Care service inspection report

Fairfield Care Home

Care Home Service Adults

68-70 Fairfield Road
Inverness
IV3 5QP
Telephone: 01463 233155

Type of inspection: Unannounced

Inspection completed on: 12 January 2015

Contents

Service provided by:

T S Manda

Service provider number:

SP2003002398

Care service number:

CS2003010530

If you wish to contact the Care Inspectorate about this inspection report, please call us on 0345 600 9527 or email us at enquiries@careinspectorate.com

Summary

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change after this inspection following other regulatory activity. For example, if we have to take enforcement action to make the service improve, or if we investigate and agree with a complaint someone makes about the service.

We gave the service these grades

Quality of Care and Support	2	Weak
Quality of Environment	2	Weak
Quality of Staffing	2	Weak
Quality of Management and Leadership	2	Weak

What the service does well

There was some positive feedback from relatives and residents that we spoke with.

The service offered activities over 7 days of the week and the residents that we spoke with enjoyed the interaction of the staff.

What the service could do better

During this inspection we concluded that the service was still not operating in compliance with Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

We have maintained the Improvement Notice and given extended timescales for those requirements that have not been fully addressed. Information about this can be found on our website at www.careinspectorate.com We also concluded that not all of the requirements and recommendations that were highlighted within the inspection report of August 2014 had been satisfactorily addressed.

The service needs to address the following areas:

The way the care is planned and reviewed needs to be better, to make sure that the residents are getting the right amount of care and support to meet their needs.

The service must further develop and carry out skin assessments and take appropriate actions, to ensure residents' needs are met.

The management of medication needs to be better. Also the overall administration, dispensing, recording and ordering and storage of medications needs to be better.

The provider needs to put in place and implement an effective programme of training for staff, which includes management of continence, pain management, medication, wound management/tissue viability, moving and handling, infection control, dementia awareness, adult support and protection, restraint, dignity and respect, SVQ and care planning and review, to ensure that staff have the appropriate skills to carry out their work effectively.

The provider needs to further develop effective systems for the monitoring of staff practice in all aspects of their work.

The provider needs to further develop an effective programme of induction, supervision and appraisal. To provide all staff with support, the opportunity to raise individual issues and as a means of monitoring staff communication skills, staff awareness of working practices, effectiveness of induction and training and to identify any further training and support needs.

The provider needs to demonstrate that staff practice has improved in all aspects of the care provided to residents and whenever poor practice occurs. They were to ensure that they were taking appropriate action to ensure such practice is eliminated and that future practice is being monitored, to ensure poor practice does not recur.

At this inspection we found that the service had not sufficiently addressed the seven requirements and five recommendations that were highlighted within the inspection report of August 2014. The service had not addressed the requirements that were made from three complaints, which were made to us and which were upheld. Furthermore they had not provided us with an action plan within the given timescales, as highlighted within the complaint reports. Please refer to the body of the report for further information.

What the service has done since the last inspection

We could see that some improvements had been made such as, how the residents' needs were monitored in relation to nutrition and hydration and tissue viability.

Formal reviews of residents' care and support needs had been carried out with the majority of the residents and their relatives. The remaining reviews were planned for the near future.

We could see that staff had started working on developing and planning the care for the residents.

Further refurbishment work had been carried out.

There were some new furniture and fixtures and fittings in place.

Conclusion

We identified many areas that required to be improved upon and concluded that this care home was not providing an overall satisfactory level of care to all residents.

The Improvement Notice that was issued on 4 September 2014 has been extended, which addresses the most serious concerns. Further requirements are made within this report. This care home is under a formal embargo from NHS Highland, which means that there will be no new admissions to the home until the areas we identified as requiring to be addressed, are satisfactorily met.

1 About the service we inspected

The Care Inspectorate regulates care services in Scotland. Prior to 1 April 2011, this function was carried out by the Care Commission. Information in relation to all care services is available on our website at www.careinspectorate.com.

