Abbotsford Care, Glenrothes
Care Home Service

Strathburn Drive
Glenrothes
KY7 4UQ

Telephone: 01592 631 333

Type of inspection:
Unannounced

Completed on:
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Service provided by:
ABBOTSFORD CARE LTD

Service provider number:
SP2010010867

Service no:
CS2010248949

About the service

Abbotsford Care, Glenrothes (Strathburn Lodge) is a single storey care home situated in a residential area of Glenrothes. The home provides care and support for up to 40 people including older people, people living with dementia, dementia related illnesses and people under 65 who have mental and physical health conditions.

The care home is separated into four living areas, each with its own dining area and lounge. There are accessible garden grounds around the home with a variety of seating areas. The home is centrally located, with good access to local amenities and bus routes.

About the inspection

This was an unannounced inspection which took place between 14 and 19 April 2026. The inspection was carried out by four inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this 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 using the service and four of their relatives
- spoke with 15 staff and management
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals

Key messages

Opportunities for people to experience meaningful days was limited

Oversight of clinical care was inconsistent and unreliable

People and staff had formed warm, positive relationships

The home was clean and tidy

Support plans were not consistently reflective of people's care and support needs

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?	3 - Adequate
How good is our staff team?	3 - Adequate
How good is our setting?	3 - Adequate
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 evaluated this key question as 'weak'. An evaluation of weak applies to performance in which strengths can be identified but these are outweighed by significant weakness.

We observed staff who treated people with dignity and respect. Feedback from people and relatives was of staff who were patient and kind. Comments included 'wonderful' and 'brilliant'. We observed interactions between people and staff where it was evident they had built a positive rapport and could laugh and have fun together.

During this inspection we observed some opportunities for people to engage in 1 to 1 and group activity with staff. We reviewed evidence of activities taking place in some areas of the home; however, it remained unclear how well these activities were planned around people's individual interests. The service did not clearly demonstrate everybody had the same opportunities to engage in ways that were meaningful to them. Relatives provided consistent feedback that there were limited opportunities for their relatives to experience meaningful days. Relatives described their relatives having "nothing to do" and referred to it as "God's waiting room," indicating significantly limited opportunities for engagement. There is an outstanding area for improvement to address this (see area for improvement 1 in 'outstanding areas for improvement' section of this report).

We found a number of examples where restrictions were in place for individuals. Restrictions included limited access to the garden, tobacco and use equipment to monitor peoples whereabouts. During discussion staff were able to identify risks to people, however they didn't always follow this through with clear actions to reduce or manage identified risks. Comments from staff included, "We have always done it this way,". There was little evidence that people were supported to take positive risks or maintain independence. Risk assessments we sampled were generic and didn't clearly explain what the actual risks were or how staff should respond to keep people safe. In cases where people's rights were being restricted, there wasn't always clear reasoning or the right legal paperwork in place. We couldn't be confident that proper safeguards were in place. As a result we made a requirement (see requirement 1).
We observed mealtimes which were generally unhurried, calm and well managed. Staff deployment was considered and adjusted during these times based on the needs of supported people. In other areas of the service people spent most mealtimes in their rooms. We identified some people may have benefited from greater involvement in mealtimes. Relatives provided feedback that food did not always meet people's needs. We observed evidence of staff responding to these concerns by engaging with people about menu planning and making adjustments to support individual preferences. We were reassured staff were aware and making changes to support individual needs and preferences.

Medication audits had been effective in identifying errors in medication administration. However, concerns remained regarding oversight and management of medication. We identified gaps in daily audit sheets and noted that staff expectations were not always clearly communicated or met. Audits did not consistently demonstrate that they led to improved practice. We identified occasions where people did not receive their as prescribed medication because it was out of stock. Additionally there were occasions where records indicated homely remedies were out of stock. As a result, responses to constipation had been delayed. We found examples where 'as required' (PRN) protocols were missing. As a result people were at risk of not being appropriately supporting with their changing health needs. As a result we made a requirement (see requirement 2).

