarding the date of identification of the wound.

b) Support plans must detail the frequency and detail in the recording of wound care.

c) Where photographs are used; that these are clear, measured and carried out at stated frequencies in support plans.

d) That pain assessments are completed and in place prior to wound care.

e) Where changes in condition or frequency of wound care have been made, these should be clearly documented and kept up to date.

f) Prompt referral to peripatetic professional staff where necessary.

This is in order to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 4(1)(a) Welfare of users and Regulation 5(2) - Personal Plans.

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

We sampled personal plans and records for people receiving wound care and found that documentation provided clear details of ongoing treatment and management.

Plans included the date of wound identification, the frequency of care, and detailed recording of treatment. Photographs were clear, measured, and taken at the stated intervals outlined in support plans. Pain assessments were completed prior to wound care, and changes in condition or treatment frequency were documented and kept up to date.

We also saw evidence of prompt referrals to peripatetic professional staff where necessary. These improvements ensured wound care was delivered in a planned and safe way, supporting people's health and wellbeing.

This requirement has been met.

Met - within timescales

Requirement 3

By 05 November 2025, the provider must ensure that people benefit from a service that is well led by developing and implementing comprehensive and structured systems for assuring the quality of the service.

To do this, the provider must as a minimum:

a) Include formal auditing and monitoring of all areas of the service provided to evidence that the standards set out in the quality assurance plan, including people's support plans, are met.

b) Ensure that feedback from residents, relatives and staff is included in the improvement plan and actioned.

c) Implement effective action planning to address areas of required improvement to include appropriate timescales for completion and review of actions to be undertaken.

d) Ensure that staff are accountable for, and carry out the required remedial actions.

This is to comply with: The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) Regulation 4(1)(a).

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

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes'. (HSCS 4.19)

This requirement was made on 3 September 2025.

Action taken on previous requirement

The service had made initial progress in developing systems for assuring quality. A wide range of formal audits was in place, and staff were being empowered to support these processes, which was positive. An improvement and action plan had been developed and embedded, showing commitment to structured quality assurance, and regular observations of practice were taking place.

However, these systems were still in their infancy and required time to become fully embedded into practice. Continued monitoring will be necessary to ensure they are consistently implemented and lead to sustained improvements across all areas of the service.

We observed some inconsistencies in oversight of food and fluid monitoring and care plans, but the provider gave assurances and an action plan to mitigate these risks. The provider had done enough to meet this requirement, but further work is needed to ensure quality assurance systems consistently improve outcomes for people and reduce risks in all areas of care.

This requirement has been met.

Met - within timescales

Requirement 4

By 05 November 2025, the provider must ensure the home environment, fixtures and fittings are in a good state of repair to ensure that people experience an environment that is well looked after with clean, tidy and well-maintained premises, furnishings and equipment. This should include but is not limited to:

a) Manager daily walk rounds should identify areas for improvement and ensure that processes are in place to ensure all areas are clean and clutter free, and free of malodour and any repairs and essential maintenance are carried out timeously.

b) People's bedroom areas should be comfortable and welcoming.

c) The management team should ensure that a refurbishment / maintenance plan is put into place to ensure that priority areas are agreed and carried out.

d) External clinical waste bins are locked at all times and are contained in a safe area.

e) Where there are unavoidable delays in repairs or planned refurbishment /maintenance, there should be a risk assessment in place to ensure people's safety and comfort are maintained

This requirement was made on 3 September 2025.

Action taken on previous requirement

The provider has made significant improvements to ensure the home environment, fixtures and fittings are in a good state of repair. The home was clean and clutter-free.

Refurbishment work was underway, with new flooring installed upstairs and plans in place to decorate bedrooms. One professional told us, "It's very clean now and there's a big difference", and a staff member shared that the refurbishments had given the team "a boost", which was reflected in the positive morale we observed. These improvements have enhanced the environment and contributed to a safer, more comfortable experience for people.

People's bedrooms were tidier and more welcoming, and staff took time to maintain wardrobes, promoting people's dignity. During the inspection, we observed cleaning staff maintaining bedrooms, which were clean and fresh. We identified one person's bedding that was not up to the expected standard, and this was addressed immediately.

External clinical waste bins were locked and stored safely outside the building. A recent infection control audit carried out by the local infection control team provided positive feedback to the service.

These improvements ensured the environment was well looked after and supported people's health, safety and wellbeing.

This requirement has been met.

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

The provider should ensure that stress and distress plans clearly set out how staff should support people during periods of distress. These should include clear guidance regarding the frequency and timings of administration of as-required medication and include how people's representatives have been involved and informed.

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

'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty.' (HSCS 3.18).

This area for improvement was made on 3 September 2025.

Action taken since then

The provider has made some progress in updating stress and distress care plans, which now include clear guidance on how best to support people during periods of distress.

Guidance about as-required medication was included; however, during the inspection we found that the information did not always match what was recorded on the prescription details in the electronic medication administration record (EMAR) system. For example, we identified incorrect dosage information for two people.