This service was previously registered with the Care Commission and transferred its registration to the Care Inspectorate on 1 April 2011.

The Care Inspectorate will award grades for services based on findings of inspections. Grades for this service may change after this inspection if we have to take enforcement action to make the service improve, or if we uphold or partially uphold a complaint that we investigate.

Requirements and recommendations

If we are concerned about some aspect of a service, or think it could do more to improve its service, we may make a recommendation or requirement.

- A recommendation is a statement that sets out actions the care service provider should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

- A requirement is a statement which sets out what is required of a care service to comply with the Public Services Reforms (Scotland) Act 2010 and Regulations or Orders made under the Act, or a condition of registration. Where there are breaches of the Regulations, Orders or conditions, a requirement must be made. Requirements are legally enforceable at the discretion of the Inspectorate.

Fairfield Care Home is registered to provide a care home service for up to 35 older people, some of whom may require nursing care. Up to four of these places may be used to provide respite care. Accommodation is in two, formerly private, detached two-storey houses, which have been joined together, extended and converted for the present use. All bedrooms are single and have en-suite facilities consisting of a wash hand basin and toilet. The care home is situated in a residential part of Inverness. There were 28 residents at the time of the inspection.

The Charter of Care states that the service intends to endeavour to support service users to live their lives as normally as possible, to promote their independence and maximise their individual potential by providing individually tailored services within a culture of continuous improvement.

Based on the findings of this inspection this service has been awarded the following grades:

Quality of Care and Support - Grade 2 - Weak
Quality of Environment - Grade 2 - Weak
Quality of Staffing - Grade 2 - Weak
Quality of Management and Leadership - Grade 2 - Weak

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change following other regulatory activity. You can find the most up-to-date grades for this service by visiting our website www.careinspectorate.com or by calling us on 0345 600 9527 or visiting one of our offices.

2 How we inspected this service

The level of inspection we carried out

In this service we carried out a high intensity inspection. We carry out these inspections where we have assessed the service may need a more intense inspection.

What we did during the inspection

We wrote this report following an unannounced inspection. This was the second statutory inspection for this service, therefore we only looked at how the service was addressing the requirements and recommendations made at the inspection of August 2014. We also looked at how the service was addressing the areas highlighted within the Improvement Notice, which was issued on 4 September 2014. The inspection took place on 7 and 8 January 2015 between the hours of 9.30am and 8pm. We gave feedback to the provider and the interim manager on 12 January 2015. Also present at the feedback were an NHS District Manager and the NHS Lead Improvement Lead (older people residential/day care services).

During this inspection process, we gathered evidence from various sources, including the following:

We spoke with:

- ten residents
- six relatives/friends
- the interim manager
- three qualified staff (including night staff)
- three care assistants
- an activities co-ordinator
- the handyman/maintenance staff member
- the cook

We looked at:

- the participation strategy, this is the service's plan for how they will involve the people who use the service, their relatives and other stakeholders
- minutes of staff meetings
- care plans/support plans
- reviews of care and support needs
- nutrition/hydration and tissue viability monitoring charts

- the overall management of medication
- risk assessments for people who use the service
- the overall management of residents finances
- evidence of meetings with other health care professionals
- accident and incident records
- the staff rota
- staff training records
- the training plan
- staff supervision and appraisal records
- staff induction records
- staff recruitment records
- the environment and equipment
- maintenance records
- the services policies and procedures in relation to the quality statements that were being looked at
- the environment and equipment.

Grading the service against quality themes and statements

We inspect and grade elements of care that we call 'quality themes'. For example, one of the quality themes we might look at is 'Quality of care and support'. Under each quality theme are 'quality statements' which describe what a service should be doing well for that theme. We grade how the service performs against the quality themes and statements.