We observed some improvement in clinical oversight since the last inspection. Improvements included efforts to address individual health concerns through clinical risk meetings. We found examples of this working well to address and monitor health concerns, however this arrangement was reliant on agency staff which made it fragile. External health professionals told us they had confidence the service would source appropriate medical support, guidance, and assessment when required. However, where people experienced a decline in physical health appropriate actions were not always followed through. We found examples where recognised health assessment tools had identified risks of declining health, however not follow up actions or monitoring were implemented. Additionally where food and fluid targets had not been met, evaluation and follow up was inconsistent. The service begun taking steps to address these concerns during the inspection. The service did not meet an outstanding requirement from a previous inspection (Requirement 2). Due to ongoing clinical concerns we re-evaluated this key question as 'weak', meaning improvement in this area must be prioritised.

IPC standards were generally positive. Walkarounds and spot checks identified a clean, tidy environment that was free from odour. Domestic staff demonstrated knowledge and pride in their work. Cleaning schedules were completed with very few gaps. The laundry area was well managed and orderly. People could be confident the risk of spread of infection was being minimised.

Requirements

1. By 17 July 2026, the provider must ensure that people living in the service can experience full, meaningful and purposeful lives. To do this, the provider must, at a minimum:

a) review all restrictive practice used within the service, promoting a positive risk-taking culture

b) ensure that where restrictions in place they are supported by the appropriate legal framework

c) ensure staff have adequate training to recognise practice that may be restrictive and promote positive and life enhancing risk

This is in order to comply with Regulations 3 and 4(1)(a)(c) of The Social Care and Social Work (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: 'If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively' (HSCS 1.3).

2. By 19 June 2026, the provider must protect the health and wellbeing of people living in the service by ensuring there is safe and effective clinical care.
To do this, the provider must, at a minimum:

a) ensure adequate clinical oversight to monitor people's changing health needs and identify clearly defined roles and responsibilities for staff

b) ensure risks are identified and referrals to health professionals are completed timeously

c) ensure charts and records are completed timeously and are used to inform decisions about clinical risk

d) ensure there is effective medication management and adequate stock of prescribed medication at all times

e) ensure there is appropriate guidance for staff for the use of 'as required' medication and homely remedies.

This is in order to comply with Regulation 4(1)(a) and 4(2)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210). This is in order to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that: 'My care and support meets my needs and is right for me.' (HSCS 1.19).

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate. An evaluation of adequate applies where there are some strengths but these just outweigh weaknesses. Strengths may still have a positive impact but key areas of performance need to improve.

People should expect quality assurance and improvement to be led well. The service maintained clear oversight of professional registrations, including SSSC and NMC requirements for staff. Leaders had developed clear and effective systems to support managerial oversight of staffing, including training, professional registrations, and vacancies. These systems were easy to review and provided assurance regarding staffing oversight and compliance.

Records we reviewed demonstrated evidence of learning from significant events, accidents, incidents, and complaints. Leaders regularly reviewed circumstances surrounding events and addressed learning needs and areas practice could be improved, to reduce the risk of reoccurrence. We identified some occasions where incidents had not been reviewed or had been missed. The service should continue to work towards developing a consistent approach.

Staff told us they felt well supported by managers who were visible and approachable. Staff working nights also reported feeling well supported by specific night shift leadership who provided practical support and as well as advice on the phone. Staff received regular support during both formal supervision and informal discussions with managers. We reviewed accounts of reflective conversations which evidenced how staff had been supported, based on individual skills and needs. Leaders were focused on developing the staff team, whilst recognising both strengths and areas for development.

Staff had undertaken mealtime observations throughout the service. Observations were discussed with staff and included opportunities for reflection on practice and identified areas for development. Records of these observations were thorough, well maintained and were being effectively used as a tool to support quality and improve dining experiences for supported people.

Feedback from relatives was mixed. In the main relatives told us there were opportunities to provide feedback however this was not acted upon in practice. The service had taken some steps to attempt to engage relatives in improvement planning with little success. We suggested the service reconsider how it engages relatives in a way that is accessible to them (see outstanding areas for improvement, area for improvement 5).

We remained concerned about the effectiveness and inconsistency in oversight of clinical risk and medication. We have addressed this in key question 1 with a requirement (see requirement 2).