We raised this with the management team during the inspection, and they agreed to review and update all plans promptly. While improvements have been made, this inconsistency could compromise people's safety and wellbeing. Further action is required to ensure accuracy and alignment between care plans and prescription records.

This area for improvement has been partially met and will remain in place.

Previous area for improvement 2

The provider should ensure that people experience meaningful interaction, connection, and stimulation as part of their daily care and support, and that activities reflect people's preferences as stated in their support plans.

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

'I experience warmth, kindness and compassion in how I am supported and cared for.' (HSCS 3.9); 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors'.
(HSCS 1.25).

This area for improvement was made on 3 September 2025.

Action taken since then

We observed warm and positive interactions between staff and people experiencing care. Staff were engaging and friendly, and we saw examples of light-hearted conversation that helped people feel at ease.

A new wellbeing staff member had started and staff were spending time getting to know people through activities such as "10 things you didn't know about me". This demonstrated that staff had developed genuine, caring relationships.

However, while improvements have been made, more work is needed to ensure meaningful, person-centred stimulation. For example, nail care was recorded as an activity, but this should be considered part of routine care rather than meaningful engagement. Records indicated that on one day, people spent the entire day watching television, including a remembrance service followed by a film. While this may have been appropriate for some, it does not reflect a varied or personalised approach to stimulation.

We also found gaps in promoting mobility and independence. Daily records showed that one person appeared to have been out of bed only twice in a week, and this was for family visits. We heard that the person found their chair uncomfortable, but this was not recorded in their plan, which could impact their comfort and wellbeing. These gaps meant that while progress had been made, people were not consistently experiencing activities that reflected their preferences or promoted independence and comfort.

This area for improvement has not been met and will remain in place.

Previous area for improvement 3

The provider should ensure that staff arrangement systems are in place including suitable staff allocation of duties, and that staff effectively support people's outcomes. This is not limited to, but should include access to adequate bathing and personal care in accordance to preferences recorded in support plans, support at mealtimes and during periods of distressed behaviours.

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

'My care and support is consistent and stable because people work well together'. (HSCS 3.19).

This area for improvement was made on 3 September 2025.

Action taken since then

During the inspection, we observed that staffing arrangements were not sufficient in the dementia unit on day one, particularly during the tea-time meal service. Staff described the situation as "chaotic" and told us, "We just can't support people in the way we would like" and "We need more staff to be able to meet the complex needs here".

We observed missed opportunities to meet people's needs in line with their preferences. For example, one person missed support and was not offered an alternative in line with their care and support plan, and others who required encouragement to eat were not consistently supported. These gaps compromised people's nutritional health and wellbeing.

The leadership team responded promptly after we raised this concern, by allocating an additional member of staff to mealtimes the following day, which helped support better outcomes for people. It was concerning that this required intervention from inspectors rather than being proactively addressed by the service. Staff working in this unit told us that this was a typical day. This indicated that staffing arrangements were not yet robust or consistently planned to meet people's needs.

This area for improvement has not been met and will remain in place.

Previous area for improvement 4

The provider should ensure that staff practice is supported by effective supervision and support, in accordance with the service's own policies and procedures. Supervision records should be meaningful and detailed to accurately reflect these discussions.

This is to ensure that 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 codes of practice'. (HSCS 3.14).

This area for improvement was made on 3 September 2025.

Action taken since then

Staff we spoke to told us they felt well supported in their roles. The leadership team were transparent and told us that some supervisions had lapsed, but we observed a clear plan in place to bring these up to date, alongside other sessions already being held.

Group supervisions had been introduced when gaps in practice were identified, which was a positive approach to supporting improvement. For example, discussions focused on reminding staff to offer people fluids if they were awake overnight and ensuring residents were offered supper. These sessions helped reinforce good practice and highlighted areas where consistency was needed.

However, the impact of these supervisions was not always evident in daily care delivery. For example, we observed missed opportunities to offer fluids despite this being discussed in group sessions. One instance involved a person who had gone to bed and later got up; records indicated they were not offered a drink until much later. This inconsistency meant that while the provider had taken steps to address issues, further work was needed to ensure improvements translate into sustained outcomes for people's health and wellbeing.

This area for improvement has been partially met and will remain in place.

Previous area for improvement 5

The provider should ensure that the views of people's representatives are clearly expressed and included in people's care and support plans and review documentation, and that they are informed promptly when concerns arise in meeting people's support outcomes.

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

'If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account'. (HSCS 2.12).

This area for improvement was made on 3 September 2025.

Action taken since then

The provider had made positive progress in involving people's representatives in care planning and reviews. We saw efforts to strengthen family engagement, including posters, advocacy visits, and regular calls to families. Most families told us communication was good, saying, "The manager is good at keeping in touch, we feel well informed".

However, one family member expressed concern about not receiving an update following a referral and not knowing their relative had a care plan. We raised this with the leadership team, and it was promptly addressed.

While improvements were evident, inconsistencies in awareness and accessibility of information mean this improvement is not yet fully embedded. Further work is needed to ensure consistent involvement and clear communication, particularly where concerns arise.

This area for improvement remains in place.

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?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	3 - Adequate

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