DGMHA East
Housing Support Service

Cairnsmore House
Crichton Estate Bankend Road
Dumfries
DG1 4GW

Telephone: +447845811456

Type of inspection:
Unannounced

Completed on:
20 March 2026

Service provided by:
Dumfries & Galloway Mental Health Association

Service provider number:
SP2003003483

Service no:
CS2003053382

About the service

DGMHA East is registered to provide housing support and care at home services. The provider is Dumfries & Galloway Mental Health Association.

The service supports adults with mental health problems living in Nithsdale, Annandale and Stewartry. At the time of inspection 64 people were being supported.

Support is provided in people's homes and ranges from short daily visits to more intensive support depending on assessed need.

The registered manager is based in the Dumfries office and is responsible for the overall running of the service. Team leaders support the management of staff who provide direct support to people.

About the inspection

This was an unannounced inspection carried out between 17 and 20 February 2026 between 09:00 and 18:00.

The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about the service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with 10 people supported by the service
- spoke with 11 staff and managers
- visited two houses of multiple occupancy in Dumfries and Castle Douglas and four people in their own homes across the Dumfries area
- invited feedback from staff and external professionals through questionnaires
- reviewed a range of records and documentation.

Key messages

- People valued the support they received and spoke positively about staff. Some people told us the support helped them keep their tenancy and avoid hospital admissions.
- However, we found weaknesses in care planning, risk management and medication systems. This meant people's health and wellbeing needs were not always supported in a consistent way.
- Systems used by managers to check the quality and safety of the service were not working well. As a result, problems were not always identified or acted on quickly.
- Recruitment, induction and staff training needed improvement to ensure staff had the skills and knowledge to support people safely.
- People were not always told who would be supporting them or when visits would take place. This caused uncertainty and reduced people's confidence in the service.
- Personal plans did not always record people's wishes, outcomes or legal decision-making arrangements.
- An area for improvement made at the previous inspection about self-evaluation had not been addressed.
- As a result of this inspection, six requirements and 5 areas for improvement were made.

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?	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? 3 - Adequate

We evaluated this quality indicator as adequate, where strengths just outweighed weaknesses.

People told us they valued the support they received and had positive relationships with staff. Many people told us the support helped them remain well at home. One person said, "I don't think I could have held down my tenancy without the support." Another said, "I think receiving support has helped me avoid hospital admissions." People told us staff encouraged independence and supported them to maintain their tenancy and daily routines. This helped promote people's wellbeing and supported their recovery and ability to live independently in their community. People described staff as approachable and said they felt listened to, which contributed positively to their wellbeing.

However, the majority of personal plans were out of date and did not provide the detail staff needed to support people's health and wellbeing safely. Where people had identified health conditions, clear care plans were not always in place to guide staff practice. For example, some people had diagnoses such as cancer, diabetes or mental health conditions, but plans did not consistently explain how these conditions affected the person, what support they required or what signs of deterioration staff should monitor. Without clear guidance, staff may not recognise changes in people's health or respond consistently when concerns arise.

Reviews had taken place, but plans were not always updated afterwards. This meant staff did not always have accurate information about people's needs, which could affect how consistently people were supported. (See Requirement 1)

Risk assessments were in place but were not always updated when people's circumstances changed or after incidents. Some risks, such as emotional distress or self-neglect, were not clearly described and did not include guidance for staff about how to respond. This meant staff may not always know how to respond when people's wellbeing changed. (See Requirement 1)

Medication processes were not in line with best practice and required improvement. We identified gaps in medication records and inconsistent recording procedures. This meant the service could not always show that people were receiving their medication safely and at the right time. The process for escalating and responding to medication errors was unclear, increasing the risk that learning would be missed and issues would not be addressed. In addition, routine audits were not taking place, meaning concerns may not be identified or addressed promptly. This placed people at risk of not receiving their medication safely or as prescribed. (See Requirement 2)

Personal plans did not reliably record people's legal decision-making arrangements, such as Power of Attorney or Guardianship. As a result, staff could not always be certain who held legal authority or who should be consulted when important decisions about care and support were required. This created avoidable delays and increased the risk that decisions could be taken without the correct involvement, which created a risk that people's rights and preferences may not always be upheld. We have commented further on this under Key Question 5: How well is our care and support planned.

Requirements

1. By 15 June 2026, the provider must ensure people’s needs and risks are clearly assessed, recorded and reviewed so staff have accurate guidance to support people safely.

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

a) ensure care plans and risk assessments clearly describe people's current needs, risks and the actions staff must take
b) ensure plans and risk assessments are updated when people's needs change or following incidents
c) implement effective oversight of records to ensure information remains accurate and up to date.

This is to comply with:

Regulation 4(1)(a) (Welfare of users) and Regulation 5(2)(b) (Personal plans) 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:
"My personal plan is right for me because it sets out how my needs will be met" (HSCS 1.15).

2. By 15 June 2026, the provider must ensure medication support is managed safely so that people receive the right medication at the right time.

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

a) maintain accurate medication records
b) ensure medication errors are recorded, investigated and learning shared
c) implement effective auditing to monitor medication practice and address any issues identified.

