Newark Care Home
Care Home Service

Southfield Avenue
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Type of inspection:
Unannounced

Completed on:
29 January 2026

Service provided by:
SCCL Operations Limited

Service provider number:
SP2014012299

Service no:
CS2014326119

About the service

Newark Care Home is registered to provide care to 61 older people. The service provider is SCCL Operations Limited.

The home is located in Port Glasgow and is within close proximity to local shops and public transport. The accommodation is a purpose built, modern style two-storey building. All of the bedrooms are single occupancy and have ensuite facilities which include a toilet and shower. The home is split into four units named Gleddoch, Finlaystone, Birkmyre and Lithgow. Each unit has its own living room, dining room, bathing facilities and quiet lounge area. There is access to an enclosed garden area directly from the ground floor and the upper floor is accessed by a lift. Parking is available on site.

There were 44 people living in the service at the time of inspection.

About the inspection

We carried out a series of unannounced follow up inspections to monitor the progress of the requirements made at the inspection on 07 October 2025. These follow up inspections took place on 13 November 2025, 18 December 2025, 28 and 29 January 2026 between the hours of 07:45 and 21:00.

Following the inspection on 07 October 2025 the local authority began a Large Scale Investigation (LSI) in response to adult protection concerns identified and subsequently reported by the provider. Alongside the LSI process weekly Multi Disciplinary Meetings continued and regular meetings were implemented with the provider, Health and Social Care Partnership (HSCP) and Care Inspectorate representatives to monitor progress.

The inspections were carried out by three inspectors from the Care Inspectorate. To prepare for the inspections we reviewed information about the service. This included previous inspection findings, registration and complaints information and information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we reviewed documents and observed practice and daily life. We also spoke with:

Fifteen people and two of their family members
Twenty three staff and managers
Two visiting professionals.

Key messages

- Medication management had improved and reduced the risk of missed or incorrect doses.
- Staffing was more stable, improving continuity of care for people.
- Nutrition and hydration support remained inconsistent, placing some people at risk.
- Governance systems were weak and did not reliably identify or reduce risk.
- Staff supervision and accountability had not improved sufficiently, increasing the risk of repeated errors.
- Clinical monitoring tools were used inconsistently.
- Leaders showed commitment to improvement, but key systems and progress needed to be embedded into practice to keep people safe.

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?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	2 - Weak
How well is our care and support planned?	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? 2 - Weak

We followed up on a requirement in this key question in relation to how people were supported with their prescribed medication. We were assured that significant improvement had been made which meant people were supported safely with their daily medication. Please see "What the service has done to meet any requirements we made at or since the last inspection" section of the report.

A requirement was made at the last inspection in relation to how people were supported with their nutritional needs, which had not been met. During the inspection, we remained concerned that people were not consistently receiving appropriate support to meet their nutritional needs. The service was liaising with community nursing teams to improve people's experiences, including the provision of support in line with people's assessed nutritional needs.

Although we were assured that training had been organised to upskill staff in supporting people with eating and drinking, further action is required to ensure people receive safe and effective support and are not exposed to avoidable harm. Please see "What the service has done to meet any requirements we made at or since the last inspection" section of the report.

How good is our leadership? 2 - Weak

The provider had engaged in Large Scale Investigation (LSI) processes and meetings and was working with multi-disciplinary partners, including community nursing teams, the Care Home Collaborative (CHC), the HSCP and the Care Inspectorate, to support improvements in the service. While these arrangements had the potential to strengthen oversight and improve people's experiences, the impact of this work was not yet sufficiently evident at the time of the inspection.

We also identified wider service pressures which had adversely affected leadership, clinical oversight, and continuity of care. These included the absence of the registered manager, significant staff turnover, and ongoing vacancies. The service had closed one unit in the service due to reduced occupancy levels, as result of a voluntary moratorium on admissions, and was reliant on agency staff alongside short term management arrangements.

While some actions were taken to stabilise the service, we remained concerned about the capacity for improvement in both the leadership and staff teams and their ability to deliver safe and consistent care. In particular, there was insufficient assurance that robust clinical oversight and governance arrangements were in place to effectively monitor risks, support staff, and ensure people's nutritional needs were met safely and consistently. The requirement in this area therefore was unmet. Please see "What the service has done to meet any requirements we made at or since the last inspection".

How good is our staff team? 2 - Weak

We followed up on an requirement made at the last inspection in relation to staffing arrangements, which was met. Please see "What the service has done to meet any requirements we made at or since the last inspection" section of the report.