Leaders demonstrated a clear commitment to supporting improvement while acknowledging significant staffing challenges which had impacted their ability to implement and embed change. Despite challenges, the senior leadership team demonstrated a strong and sustained focus on improvement. Leaders had considered feedback from inspections and other professionals developed improvement plans and were actively working towards achieving actions. People could be assured the organisation was committed to improving outcomes across the home.

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate. An evaluation of adequate applies where there are some strengths but these just outweigh weaknesses. Strengths may still have a positive impact but key areas of performance need to improve.

Staff told us they felt part of a good team who worked well together to support each other. Staff felt the current arrangements for deployment supported effective teamwork. Where possible, staff worked primarily within specific areas to maintain continuity of care. Senior staff each focused on a designated area to support effective oversight. Feedback from relatives and people was that despite regular use of agency staff, there were some consistent staff who they knew well. This helped people to feel safe and gave relatives confidence. Staff described doing the best they could with the resources available.

Our observations were of warm interactions between people and staff. Staff did not appear rushed, Staff engaged in supportive interactions with people. On other inspection days, we observed that some areas of the home felt busier. This appeared to reflect the high level of support required by some people, which was evident during observations. Overall feedback regarding staffing levels was mixed across people using the service, relatives, and staff. Leaders identified ongoing staffing pressures including the absence of permanent day-shift nurses. As a result agency staff are regularly relied on to provide support. The organisation continue to attempt to recruit for a number of direct care roles.

Staff told us induction and ongoing training was beneficial and provided them with most of the skills they needed to do their job well. Since the last inspection leaders and staff had worked hard to improve compliance with mandatory training. However the rate of completion at 65% was still below what people should expect. We further identified some gaps in training related to people's specific needs. This included how information is shared across the staff team. Whilst we recognise training compliance had improved significantly, it had not yet reached a level people should reasonably expect (there is an outstanding area for improvement to address this, See area for improvement 6).

The service remained extremely fragile in terms of staffing. Leaders relied heavily on agency staff to support day-to-day care delivery and to maintain ongoing clinical oversight. This reliance continued to present risks to continuity and stability of care.

How good is our setting? 3 - Adequate

We evaluated this key question as adequate. An evaluation of adequate applies where there are some strengths but these just outweigh weaknesses. Strengths may still have a positive impact but key areas of performance need to improve.

Maintenance records showed that equipment and utilities had been serviced and checked within recommended timescales. We checked a sample of taps and radiators and found no issues. Maintenance issues were resolved quickly. Call buzzers were in working order and could be used by residents to call for help if needed. These calls were answered quickly. We were confident that people were living in a safe environment.

A fire safety audit last year had highlighted some areas for improvement, however these had not been actioned. We raised this with the service. An action plan had been put in place before we concluded our inspection but asked the service to be more proactive in acting on such recommendations.

Personalisation was encouraged and this was evident through some areas of the home including in communal areas and in people's bedrooms. There were various pictures, decorations and ornaments on display. This contributed to a warm and homely atmosphere in some parts of the home. However, some areas of the home lacked homely touches. There were also several areas of the home which would benefit from repair and refurbishment. We also found that staff work stations being in the middle of communal areas detracted from the homely feel of the service.

We were encouraged to see that the service was using the King's Fund Assessment Tool, which promotes appropriate signage and design features to support people living with dementia to be as independent as possible. There were still several areas for improvement which the service had identified but not yet actioned. We will check on progress at our next inspection.

The home was generally clean, tidy and free from odour. Laundry and kitchen areas had clear processes in place to maintain cleanliness. Staff wore Personal Protective Equipment (PPE) correctly when required and disposal of PPE was in line with good practice guidance. Staff sanitised their hands when moving through the home and between tasks and we saw frequently touched surfaces being cleaned throughout the day. Domestic staff were visible throughout the inspection and were knowledgeable about best practice guidance. We were confident that the risk of infection spread was reduced and people were kept safe as a result.

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

We evaluated this key question as adequate. An evaluation of adequate applies where there are some strengths but these just outweigh weaknesses. Strengths may still have a positive impact but key areas of performance need to improve.

