care inspectorate

Assisted Services Fife Ltd
Support Service

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Type of inspection:
Announced (short notice)

Completed on:
3 April 2026

Service provided by:
Assisted Services (Fife) Limited

Service provider number:
SP2025000398

Service no:
CS2025000439

HAPPY TO TRANSLATE

About the service

Assisted Services Fife Ltd registered with the Care Inspectorate in October 2025. This was the service's first inspection.

The service provides care at home for people living in their own homes. Support can be provided up to four visits per day by one or two members of staff depending on the needs of individuals. Services are commissioned by Fife Health and Social Care Partnership who determine the level of care and support people receive.

Thirty two people were using the service during the inspection.

About the inspection

This was a full inspection that was carried out at short notice which took place between 23 March and 3 April 2026 . The inspection was carried out by two inspectors from the Care Inspectorate.

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

In making our evaluations of the service we:

- spoke with six people using the service and two of their representatives;
- spoke with six staff and management;
- observed practice and daily life;
- reviewed documents; and
- spoke with visiting professionals

Key messages

- People were supported
- People were supported with dignity and respect by a consistent team of staff who knew them well.
- Risks to people were not identified or mitigated. This put people at risk of harm.
- Quality assurance and service improvement required improvement.
- Staff had not undertaken appropriate training to meet the full range of people's needs.
- Care plans were not person-centred or strengths-based and did not provide sufficient information and guidance to inform staff practice.

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 identified strengths in the care and support people received but these just outweighed weaknesses. Strengths still had a positive impact but the likelihood of achieving positive experiences and outcomes for people was reduced significantly because key areas of performance needed to improve. Therefore, we evaluated this quality indicator as adequate.

We observed good practice when staff provided care and support for people. It was apparent that relationships were warm and caring. We noted at times humour was used appropriately and this put people at their ease. People were supported with compassion, dignity and respect. People using this service told us they had good relationships with the staff who provided their care and support. They had confidence in staff and told us they felt safe. It was important to people that they knew the staff who provided their care and support (see area for improvement 1).

People's previous medical history was recorded in care plans as well as their current health and wellbeing needs. People were mostly supported by a consistent team of staff. This meant the staff knew people well and were able to pick up changes in people's needs and presentation and take relevant action. This included contacting healthcare professionals to raise concerns or issues such as catheter care and skin integrity issues.

Communication between staff and members of the leadership team was good. Staff passed on any concerns regarding people's health and well-being and referrals to professionals were made by the management team as appropriate. People's representatives told us communication with staff providing support and members of the leadership team was positive. They were kept up to date with any issues, and they felt involved and informed. People and their representatives were satisfied with the care and support provided.

Staff were only permitted to prompt people to take their medication. Where staff prompted and witnessed people taking their medication, this was recorded in people's daily notes. This ensured people took their medication as prescribed to ensure their health and wellbeing. Staff could apply prescribed creams. We discussed using tools, such as body maps to provide guidance for staff and ensure creams were applied as prescribed.

We were concerned that the provider did not have oversight of key risks in the service and how these were being mitigated. We were concerned that risks to people were not identified or mitigated by the provider. This included risks to people who experienced difficulties with eating and drinking, mental health conditions, and seizures/epilepsy. There was little information regarding how these conditions impacted on people and little information or guidance for staff to ensure people's care was safe, consistent, and effective. Where people required support to move, risks of developing pressure injuries were not identified. Mitigating factors such as regular repositioning were not used. There was no evidence that relevant professionals were consulted for information or guidance. This put people using the service at risk of harm (see requirement 1).

We were not assured risks to people would be identified and addressed. This could have a detrimental impact on people's health, safety, and wellbeing.

The provider could not demonstrate an understanding of Adults with Incapacity legislation or how this should be used in practice daily. The provider was not aware if people had granted Power of Attorney or if guardianship orders were in place. Copies of relevant Adults with Incapacity documentation were not available for reference. The provider was complying with requests or guidance without knowing if people's representatives had the necessary authority or powers to consent on people's behalf. This was important to ensure that people's rights were upheld. For example, taking into people's previous views and opinions.

People were generally supported by a consistent group of staff. However, some people told us they were supported by "strangers" on occasion. People told us members of staff they had not yet met arrived to provide their care and support. People felt uncomfortable and had to explain how they "liked things done". People were not informed who would be providing their support or when there were changes to the times of their support. People felt "out of control" and powerless. The issues identified must be addressed to improve people's outcomes and ensure their health, safety, and wellbeing (see requirement 2).