People experienced improved continuity of care, which had a positive impact on people's comfort, dignity and emotional wellbeing. While staffing stability had improved, further work was required to strengthen leadership, guidance and the organisation of staff on duty to ensure consistent and well coordinated care. This is to reduce risks of the quality of people's experiences being variable depending on which staff are on duty. (See area for improvement 1).

Since the last inspection, there had been a significant turnover of staff across a range of roles, including frontline care staff, senior care staff, nursing staff, and management positions. While the service had worked to fill many of these posts, this resulted in a workforce where a large proportion of staff were new to their roles and required further support, supervision, and development.

This had a direct impact on staff accountability, with some staff demonstrating a limited understanding of their roles and responsibilities. As a result, practice was not consistently monitored or supported. At the previous inspection, we made a requirement to improve staff accountability, practice, and performance. Due to the ongoing instability within the workforce and insufficient oversight arrangements, this requirement had not been met at the time of this inspection. Please see "What the service has done to meet any requirements we made at or since the last inspection" section of the report.

Areas for improvement

1. To ensure people consistently receive timely and responsive support, the provider should improve shift allocation and organisation. This should include clear leadership on each shift, effective deployment of staff based on people's assessed needs, and robust oversight of how care tasks are prioritised and completed.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state: "My needs are met by the right number of people" (HSCS 3.15) and "I am confident people respond promptly, including when I ask for help" (HSCS 3.17).

How well is our care and support planned? 3 - Adequate

Since the last inspection the service had closed one unit, and had implemented a voluntary moratorium on admissions. This meant we were unable to assess the progress of an area for improvement we made at the last inspection in relation to pre-admission assessments.

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

Requirements

Requirement 1

By 9 November 2025, the provider must implement safe and effective medication management systems. This is to ensure people's health and wellbeing is safe and protected. To do this, the provider must, at a minimum:

a) Complete a full audit of medication stock and ensure all prescribed medications are available.
b) Carry out regular counts of medication to ensure prescribed medication and homely remedies are available.
c) Implement robust systems for checking in new medication and maintaining accurate stock balances.
d) Ensure staff competency in medication administration and competence in use of the electronic medication system is regularly observed and recorded.
e) Establish a process for notifying and investigating missed medication doses, and ensure this is consistently followed.

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

This is to ensure 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 7 October 2025.

Action taken on previous requirement

The provider had taken appropriate and sustained action to improve medication management systems. Managers completed full medication stock audits and introduced clearer systems for ordering, and checking when medication was delivered by the pharmacy. Monitoring of medication administration was implemented to ensure this was carried out correctly.

Medication storage arrangements had improved for all prescribed medication as well as homely remedies, making these more easily accessible and organised. Staff completed refresher training, supported by observations of practice to ensure they were competent in all aspects of supporting people with their prescribed medication.

The service had returned to paper medication administration records, due to issues with the use of the electronic medication system. Staff told us this had provided them with increased confidence and we were assured that medication records accurately reflected people's medication support. Daily and monthly quality assurance checks were in place to identify recording errors, stock discrepancies and administration errors.

Where any omissions had been identified, these were rectified to ensure people received their medication at the right time as prescribed.

These actions reduced the risk of medication being unavailable or administered incorrectly. People were more consistently supported to receive their medication as prescribed, which helped protect their health and wellbeing. We were assured that medication practices were sufficiently safe and well managed.

Met - outwith timescales

Requirement 2

By 9 November 2025, the provider must improve mealtime arrangements and ensure effective support is provided with eating and drinking. This is to ensure people are supported well with their nutritional needs and to reduce the risk of potential harm. To do this, the provider must, at a minimum:

a) Ensure staff provide timely and coordinated mealtime support, including appropriate postural support for people, particularly people who eat their meals in bed. Risk should be minimised to promote safe swallowing, reducing risks of choking or aspiration.
b) Ensure staff are aware of and follow current guidance on the International Dysphagia Diet Standardisation Initiative framework (IDDSI), food fortification, diets and preferences.
c) Maintain up-to-date care plans that clearly reflect people's nutritional needs and support, and ensure daily records clearly reflect their support.
d) Ensure snack stations are consistently stocked and accessible.
e) Implement systems to monitor and evaluate mealtime experiences and nutritional outcomes.

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

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state: "My meals and snacks meet my cultural and dietary needs, beliefs and preferences". (HSCS 1.37)

This requirement was made on 7 October 2025.

Action taken on previous requirement
The provider had taken some action to improve mealtime support, including allocating staff roles at mealtimes, ensuring snack stations were regularly refilled and completing mealtime audits.

Nutritional care plans were in place where needed, and regular weight monitoring was carried out to identify where people may be at risk of malnutrition or poor health. However, screening and assessment tools to support decisions on what action should be taken to support improved nutrition were not always followed or implemented.