We sampled plans across the service, the quality of these was inconsistent. Some plans included very detailed information specific to the person. However other plans lacked the same level of detail to guide consistent care and support. Some plans included contradicting information. The service should review plans to ensure they are accurate and include enough information to guide consistent care and support. As a result we made a requirement (see requirement 1).

People should expect that their personal plan is regularly reviewed. Plans should be reviewed in consultation with the supported person and/or their representative. We found evidence of reviews taking place within some units of the service. In the main reviews were basic and there was a lack of evidence of involvement from the person. Some plans had not been reviewed for an extended period of time. The provider was aware that some people had not had a review for longer than expected. The provider should implement plans to ensure people have reviews in a timely manner. As a result we made a requirement (see requirement 1).

Requirements

1. By 17 July 2026, the provider must promote the health, safety and wellbeing of people living in the service by ensuring that all care plans and risk assessments are accurate and up-to-date.

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

a) identify people's health and care needs and accurately describe the support required to meet those needs

b) have in place appropriate risk assessments and risk management plans in order to identify, reduce and mitigate risks

c) review care plans every six months, or more often if required, with the person and/or their representative

d) ensure care plans and risk assessments are easily accessible and contain clear instructions for staff.

This is in order to comply with Regulation 4(1)(a) and 5 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).

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

Requirements

Requirement 1

By 21 November 2025, the provider must ensure people receive consistent support to manage and monitor their physical health in line with their assessed care needs. To do this, the provider must, at a minimum:

a) ensure topical treatments are applied as directed

b) ensure people are supported to reposition as directed in their plan of care

c) ensure records associated with the management of skincare are accurate and up to date

d) ensure fluids are encouraged and records maintained.

This is in order to comply with Regulations (4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 211/210).

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

'My care and support meets my needs and is right for me' (HSCS 1.19).

This requirement was made on 18 September 2025.

Action taken on previous requirement

It is important that people's health and wellbeing benefits from their care and support. The service had made several improvements in how they support people whose skin is at risk of breakdown. Repositioning and regular checks were taking place in line with people's care plans and risk assessments. In addition, a daily wound review sheet was being completed and the treatment of all wounds were discussed at clinical risk meetings. We were pleased to see that several wounds had healed and no longer required treatment. The recording of food and fluid charts and topical cream applications had improved and we could see that this was further supporting improvement in people's skin integrity.

As a result this requirement was met.

Met - outwith timescales

Requirement 2

By 21 November 2025, the provider must ensure systems to support oversight of service provision are effective in improving outcomes. In order to do this the provider must at a minimum:

a) ensure there are regular and effective audits in place covering key aspects of service delivery including the environment, mealtimes, engagement and support planning

b) ensure areas identified as posing a risk to people's physical health are addressed without delay

c) ensure that where areas for improvement are identified they contribute to a development plan and are drivers for change.

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

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

This requirement was made on 18 September 2025.

Action taken on previous requirement

Leaders had developed improvement plans based on previous inspection findings, complaints, and incidents. This provided assurance the service was striving for improvement.

Managers had developed audit processes since the last inspection. Audits of mealtime experience and staff practice had been implemented consistently. We found evidence of these contributing to improved outcomes for people.

However audits associated with the environment were less consistent. Whilst the home was clean and tidy, managers did not consistently undertake organisation audits including, walkarounds. We were concerned the provider had failed to follow up on fire safety actions from a recent audit. We raised this during the inspection and were reassured the provider took immediate action to address concerns.

The service had begun to review personal plans. However plans we sampled plans included outdated or unclear information, which led to inconsistent care. We identified examples where staff recognised risks but did not take appropriate action to manage them, including poor monitoring of nutrition, hydration, and bowel management and limited response when people did not meet targets. Oversight of medication was poor, which had resulted in people not receiving the right medication at the right time. Although there had been improvements in aspects of clinical oversight, standards were still below what people should expect. The home relied heavily on agency staff to support clinical oversight, resulting in significant vulnerability and risk of falling standards. We found examples where referrals had not been made or followed up. Overall systems did not yet ensure safe and effective care.

This requirement was not fully met for a third time. As a result the evaluation for 1.3 has been re evaluated to a grade of 2 which is weak. We have re stated this requirement and changed the wording to better reflect progress.