Requirements

1.
By 6 July 2026, in order to protect people's health, safety and welfare, the provider must
identify, assess and mitigate risks to people using the service. The provider must:

a) ensure staff, including members of the leadership team, complete training in identifying and mitigating risks;
b) assess people's needs on a regular basis and ensure changing needs and emerging or increasing risks are identified and appropriately addressed;
c) develop and regularly review relevant person-centred, supporting positive risk-taking plans. This should involve people and their representatives with input from members of the multi-disciplinary team as appropriate;
d) promote people's independence, rights and outcomes through opportunities to take positive, life-enhancing risks;
e) ensure measures to mitigate or reduce risks to people are fully researched and implemented as appropriate. This should include information and guidance from relevant health professionals; and
f) ensure residual risks are shared with people's representatives and health and social work professionals.

This is in order to comply with Regulations 3, 4(1)(a)(b) and 15 (b)(i)(ii) of The Social Care and Social Work (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 that:

'I make informed choices and decisions about the risks I take in my daily life and am encouraged to take positive risks which enhance the quality of my life.' (HSCS 2.24).

2. By 6 July 2026, in order to protect the health, safety and rights of people using the service, the provider retain copies of Adults with Incapacity orders. The provider must:

a) ensure relevant staff complete appropriate training and can demonstrate knowledge and understanding to comply with Guardianship or Power of Attorney orders; and
b) ensure the appropriate powers have been granted to ensure representatives have the authority to give consent and direct people's care and support needs.

This is in order to comply with Regulations 3, 4(1)(a)(b) and 15 (a) and(b)(i)(ii) of The Social Care and Social Work (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 that:

'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).

Areas for improvement

1.
The provider should ensure people using the service are fully informed and in advance about the staff who will be providing their care and support and when changes to staff are necessary. People should be consulted when the times of their support are changed.

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

'I know who provides my care and support on a day to day basis and what they are expected to do. If possible, I can have a say on who provides my care and support.' HSCS 3.11).

How good is our leadership? 2 - Weak

We identified strengths in quality assurance and improvement in the service. However, these were outweighed or compromised by significant weaknesses. The weaknesses substantially affected people's experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met.

We received positive feedback regarding the support, flexibility, and approachability of the leadership team. Staff said they could pick up the phone or drop into the office for support. They felt comfortable to discuss both professional and personal concerns. Staff told us support from the provider enabled them to continue in the post.

People using the service and their representatives described positive communication with the leadership team.

The Health and Social Care Standards state that people should benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes. There were few examples of quality assurance checks or audits carried out. This meant we were not assured that the provider had oversight of the key risks or areas for improvement in the service. We suggested a service improvement plan should be developed. This would provide information about the provider's understanding of their improvement/ development needs and how and when these would be addressed.

Members of the leadership team were only recently appointed. They would benefit from a clear learning and development plan to support their transition into leadership roles. This includes ensuring staff providing supervision for staff are suitably qualified. The provider must address quality assurance as a priority (see requirement 1). "Spot checks" were conducted by a dedicated member of staff. However, they had not undertaken any specialist training regarding quality assurance or service improvement. The leadership team evidenced efforts to oversee staff practice through observations of practice or 'spot checks' and staff competency checks. We sampled records and saw monitoring of infection prevention and control (IPC), moving and handling and levels of interaction with people. "Spot checks" should include a focus on outcomes experienced by people using the service and identify areas for improvement rather than task-based checks. This should include identifying staff learning and development needs. This is to ensure the health, safety and wellbeing of people using the service. The provider should ensure targets set are achievable. The regularity of "spot checks" was not being complied with in line with the provider's policy.

Incidents and accidents were not formally recorded through the service's quality assurance or health and safety processes. Although the service complied with reporting requirements from Fife Health and Social Care Partnership, they were not always submitted to the Care Inspectorate. We sent the provider a link to the Care Inspectorate Guidance on records providers must keep and notifications they must make. Incidents, accidents and prompts to take medication were recorded in people's care plans which made tracking events and actions taken difficult for members of the leadership team who conducted audits. This also involved checking a large number of records. There was no evidence of analysis of incidents or identification of trends. This would have supported the leadership team to identify and take appropriate action to reduce the risk of similar incidents or accidents reoccurring. This demonstrated a lack of understanding and accountability and put people's health, safety, and welfare at risk.