Details of what we found are in Section 3: The inspection

Inspection Focus Areas (IFAs)

In any year we may decide on specific aspects of care to focus on during our inspections. These are extra checks we make on top of all the normal ones we make during inspection. We do this to gather information about the quality of these aspects of care on a national basis. Where we have examined an inspection focus area we will clearly identify it under the relevant quality statement.

Fire safety issues

We do not regulate fire safety. Local fire and rescue services are responsible for checking services. However, where significant fire safety issues become apparent, we will alert the relevant fire and rescue services so they may consider what action to take. You can find out more about care services' responsibilities for fire safety at www.firelawscotland.org

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

The requirement

It is a requirement that the provider ensures that the information provided regarding the service on offer is accurate.

This is in order to comply with:

Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement: 19 December 2014.

What the service did to meet the requirement

The brochure had been taken out of circulation and there had been no replacement.

The requirement is: Not Met

The requirement

It is a requirement that the provider ensures that each resident was fully assessed in relation to their continence needs.This information was then to be used to develop and implement effective care plans.The care plans were then to be reviewed on a regular basis and any changes to needs were to be documented.

This is in order to comply with:

Regulations 4(1)(a), 5(1)(a)(b)(i)(ii)(iii) of the Social Work Improvement Scotland (Requirements of Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement is: 19 December 2014.

What the service did to meet the requirement

There had been some work completed within the care plans, however, this was not significant enough to warrant having met the requirement. Please refer to the body of the report for further information.

The requirement is: Not Met

The requirement

It is a requirement that the provider makes proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider having appropriate procedures for the control of infection.

This is in order to comply with:

Regulation 4(1)(a)(d) and 10(2)(a)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement: 19 December 2014.

What the service did to meet the requirement

There had been some improvements in relation ot the overall management of infection control, however, this was not significant enough to warrant having met the requirement. Please refer to the body of the report for further information.

The requirement is: Not Met

The requirement

It is a requirement that the provider makes proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider reviewing the overall management of accidents/incidents/falls to ensure that service users were not left at continued risk.

This is in order to comply with:

Regulation 4(1)(a), 5(1)(2)(a)(b)(i)(ii)(iii) and 10(2)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement: 19 December 2014.

What the service did to meet the requirement

This requirement was included within the Improvement Notice, which was issued on 4 September 2014. It had not been met. Please refer to the body of the report for further information.

The requirement is: Not Met

The requirement

It is a requirement that the provider makes proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider having appropriate procedures for the control of health and safety across all areas of the service.

This is in order to comply with:

Regulation 4(1)(a)(d) and 10(2)(a)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement: 19 December 2014.

What the service did to meet the requirement

There had been some development in relation to the overall management of health and safety issues, however, this was not significant to warrant having met the requirement. Please refer to the body of the report for further information.

The requirement is: Not Met

The requirement

It is a requirement that the provider makes proper provision for staff to take part in an effective and appropriate induction. At the end of the induction staffs competence and any further training needs were to be addressed.

This is in order to comply with:

Regulation15(a)(b)(i) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement: 19 December 2014.

What the service did to meet the requirement

There had been no improvements in relation to the development of the induction process. Please refer to the body of the report for further information.

The requirement is: Not Met

The requirement

It is a requirement that the provider ensures that they develop and implement quality assurance systems and processes that service users and their relatives/ representatives, could be assured that the service they were receiving was of a high quality.

This is in order to comply with:

Regulations 3 and 4(1)(a) of the Social Work Improvement Scotland (Requirements of Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement is: 19 December 2014.

What the service did to meet the requirement

There had been no overall development of quality assurance systems. Please refer to the body of the report for further information.

The requirement is: Not Met

The requirement

It is a requirement that the provider demonstrate that staff practice has improved in all aspects of the care provided to service users and whenever poor practice occurs.Through putting into place and implementing a procedure which will detect poor practice and that:

a) you are taking appropriate action to ensure such practice is eliminated;

b) such action is being recorded; and

c) that future practice is being monitored to ensure poor practice does not recur.