Staff knowledge of people's specialist diets and safe swallowing guidance varied across each unit. We found examples where food textures did not align with people's assessed swallowing needs, despite recent input and advice from Speech and Language teams. Care plans and food records were unclear, inconsistent or out of date. Food and fluid records did not always provide enough detail to show what people had been offered or how much they had eaten. People who required their meals to be fortified to promote weight gain were not always provided with this when needed, and some people were provided with this where it was not needed. For example, where weight loss should have been promoted.

People's experiences of mealtimes across the service were variable. Some people were supported by staff who took time to offer kind and compassionate assistance, including support with eating where required. However, this approach was not consistent, and not all people experienced the same level of support during mealtimes. The organisation and delivery of mealtimes did not always ensure that people received timely, unhurried, appropriate supervision and person-centred support in line with their needs.

Because systems were not embedded, we could not be assured that people with complex nutritional needs were consistently supported safely. Some people remained at risk of choking, aspiration or poor nutrition. These issues had the potential to negatively affect people's health, comfort and enjoyment of mealtimes.

The service had been working alongside Speech and Language teams and Dieticians to identify where improvements needed to be made. This included organising training for all staff, including kitchen staff who were responsible for preparing specialised meals. This provided some assurances that improvements could continue and the provider recognised where focused action was needed.

This requirement has not been met, and we have agreed to extend the timescale of this requirement to 15 March 2026.

Not met

Requirement 3

By 7 December 2025, the provider must use effective governance and quality assurance systems to identify, respond to, and learn from adverse events and risk of harm. This is to ensure people's safety and wellbeing. To do this, the provider must, at a minimum:

a) Ensure that adverse events, including medication errors, are consistently escalated and investigated to identify patterns and risks.
b) Analyse audit findings and clinical governance data to identify where changes can be made that improve people's care and experiences.
c) Ensure there are clear procedures for reporting and learning from adverse events.
d) Ensure notifications are made timeously to relevant bodies, including; the local authority, adult protection teams, and Care inspectorate in accordance with Care Inspectorate's "Guidance on records you must keep and notifications you must make, March 2025".

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

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which that "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities" (HSCS 3.20).

This requirement was made on 7 October 2025.

Action taken on previous requirement

Managers had increased checks of incident and accident records, which led to some retrospective notifications being made to regulatory bodies and the local authority where issues were identified. A handover system was introduced to record and discuss where adverse events had taken place, to ensure this information was shared with the relevant staff and appropriate actions taken. The provider had recently appointed a new internal quality and compliance role to support oversight and identify where improvements could be made. Despite these actions we were not assured that sufficient progress had been made in this area.

A number of audits were carried out across several areas of care, which had identified where improvements where required. However, many of the actions required remained open or delayed due to leaders and managers lack of capacity to progress these.

Information about incidents or adverse events that had occurred were not always recorded accurately, consistently or communicated by staff. Including where some people experienced falls, sustained injuries, experienced stress and distress and where unsafe moving and assisting practice had taken place. This meant that learning was not always identified, shared or used to improve practice. Poor recordings and unclear communication made it difficult for leaders to identify patterns or risks to protect people from harm.

Because oversight systems were weak, leaders could not always spot problems early or prevent them from happening again. This meant people were at risk of repeated harm, particularly after falls, incidents of stress and distress or changes in their health.

This requirement has not been met, and we have agreed to extend the timescale of this requirement to 15 March 2026.

Not met

Requirement 4

By 4 January 2026, the provider must improve staffing arrangements and ensure staff are appropriately inducted and deployed. This is to ensure people receive safe, effective, and person-centred care. To do this, the provider must, at a minimum:

a) Ensure staffing levels and deployment are responsive to people's assessed needs, including peak times in the day and non-direct care duties.
b) Demonstrate understanding and application of the Health and Care (Staffing) (Scotland) Act 2019 to support safe staffing decisions.
c) Ensure agency and new staff receive a robust induction to support continuity of care.
d) Implement systems to monitor staffing pressures and take action to support staff wellbeing and morale.

This is to comply with Regulation 4(1)(a) (welfare of service users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/ 210 and Sections (7)(1)(a) and (b) (Ensure appropriate staffing) of the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA).

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state: "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes". (HSCS 4.19).

This requirement was made on 7 October 2025.

Action taken on previous requirement

Staffing arrangements had improved sufficiently by the third follow-up visit to the service. Staffing levels had been increased and were more stable. The reliance on agency staff had reduced due to the recruitment of care staff and nurses and redeployment of senior care staff from sister homes. This had a clear impact on staff morale. Some staff told us that this had improved the atmosphere in the service and they were happier in their work, which positively impacted on the people living in the service.