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 promote the health and wellbeing of people using the service, the provider should ensure that activities are planned, recorded and evaluated on a regular basis. This should include, but is not limited to, ensuring people who prefer not to take part in group activities are given the opportunity to experience a meaningful day in other ways.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors' (HSCS 1.25); and 'I can maintain and develop my interests, activities and what matters to me in the way that I like' (HSCS 2.22).

This area for improvement was made on 18 September 2025.

Action taken since then

People should expect to be supported to spend their time in ways that meet their personal preferences and outcomes. During our visits we observed some people being supported to engage in one-to-one activities including nail painting, music and conversation. However we did not observe any meaningful engagement with other people, including those who spent most of their time in their bedrooms. Relatives told us they were concerned about the lack of activity for their loved ones and were of the view this had a detrimental impact of their wellbeing. Staff told us they facilitated some group activities, but these were based largely on what staff thought people would enjoy rather than people's preferences or outcomes.

As a result this area for improvement has not been met.

Previous area for improvement 2

Staff should receive regular supervision and appraisals to ensure their learning and development needs are assessed, reviewed, and addressed. Alongside this, the service should develop systems to support oversight of when supervision and appraisals have taken place and when they should be undertaken again.

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).

This area for improvement was made on 13 November 2024.

Action taken since then

Staff we spoke with told us they felt well supported by managers both working days and nights. Oversight of supervision was clear and provided assurance staff were receiving this regularly. Where learning needs were identified within the staff team, individual development plans were implemented.

Newer staff told us they felt well supported, and we saw evidence that new staff received structured support during induction. Overall, leaders actively supported staff through both formal supervision and ongoing informal discussions, which helped promote development and address performance effectively.

This area for improvement has been met.

Previous area for improvement 3

The service should be able to demonstrate staffing levels, skill mix and deployment of staff contribute to supporting the emotional and physical wellbeing of people living in the service.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My needs are met by the right number of people' (HSCS 3.15); and 'I can maintain and develop my interests, activities and what matters to me in the way that I like' (HSCS 2.22).

This area for improvement was made on 13 November 2024.

Action taken since then

The service had experienced significant challenges related to staffing levels and skill mix. We recognise this is an ongoing pressure within the sector and the provider continues to attempt to recruit suitably skilled staff. We found leaders utilised available resources and supported staff well despite current staffing pressures. The service maintained consistency by block booking agency staff, which helped provide continuity of care. Staff told us they worked well together as a team, and this was reflected during our observations of practice. Leaders used a dependency tool to help inform staffing numbers and guide deployment. This demonstrated a structured and proactive approach to ensuring people received the right support at the right time.

As a result this area for improvement has been met.

Previous area for improvement 4

To promote the health and wellbeing of people using the service, the provider should ensure feedback is regularly sought from people about food quality and choices. This feedback should be clearly used to inform future menu planning.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I can choose suitably presented and healthy meals and snacks, including fresh fruit and vegetables, and participate in menu planning' (HSCS 1.33).

This area for improvement was made on 18 September 2025.

Action taken since then

We spoke with kitchen staff who demonstrated clear oversight of people's personal preferences. We observed kitchen staff directly asking people about their food choices and if they had enjoyed their meal. We found evidence of daily feedback sheets being completed by people and being reviewed by the chef. We found further examples where feedback had been acted upon and individual meal plans been developed as a result.

This area for improvement has been met.

Previous area for improvement 5

In order to support health and wellbeing the service should promote a culture of responsive and continuous improvement. In order to do this the provider should ensure that people's views, suggestions, and choices are gathered on a regular basis and used to inform improvement planning.

This is to ensure that my care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I can be meaningfully involved in how the organisations that support and care for me work and develop' (HSCS 4.6); and 'I am supported to give regular feedback on how I experience my care and support and the organisation uses learning from this to improve' (HSCS 4.8).

This area for improvement was made on 18 September 2025.

Action taken since then

Managers had recently distributed questionnaires for relatives to provide feedback on the service. However reported engagement was significantly limited. Relatives told us they felt able to give feedback however this was not acted upon. Some relatives told us they had lost confidence in the leadership team, because feedback did not result in change. The service should continue to develop ways for relatives to provide feedback that are accessible to them. Feedback should be used to inform future improvement planning.