People using the service or their representatives should be at the heart of improving their service. Currently, people had little opportunity to provide feedback about their service other than formal reviews. Service improvement should be a continuous process with people being consulted regularly regarding their satisfaction with their service. Meetings should be recorded to evidence how people's needs, wishes and feedback have been addressed (see requirement 1).

A complaints policy and procedure were in place but there was no evidence of systems or processes to capture informal or formal complaints. The provider said the service had not received any complaints yet. This demonstrated a lack of understanding of quality assurance and improvement and a lack of oversight of the service, key risks and how these are mitigated.

We were not confident that the provider had appropriate knowledge, experience or understanding to facilitate safe and effective quality assurance and improvement based on consultation and upholding people's rights to make their own choices and decisions. The provider should ensure appropriate staff are supported to develop the necessary knowledge and skills.

Requirements

1.
By 6 July 2026, the provider must ensure service users' health, safety and well-being needs are met. In order to achieve this, the provider must ensure that the service is led well and quality assurance for the service is responsive and carried out effectively. This must include:

a) ensuring relevant staff undertake training in quality assurance and service improvement;
b) ensuring that people and their representatives are involved in identifying and planning improvements to their service. People's views, suggestions and choices are gathered on a regular basis and that this information is used to improve people's outcomes and experiences;
c) ensuring "spot checks" and practice observations are based on people's wishes, choices and outcomes and should not be task focused; and
d) appropriate governance and oversight is in place by the provider. This must include audits for monitoring and checking the quality of service which are accurate, up-to-date and ensure that analysis and follow-up leads to any necessary action to achieve improvements or change without delay;

This is in order to comply with Regulations 3 and 4(1)(a) and (b) 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 that:

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

How good is our staff team? 2 - Weak

We identified some strengths in staffing in the service. However, these were outweighed or compromised by significant weaknesses. The weaknesses substantially affected people's experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met.

The Health and Care (Staffing) (Scotland) Act 2019 was enacted on 1 April 2024. In terms of the provision of social care services, the legislation placed a duty on service providers to make appropriate staffing arrangements to ensure the health, welfare and safety of people using the service. This includes ensuring, at all times, appropriate levels of staff who have the required qualifications and training to provide safe, high-quality care. Service providers must also support staff wellbeing to ensure people's care and support is not adversely affected.

Staffing levels were appropriate. Services were commissioned on an individual basis. Fife Health and Social Care Partnership staff conducted assessments of people's needs. This determined the level of support people received. Where people's needs changed, systems were in place to request additional support or decrease people's support.

For people who required the use of equipment to support safe moving, two members of staff provided the service. To ensure staff worked well together the provider took factors such as staff training, experience and relationships between people using the service and staff.

Staff wellbeing was important to the provider and a range of wellbeing resources were available from both internal and external sources. Staff said they felt supported.

A review of previous induction records observed a structured induction and probation programme. However, we had significant concerns about staff learning and development. Staff training should be addressed as a priority. (see requirement 1).

Training records were only available for a limited number of courses including moving and assisting people, adult support and protection and dementia. There was no information regarding the mandatory and people's needs led training that staff had to undertake. We were concerned that there was no oversight of staff's learning and development regarding what training staff had undertaken, when refresher training was due and what training they had yet to complete (see requirement 1).

The service did not conduct regular training needs analysis. This would ensure the provider could respond to people's changing needs and the needs of people newly using the service. We identified gaps in training including supporting people living with epilepsy/seizures and mental health conditions. Training in moving and assisting people had expired for most staff. This meant staff were using equipment to support people when their skills-based competency assessments had expired. Whilst staff had previously completed the practical training and had competency assessments conducted, we advised the provider to develop a risk assessment which should be shared with relevant people and agencies until the matter is resolved. We were not assured that staff had the necessary skills, knowledge and understanding to meet the full range of people's needs. This put people's health, safety, and wellbeing at risk (see requirement 1).

Training was required in identifying and managing risk, quality assurance and improvement and adults with incapacity legislation and putting this into day-to-day practice. Members of the leadership team and other relevant staff must undertake this training.

The provider must be assured that staff can transfer their learning from training into practice in person-centred ways. The provider must develop tools and approaches to conduct assessments as appropriate. This is to ensure people experience safe, effective, and person-centred care and support.