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 HSCS, which state:
"Any treatment or intervention that I experience is safe and effective" (HSCS 1.24).

How good is our leadership? 2 - Weak

We evaluated this quality indicator as weak, where strengths were outweighed by significant weaknesses. These weaknesses reduced assurance that the service was well led and that people could rely on the service to provide safe and effective care.

The systems used by managers to check how well the service was working were not effective. There was no current improvement plan setting out what needed to improve, how this would be achieved or who was responsible for taking action. Without a clear plan, the service could not demonstrate how priorities were identified or how progress was being monitored. Although some audits were carried out, these had not identified several of the issues we found during the inspection, including gaps in care planning, medication systems and risk management. As a result, concerns were not always recognised or addressed, and the service could not show how learning was being used to improve outcomes for people experiencing care. (See Requirement 1)

Arrangements for reviewing incidents also required improvement. Records about incidents were not always reviewed effectively to identify patterns or learning. Some incidents that should have been reported to the

Care Inspectorate had not been submitted. Investigation records did not always show what actions had been taken in response or how risks had been reduced afterwards. Without clear review and follow-up, opportunities to improve practice and reduce the likelihood of similar incidents happening again may be missed. (See Requirement 2)

Important policies, including those relating to medication, finances, recruitment and adult protection, were out of date. In some cases they referred to systems that were no longer used. Staff therefore did not always have clear or up-to-date guidance about how to carry out key parts of their role. Where guidance is unclear or outdated, staff may follow different approaches when supporting people. (See Area for Improvement 1)

Support for people to manage their money was not always clear or consistent. Staff supported people in different ways, and these approaches were not always guided by policy or individual assessments. As a result, people were not always supported to manage their money in a way that reflected their needs. We also saw limited checks to confirm that people's money was being managed safely, which reduced assurance that appropriate safeguards were in place. (See Area for Improvement 2)

Although staff said they could approach the registered manager for advice, the overall arrangements for checking how well the service was working were not strong enough to identify concerns early or ensure improvements were made. This reduced confidence that the service was consistently learning from issues or making the changes needed to improve people's experiences of care.

Requirements

1. By 15 June 2026, the provider must establish effective and transparent quality assurance arrangements so that risks are identified, learning is used to improve practice and people experience safe and consistent care.

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

a) develop and maintain a live service improvement plan that identifies priorities, responsible persons and timescales for improvement
b) implement regular auditing of key aspects of the service to monitor the quality and safety of care and support
c) analyse information from audits, incidents and other quality monitoring to identify themes, trends and risks
d) take timely action to address identified issues and monitor the impact of these actions on outcomes for people.

This is to comply with:

Regulation 3 (Principles) and Regulation 4(1)(a) (Welfare of users) of SSI 2011/210.
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).

2. By 15 June 2026, the provider must ensure concerns, incidents and risks are recognised, recorded and responded to promptly so that people are protected from harm.

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

a) ensure staff recognise and report concerns that may indicate harm or risk of harm
b) maintain effective systems for recording, reviewing and responding to incidents
c) ensure appropriate notifications are submitted to the Care Inspectorate in line with guidance and required timescales
d) analyse incidents and concerns to identify themes, trends and learning
e) use this learning to review care plans and reduce future risk.

This is to comply with:

Section 53(6) of the Public Services Reform (Scotland) Act 2010 and Regulation 4(1)(a) (Welfare of users) of SSI 2011/210.
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).

Areas for improvement

1. The provider should review and update key policies to ensure they are current, clear and reflect how the service operates in practice. This should include policies relating to key areas of practice such as medication management, recruitment, financial support and adult protection.
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).

2. The provider should ensure there is a clear and consistent approach to supporting people with their finances. Policies, guidance and oversight arrangements should support staff to manage people's money safely and in line with each person's assessed needs.
This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state:
"If I need help managing my money, I am able to have as much control as possible and my money is protected" (HSCS 2.5).

How good is our staff team? 2 - Weak

We evaluated this quality indicator as weak, where strengths were outweighed by significant weaknesses. These weaknesses reduced assurance that the service was well led and that people consistently experienced safe and effective care.

People described staff as kind and supportive and spoke warmly about the relationships they had built. This reassured us that many people experienced compassionate care and valued the support they received from staff.

However, people were not consistently informed about who would be supporting them or when visits would take place, and planned schedules were not always communicated clearly. This reduced people's ability to feel prepared and in control of their day. Some people described feeling anxious when unfamiliar staff arrived without notice, which reduced their confidence in the reliability of the service. Clear communication about planned visits is important so that people know who will support them and when this support will

take place. (See Area for Improvement 1)

The service did not have effective systems to monitor whether planned visits were taking place. Records did not always show if visits had been missed or shortened, or what action had been taken when this happened. There were also no clear arrangements for managing unexpected staff shortages. Without effective monitoring, the service could not demonstrate that people were consistently receiving the support they expected or that any gaps in support were identified and addressed promptly. (See Requirement 2)

Recruitment and induction arrangements also required improvement. Some staff files did not contain all the checks required before employment. Records showing that staff had completed induction or had their skills assessed were also incomplete. Training did not always prepare staff to support people with complex mental health needs, including recognising signs of distress and responding to changes in people's wellbeing. Opportunities for supervision and checking staff practice were also inconsistent. As a result, the service could not always demonstrate that staff had the skills and confidence needed to support people safely and in a way that met their needs. (See Requirement 1)

Recent changes within the organisation had affected staff morale. Some staff told us they were unclear about their roles and expectations. This sometimes led to confusion and inconsistent communication within the team, which could affect how staff worked together to support people. Strengthening recruitment processes, staff development and monitoring of visits will help ensure people receive reliable support that meets their needs.