This is in order to comply with:

Regulations4(1)(a) and 9(2)(b) of the Social Work Improvement Scotland (Requirements of Care Services)Regulations 2011 Scottish Statutory Instrument 2011/ 210.

Timescale for this requirement is: 19 December 2014.

What the service did to meet the requirement

There had been no significant developments in relation to the monitoring of staff practice. Please refer to the body of the report.

The requirement is: Not Met

What the service has done to meet any recommendations we made at our last inspection

Five recommendations were made as a result of the inspection of August 2014. These were in relation to participation, health and well being, a safe environment, staffing and quality assurance. Please refer to the body of the report for further information.

The annual return

Every year all care services must complete an 'annual return' form to make sure the information we hold is up to date. We also use annual returns to decide how we will inspect the service.

Annual Return Received: No

Comments on Self Assessment

Every year all care services must complete a 'self assessment' form telling us how their service is performing. We check to make sure this assessment is accurate.

N/A

Taking the views of people using the care service into account

We spoke with 10 residents during the inspection visit. Overall they were happy living in the home and felt that the staff were caring, kind and helpful. They all enjoyed the interactions from the activities co-ordinators and said that they were missing Margaret, as she was on holiday at the time of the inspection. Residents said that they were happy with their bedrooms and that their laundry was well taken care of. However, there was a mixed reaction to the provision of meals in terms of the quality and the range of meals offered.

Comments overall included:

"I am content"

"I am happy and I get the the support I need"

"I feel that staff morale is better than when you were last here"

"I choose what I want to eat every day"

"I am happy and I have a nice room which is kept clean and tidy"

"The food is OK but there is not a lot of variety, if it's not mince it's chicken"

"I am waiting to go to another care home to be near my family but in the meantime I am happy to be here"

"I have been speaking with my daughter on the phone and staff help me to stay in touch with her"

"Staff are very helpful"

"I would like more British food"

"I am now going downstairs for lunch and I am glad to be amongst others again"

"I know who the manager is and they provided me with some religious script recently."

Taking carers' views into account

We spoke with six relatives/friends during the inspection. All indicated that they were happy with the provision of care and support. They were all aware of who the new interim manager was and felt that they were approachable. They were all complimentary about the staff in the home and felt that they could speak with them about any issues they may have.

Individual comments included:

"Last month staff were very busy rushing around, which is not good for my relative, as they need to be treated 'smoothly'"

"Sometimes there are not many staff around"

"The activities staff are very good"

"The home is consistenly clean and smells nice"

"It is quite dark when you come into the home"

"Staff are very friendly"

"I am made to feel welcome"

"I continue to feel that my relative is well cared for."

3 The inspection

We looked at how the service performs against the following quality themes and statements. Here are the details of what we found.

Quality Theme 1: Quality of Care and Support

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Service strengths

At this inspection, we found that the performance of the service was adequate for this statement. We concluded this after we looked at the participation policy, care plans; records of reviews, information posted in the home and spoke with residents and relatives to assess this statement.

Twenty five out of the 28 residents had taken part in a formal review. The remaining reviews had been planned for the near future. Relatives and representatives had been encouraged to attend. Minutes were produced from these reviews and we could see that there was lots of discussion surrounding the current level of care and support that was offered. There was also the opportunity for residents and their relatives to give opinions and to request changes and/or additions to care and support needs. We could see in some instances that, where changes had been requested, some of these had been addressed. For example, referrals had been made to other healthcare professionals. Further monitoring of drinks and food had been carried out.

There was information at the entrance to the home for relatives such as, the inspection report, the participation strategy and how to make a complaint.

During the festive holidays the staff had organised parties for residents and their relatives. We spoke with residents and their relatives and they said that they had enjoyed these very much.

When speaking with the residents they all said that they were being cared for and supported in a manner that was of their choosing. We also spoke with some relatives

and they felt that the management and staff were approachable and that they were content with the care that was offered.