Leaders and managers had developed a clearer understanding of the Health and Care (Staffing) (Scotland) Act 2019. This had enabled them to make safer staffing decisions, which included an increase in the total staffing hours available over the day, as well as more flexible deployment of staff. As a result, most people experienced timely and responsive support throughout the day, including during peak periods such as mealtimes. Staffing pressures were effectively monitored and managed, ensuring that staff were available on each unit. This supported safer care delivery and helped people's needs to be met more consistently.

An induction process was in place for new and agency staff, which included training, job shadowing and competency assessments. This ensured staff were prepared for their role and had the necessary skills to provide safe and effective care.

Improved staffing stability meant people experienced more consistent care, with staff who knew them better and were more able to respond to their needs. This supported people's dignity, comfort and emotional wellbeing. While we were satisfied that significant improvement had been made to meet this requirement, further work was needed to ensure people had consistent and well coordinated care through shift planning. We have made a new area for improvement under "How good is our staff team?".

Met - within timescales

Requirement 5

By 4 January 2026, the provider must strengthen accountability and support staff to reflect on and improve their practice. This is to ensure the risk of errors and performance issues are reduced and promote a culture of learning. To do this, the provider must, at a minimum:

a) Ensure staff involved in incidents, including medication errors and adverse events receive appropriate follow-up and support to improve practice.
b) Ensure staff have an understanding of their roles and responsibilities across all staff levels for reporting and resolving issues, this includes concerns that may cause harm to people.
c) Provide staff with regular opportunities for support through consistent supervision and reflective learning.

This is to comply with Regulation 4(1)(a) (welfare of service users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services).

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

This requirement was made on 7 October 2025.

Action taken on previous requirement

We found inconsistencies in staff understanding of their roles and responsibilities. This included variable reporting of adverse events, and limited opportunities for reflective practice. Supervision was not routinely embedded, with few recorded supervision sessions and limited oversight due to senior staffing pressures. While some examples of reflective practice and staff conduct issues were being addressed, these were not consistently effective in preventing repeat issues.

As a result, people were at risk of experiencing inconsistent care and support. Opportunities to learn from adverse events and improve practice were not always identified. This meant we could not be assured that people consistently received safe, high-quality care.

This requirement has not been met, and we have agreed to extend the timescale of this requirement to 26 April 2026.

Not met

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To identify deterioration in people's health and respond appropriately, the provider should ensure clinical monitoring tools such as NEWS and RESTORE2 are used effectively. This should include, ensuring staff are trained and competent in using these tools, and there is clear systems for escalation and follow-up when concerns are identified.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state "I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities". (HSCS 3.20).

This area for improvement was made on 7 October 2025.

Action taken since then

Training had been provided to senior staff and nurses on clinical monitoring tools such as RESTORE2, to support clearer understanding of how these should be used to identify and respond to deterioration in people's health. While internal audits had shown some improvements in the use of these tools, we found that these were not always used consistently, especially after falls and where follow-up observation and monitoring was needed.

This means we could not be assured that changes in people's health were always recognised quickly which could delay treatment and increase the risk of deterioration.

This area for improvement has not been met.

Previous area for improvement 2

To support continuous improvement and effective oversight, the provider should develop and implement a structured service improvement plan that is Specific, Measurable, Achievable, Relevant and Time-Bound (SMART). This should include identifying recurring issues from internal and external audits and stakeholder feedback, ensuring the plan is accessible and used to inform provider-level support.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19) and "I use a service and organisation that are well led and managed" (HSCS 4.23).

This area for improvement was made on 7 October 2025.

Action taken since then

The provider had developed and implemented a comprehensive SMART improvement plan. This plan demonstrated clear links between audit findings, regulatory feedback and planned actions, which provided assurances around the level of leadership engagement and external collaboration. While not all actions were complete, the plan provided a clear and trackable system for improvement and oversight.

This area for improvement has been met.

Previous area for improvement 3

To ensure safe and person-centred care, the provider should improve pre-admission assessments to capture key health and wellbeing information and inform care planning. This should include developing care plans that reflect individual risks and support needs, and assessing whether staff have the necessary skills and information to provide effective support.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state: "I am confident that the right people are fully informed about my past, including my health and care experience, and any impact this has on me." (HSCS 3.4).

This area for improvement was made on 7 October 2025.

Action taken since then

This area could not be evaluated as there had been no admissions to the service since the last inspection.

This area for improvement has not been assessed.

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?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	2 - Weak
3.3 Staffing arrangements are right and staff work well together	2 - Weak

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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