care inspectorate

Newark Care Home
Care Home Service

Southfield Avenue
Port Glasgow
PA14 6PS

Telephone: 01475 705 800

Type of inspection:
Unannounced

Completed on:
20 March 2026

Service provided by:
SCCL Operations Limited

Service provider number:
SP2014012299

Service no:
CS2014326119

HAPPY TO TRANSLATE

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 38 people living in the service at the time of inspection.

About the inspection

We carried out a follow up inspections to monitor the progress of two requirements made at an inspection on 07 October 2025. The timescales for these requirements had been extended as they were not met at a follow up inspections on 29 January 2026. This inspection took place on 19 March 2026, between the hours of 9:30 until 17:00.

The inspection was carried out by two 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:

- five people and one of their relatives
- eleven staff and management.

Key messages

- We followed up on two requirements, which were both met.
- We followed up on three areas for improvements, one was met and two were not assessed at this inspection.
- People were benefitting from a safer and more consistent meal experience.
- Strengthened recording of nutritional needs supported risk identification.
- Increased confidence and staff skills were improving people's care experience and safety.
- Incident reporting, follow up and governance was more robust.
- Clinical tools were being used more effectively to identify health deterioration early.

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

We have re-evaluated this key question from weak to adequate. We followed up on a requirement about nutritional support, which was made on 7 October 2025. We found clear improvements in the organisation, delivery and recording of mealtime support across multiple units. Staff practice was calm, coordinated and aligned with good nutritional care. (See "What the service did since the last inspection" section of the report).

We also followed up on an area for improvement to support better decision making, and to identify when people's health and wellbeing deteriorate. Positive progress had been made in this area. (See "What the service did since the last inspection" section of the report).

How good is our leadership? 3 - Adequate

We have re-evaluated this key question from weak to adequate. We followed up on a requirement about quality assurance and governance which was made on 7 October 2025. This requirement has been met. (See "What the service did since the last inspection" section of the report).

The provider continued to invest in the service, and workforce, including strengthened management arrangements, increased training, and improved team communication. Staff morale had noticeably improved, contributing to better consistency and practice, which improved people's experiences.

The service is entering a period of management change and may experience increasing occupancy levels which can bring some risks. Sustaining improvement will require continued leadership visibility, robust oversight, and consistent implementation of strengthened systems.

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 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 conducted mealtime observations and audits throughout all units of the service, identifying areas where improvements were needed, and we observed how this had improved people's mealtime experiences.

Coordination of mealtimes had improved across all areas of the service. Staff were visible and present throughout meal service, supporting people safely and without rushing. Mealtime coordinators ensured people received appropriate support with eating and drinking where this was required. Observed examples included staff offering reassurance, checking posture, adjusting seating, and providing support at a pace that was suited to people's individual needs. This provided assurance that people received safe, attentive support which reduces the risks of choking and/or aspiration and promoted people's dignity.

Pictorial menus were clearly displayed in dining areas and staff gave people options verbally to ensure people had a choice of what they wanted to eat or drink. When someone declined the main option, staff provided an alternative that met their dietary requirements. Snack stations in all units of the service were well stocked and offered a variety of nutritious choices that were available for people to enjoy between meals. Dining environments were calm, well prepared and organised. This is important as a structured dining environment reduces distress and supports choice, especially for people living with cognitive impairments.

Mealtime planners and nutritional overviews were readily available for staff as a quick point of reference, and to easily document people's mealtime support at the point of care. These included people's modified diet level, fluid consistency, meals offered, and, how much people had eaten. Records also showed where people had their meals fortified to add more calories, where people required this support to maintain a healthy weight or gain weight. This information was then recorded in the electronic care plan system, which helped to track and support early identification of nutritional risk and guide timely intervention.

We sampled care plans and found stronger evidence between assessments and practice. For example, where some people's swallowing needs changed, modified diet levels and fluid consistency were updated and referrals to specialist health services such as Dietetics and Speech and Language were made promptly. This demonstrated improved vigilance and safer nutritional oversight.