As a result this area for improvement has not been met.

Previous area for improvement 6

The provider should ensure that service users experience a service with well trained and informed staff. All mandatory training should be up-to-date. In addition, any other relevant training should be completed, where it is appropriate to the role performed by the staff member, to meet the assessed care and support needs of service users. This should include regular monitoring to demonstrate how the training received is being implemented in practice, taking into account current best practice guidance.

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).

This area for improvement was made on 18 September 2025.

Action taken since then

Staff told us induction and ongoing training was beneficial and provided them with most of the skills they needed to do their job well. Some staff identified person specific training which may further enhance their knowledge and ability to support certain individuals. Whilst the leaders had taken steps to address gaps in knowledge amongst the staff team, we identified key areas of practice which staff would benefit from additional training and guidance in, including restrictive practices.

The organisation had set learning courses which were mandatory for all staff. We were able to view this suite of courses which included key areas of practice, including infection prevention, safeguarding, fire safety and dementia. Since the last inspection leaders had staff had worked hard to improve compliance with mandatory training. However the rate of completion at 65% was still below what people should expect. As a result we could not be confident staff were consistently well trained.

This area for improvement has not been met.

Previous area for improvement 7

To promote the health and wellbeing of people using the service, the provider should ensure staff work well together as a team, providing consistently positive experiences for people living in the home.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience stability in my care and support from people who know my needs, choices and wishes, even if there are changes in the service or organisation' (HSCS 4.15).

This area for improvement was made on 18 September 2025.

Action taken since then

Staff we spoke with told us they felt part of a good team. Most staff generally worked in specific areas of the service and with the same colleagues. Senior staff again primarily focused on supporting oversight of specific people living in the home. Feedback from relatives was of key consistent staff, who knew them and their relatives well.

This area for improvement has not been met.

Previous area for improvement 8

In order to support health and wellbeing of people the provider should ensure support plans consistently include detailed, accurate guidance to guide care and support in line with people's needs and preferences.

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).

This area for improvement was made on 18 September 2025.

Action taken since then

We sampled plans and risk assessments which included out of date and insufficient guidance to support safe and effective care.

Given concerns associated with care and support planning we made a requirement. This area for improvement is no longer in place and has been incorporated into a new requirement under key question 5.

Previous area for improvement 9

In order to promote the welfare, choice and safety of people the provider should ensure records of legal powers are clearly documented and copies retained.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account' (HSC 2.12).

This area for improvement was made on 18 September 2025.

Action taken since then

We were concerned about ongoing restrictions in place. This service was unable to demonstrate records of legal powers had been consistently sourced or retained. We sampled plans and risk assessments which included out of date and insufficient guidance to support safe and effective care.

Given concerns associated with care and support planning we made a requirement. This area for improvement is no longer in place and has been incorporated into a new requirement under key question 5.

Previous area for improvement 10

In order to ensure that people's views influence their care and support, the manager should ensure reviews take place regularly and that minutes of review meetings reflect how the person and their legal representatives have been consulted and involved in discussions.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My views will always be sought and my choices respected, including when I have reduced capacity to fully make my own decisions' (HSCS 2.11); and 'If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account' (HSCS 2.12).

This area for improvement was made on 18 September 2025.

Action taken since then

We sampled plans and risk assessments which included out of date and insufficient guidance to support safe and effective care. The service was unable to demonstrate people and/or their legal representatives had been meaningfully involved in discussions.

Given concerns associated with care and support planning we made a requirement. This area for improvement is no longer in place and has been incorporated into a new requirement under key question 5.

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
1.2 People get the most out of life	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	2 - Weak
1.4 People experience meaningful contact that meets their outcomes, needs and wishes	3 - Adequate
1.5 People's health and wellbeing benefits from safe infection prevention and control practice and procedure	4 - Good

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our staff team?	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	3 - Adequate

How good is our setting?	3 - Adequate
4.1 People experience high quality facilities	3 - Adequate

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate
5.2 Carers, friends and family members are encouraged to be involved	3 - Adequate

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Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

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