Requirements

1. By 15 June 2026, the provider must ensure that only staff who are fit, appropriately recruited and competent provide care and support.

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

a) put in place and implement systems to demonstrate that staff are appropriately and safely recruited in line with best practice guidance, including Safer Recruitment Through Better Recruitment (Scottish Government, 2016);
b) demonstrate that all staff undertake a comprehensive induction which equips them with the knowledge and skills required for their role;
c) ensure staff receive training that reflects the needs of the people they support and that records of completion and competence are maintained;
d) ensure staff are assessed as competent before undertaking specific tasks, including supporting people with medication.

This is to comply with:

Regulation 9 (Fitness of employees) and Regulation 4(1)(a) (Welfare of users) of SSI 2011/210, and Section 7 of the Health and Care (Staffing) (Scotland) Act 2019.
This is to ensure 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).

2. By 15 June 2026, the provider must ensure staffing arrangements are planned and managed so that people consistently receive support that meets their assessed needs.

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

a) assess and review people's needs to determine appropriate staffing levels and skill mix
b) plan staffing arrangements so that sufficient suitably skilled staff are available to deliver planned care and support
c) monitor planned and actual visits and take prompt action where gaps in support occur
d) ensure contingency arrangements are in place to maintain continuity of care when staffing changes arise
e) review staffing arrangements when people's needs change.

This is to comply with:

Sections 7(1)(a), 7(1)(b) and 7(2) of the Health and Care (Staffing) (Scotland) Act 2019.
This is to ensure 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).

Areas for improvement

1. To support people to feel informed and involved in their care, the provider should ensure people are told who will support them and when visits will take place.
This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state:
"People have time to support and care for me and to speak with me" (HSCS 3.16).

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

We evaluated this quality indicator as adequate, where strengths just outweighed weaknesses.

Some personal plans contained helpful, person-centred information. People told us staff listened to them and respected their choices. When staff knew people well, support felt familiar and reassuring, helping to build positive routines and relationships.

However, assessments and plans did not reliably reflect people's outcomes, wishes or current needs. Important details were sometimes missing. Plans did not always record known stressors, early signs of change or approaches that helped people remain well. This meant people might receive different support depending on which staff member was supporting them and increased the risk that people would not receive support in the way that worked best for them.

Reviews were taking place but did not consistently result in updated plans. Documentation did not always keep pace with changes in people's needs. This meant plans did not always reflect people's current needs and staff could not always rely on them to guide how people should be supported. (See Requirement 1 under Key Question 1.3)

Legal decision-making arrangements were not recorded consistently. Sections relating to Power of Attorney or Guardianship were often incomplete, meaning staff did not always know who should be involved in important decisions. This created avoidable delays and uncertainty when decisions about care and support

were required. (See Area for Improvement 2)

Records of involvement from families and representatives were also inconsistent. Although some relatives described good communication in practice, review documentation did not always record who had participated or what had been agreed. Plans should clearly reflect these discussions so that staff can deliver care that aligns with people's wishes and preferences. (See Area for Improvement 1)

Improving assessment, review and recording processes will help ensure personal plans remain accurate and reflect what matters most to each person. This will support staff to deliver care that is consistent and aligned with people's wishes.

Areas for improvement

1. The provider should ensure personal plans are reviewed regularly and updated when people's circumstances change. Reviews should clearly record who was involved and what changes were agreed. Reviews should take place at least every six months.
This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state:
"My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices" (HSCS 1.15).

2. The provider should ensure people's legal status and any powers held by representatives, such as Power of Attorney or Guardianship, are clearly recorded in personal plans.
This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state:
"If I am unable to make my own decisions at any time, the views of people who know my wishes, such as my carer, independent advocate or attorney, are sought and taken into account" (HSCS 2.12).

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

So people can be sure quality assurance drives change and improvement where necessary the service provider should consider inclusion of self-evaluation using the quality framework for care homes for older people within the quality assurance system. This is to ensure that care and support is consistent with the Health and Social Care Standards which state: "I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes" (HSCS 4.19).

This area for improvement was made on 6 February 2025.

Action taken since then

An area for improvement made at the previous inspection relating to self-evaluation had not been met. The service had not yet embedded a clear approach to self-evaluation to support improvement and identify priorities for change. This matter is now subject to Requirement 1 under Key Question 2.2.

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?	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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Contact us

Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

0345 600 9527

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