Kitchen staff demonstrated learning from recent training, including safe preparation of textured meals, correct use of language in line with the IDDSI framework, and awareness of unsafe practices. Such as adding gravy or creams to food for people who required their meals to be pureed to a specific thickness and texture. This is important as consistency in meal texture is essential for preventing aspiration or choking, to support easier swallowing and maintaining nutritional intake.

Overall, we were observed that people experienced safer mealtimes, received appropriate nutritional support, and enjoyed greater dignity and comfort. Improvements in record keeping and documentation reduced the risk of missed nutritional concerns and strengthened continuity of care.

Met - outwith timescales

Requirement 2

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

Governance had strengthened significantly, with clearer oversight, timelier follow up and improved learning systems in place. There was a substantial reduction in overdue actions on the electronic quality assurance system (RADAR). These had reduced from over 200 at previous inspections to approximately 22 at this inspection with timescales that had not elapsed. Fewer open incidents indicated a timely response and reduced organisational risk.

Notifications were submitted correctly as required, which included accidents/incidents and protection concerns. For example, when people experienced falls or where at risk of harm. This demonstrated regulatory compliance and transparency and showed where actions and lessons learned had been taken when things had gone wrong. For instance, situations identified where moving and handling practices were found to be unsafe. Leaders proactively addressed the risks of harm to people and took the appropriate action to ensure staff supported people safely, and were aware of their duty of care and professional responsibilities.

Staff across different roles confidently described how they would respond to falls, distressed behaviours, medication errors and changes in people's health, including escalation and the importance of recording the steps taken. This means that the knowledge across the team reduced the likelihood of people having unmet care needs.

Leaders held monthly clinical governance meetings, which showed meaningful analysis of trends and patterns in relation to falls, wound data, medication errors, distressed behaviours and training compliance, with clear actions identified which supported better outcomes for people. Examples included; identifying people who had re-occurring falls, steps to reduce further falls, and the involvement of relevant health professionals.

Several audits had taken place, in areas such as medication. The process involved checking medication administration records (MARs) every day to quickly spot any mistakes, allowing prompt action and sharing lessons learned with staff. Regular audits and reviews allowed issues to be promptly addressed, promoting a culture of continuous learning.

Due to the improvements in this area, we found that people were safer, risks were identified and addressed earlier, and staff demonstrated greater confidence and consistency in responding to incidents.

Met - outwith timescales

Requirement 3

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

This requirement was not met at the inspection dated 29 January 2026 and we agreed to extend the timescale of this requirement to 26 April 2026. Therefore this requirement was not assessed at this inspection.

The service had recruited and onboarded a number of new care staff, senior carers, nurses and leaders, many of whom were still relatively new in post and learning their roles and responsibilities, as well as systems and processes. Some staff told us that they had a positive and lengthy induction to the service, which was reassuring to hear. The date of the requirement does allow further time for staff to settle into their new roles before this requirement is assessed.

Not assessed at this inspection

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

The service had engaged in training sessions provided by external professionals around the use of RESTORE2. This included leaders, nursing and senior care staff. We talked to staff who spoke positively about this training, advising that this had helped to improve their practice and be more confident in their decision making skills.

We sampled records that showed that staff used clinical tools such as NEWS calculations and RESTORE2 appropriately when they were concerned about a persons wellbeing. In some cases this had prevented escalation to external health teams by identifying deterioration early, enabling nursing staff to make informed clinical decisions about people's care. In other examples, we found that timely escalation was made to external professionals, such as GPs and Paramedics when clinical tools were used effectively to demonstrate that people required urgent medical assistance.

We were assured that clinical tools were improving decisions to identify deterioration in people's health earlier, reducing the risk of avoidable harm, and avoiding unnecessary admissions to hospital and/or further health complications.

This area for improvement has been met.

Previous area for improvement 2

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 for improvement could not be evaluated as there had been no admissions to the service because of a voluntary moratorium being in place.

This area for improvement has not been assessed.

Previous area for improvement 3

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).

This area for improvement was made on 9 March 2026.

Action taken since then

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?	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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