The provider's supervision policy states that staff should have access to one-to-one supervision with their line manager on a quarterly basis. This should be considered as an opportunity for learning and development and promoting reflection and guidance. However, this was not taking place regularly, and some staff had not had supervision for a considerable length of time. Supervision should provide opportunities to review and plan staff's learning and development needs and support staff's wellbeing. Similarly, team meetings took place infrequently. The provider told us it was difficult to bring staff together. Team meetings were valued by staff and had a positive impact on morale. Team meetings are important in providing access to up-to-date best practice guidance and provider updates. The provider intends to look at providing meetings in different formats to improve staff access. We will evaluate the provider's progress at the next inspection (see requirement 1). Without regular supervision and team meetings, we could not be assured that people were being supported in line with current, best practice guidance by a well trained staff team. This put people at risk of harm.

Requirements

1. By 6 July 2026, the provider must protect the health, wellbeing, and rights of people using the service. In order to achieve this, the provider must ensure:

a) training needs analysis is carried out on a regular basis and results used to plan staff learning and development;
b) records of training and refresher training staff must undertake are organised, accessible, up-to-date and accurate;
c) training and refresher training is made available and carried out timeously to ensure staff's competencies remain current;
d) training enables staff to meet the full range of people's needs;

e) staff receive supervision regularly in line with the provider's policy; and
e) staff's understanding and ability to transfer learning into practice is assessed. Where areas for improvement are identified remedial action must be taken to ensure staff's competency.

This is in order to comply with Regulations 3, 4(1)(a)(c) and 15(a) and(b)(i) of The Social Care and Social Work (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 that:

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes.' (HSCS 3.14).

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

We identified some strengths in the care and support people received but these just outweighed weaknesses. Strengths still had a positive impact but the likelihood of achieving positive experiences and outcomes for people was reduced significantly because key areas of performance needed to improve. Therefore, we evaluated this quality indicator as adequate.

People had basic care plans in place. These were functional providing only basic and generic information about people's needs. There was little or no information about people's wishes or choices. For example, details about how people preferred their personal care to be delivered or how people like their beds made. This demonstrated that people all received the same care and support. However, we saw staff who knew people well providing support in line with their choices and clearly had the knowledge to develop more person-centred care plans (see requirement 1).

We raised concern about the use of language and terminology that infantilised people. For example, support to get to bed was referred to as "tuck calls" and supporting people with eating and drinking was referred to as "feeding" people. We were confident that the provider would take the appropriate action to address the language which appears disrespectful and undignified.

We discussed with the provider that care plans should provide the information and guidance to inform staff practice and enable unfamiliar staff to provide safe, consistent, and effective care and support. This was not the case currently. There was limited information about people's life history including important people and events, work history, and interests. This was particularly important where people were living with dementia to promote positive engagement and interaction and build trusting relationships. The provider must ensure care plans are strengths based and maintain and promote people's skills, abilities, and independence (see requirement 1).

It was not immediately apparent that people and/or their representatives participated in developing and reviewing their care plans. However, we saw people's involvement at the information gathering stage and at regular service reviews. The provider's electronic care planning system could be accessed by people using the service and their representatives and enabled input and reassurance. People told us staff went over care plans, or they read their care plans and either agreed with the content or requested changes.

As previously recorded, risks to people were not identified, assessed, or mitigated. Prompt action was required and we made a requirement. Please see the "How well we support people's wellbeing" section of this report for further detail.

Service reviews were taking place on a regular basis. We noted areas for improvement were rarely identified. This may be addressed by an increase in people's involvement in service improvement. We will evaluate the impact at the next inspection.

The service should request and retain copies of Adults with Incapacity documentation. This is to ensure the service is aware of and complies with the powers granted in legal orders. This will also ensure appropriate powers are granted to cover the decisions and requests made by people's representatives (see requirement 1).

Requirements

1. by 6 July 2026, to ensure people receive safe, consistent and effective care and support, the provider must develop care plans that as a minimum:

a) work in partnership with people and/or their representatives to develop and regularly review their care plans;
b) provide up-to date, sufficiently detailed guidance and information to inform staff's practice;
c) ensure people receive support that is person-centred and person-led where possible reflecting people's wishes and choices as well as their needs; and
d) are strengths based and maintain and promote people's independence

This is in order to comply with Regulations 3 and 4(1)(a)(b) of The Social Care and Social Work (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 that:

'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).

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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