We observed staff offering choices to residents with their meals and drinks, where they wanted to sit and when they wanted to go to their bedrooms.

Areas for improvement

A requirement had been made at the last inspection of August 2014 and this was in relation to the brochure for the home being updated. This was so that the information that potential residents and relatives were given was a true reflection of the service offered. This had not been addressed. Therefore, this requirement has not been met and will remain in force. However, it must be stated that at the current time the service was subject to an embargo, which was placed on them by NHS Highland. This meant that they were not able to admit any further residents until further improvements had been made. Once this embargo had been lifted it is expected that the brochure will be reviewed and updated accordingly. **See Requirement 1.**

The recommendation that was made at the last inspection of August 2014 had not been met. We also found at this inspection that there were other areas that needed to be further developed. This was so that the service provided meaningful opportunities in which the residents and relatives could be involved in their overall care and support. Therefore the service and provider were to ensure that:

- The participation policy was updated so that it was clear and easy to read and showed the different methods that the service used to involve people using the service. Once this has been reviewed and updated it was to be shared with residents, relatives and staff.
- The service was to recommence the use of their questionnaires. They were to be dated and give the opportunity for those completing them to state their name and contact details. They were to ensure that there was an evaluation and summary from the use of these. If there were any specific issues raised from the use of the questionnaires. the service was to ensure that there was evidence of how these had been addressed. The service was to share the evaluation and summary with residents, relatives and staff.
- The service was to recommence residents' and relatives' meetings. They were to ensure that any meetings held were fully minuted and that an action plan was developed and then reviewed, to show how the service was responding to suggestions/ideas or concerns. Meeting minutes were also to be shared with residents, relatives and staff.
- The service was to recommence the use of the newsletters. These could contain information about the outcomes from the use of questionnaires, the outcomes from any inspections, including the action plan, how to make

comments/complaints or suggestions, staffing (new and leavers) and the overall development of the service.

- The staff photograph board, which was put into place on the suggestion of relatives was not being used. The service was to review the use of this by asking residents and relatives views.
- The service was to review the use of the menu board (Please refer to quality statement 1.3 for further information regarding this).
- The service was to ensure that, where suggestions were made as part of the formal review, these were carried out (Please refer to quality statement 1.3 for further information regarding this).
- The service was to develop the care plans so that they could evidence staff offering choice or promoting participation.
- The service was to ensure that the inspection report that was made available at the entrance to the home was the most current copy.
- In looking to develop the overall participation of residents, the service should take account of those who have communication difficulties and those residents who live with dementia.

See Recommendation 1

Grade awarded for this statement: 3 - Adequate

Number of requirements: 1

Number of recommendations: 1

Requirements

1. It is a requirement that the provider must ensure that the information provided regarding the service on offer is accurate.

   This is in order to comply with:

   Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: As stated the service was subject to an NHS Highland embargo in relation to admissions. Until further significant improvements have been made this remains in force. Therefore, the provider was to ensure that, when they were able to accept admissions to the service, that they provided residents and relatives with accurate and up to date information regarding the provision of the service.

Recommendations

1. It is a recommendation that the provider should implement and further develop the methods by which they worked with residents and relatives in relation to their care and support. This is in order to promote participation and the on-going development of the overall care and support needs of the residents.

   National Care Standards, Care homes for older people
   Standard 5 - Management and staffing
   Standard 6 - Support arrangements
   Standard 8 - Making choices.

Statement 3

We ensure that service users' health and wellbeing needs are met.

Service strengths

At this inspection, we found that the performance of the service was weak for this statement. We concluded this after we looked at care plans, reviews and spoke with residents and relatives.

Four requirements were made within the Improvement Notice that was issued to the service on 4 September 2014. These were in relation to nutrition, tissue viability and skin care, the management of medication and the overall review of care plans. How the service had addressed these requirements are as follows:

By 6 January 2015 (extended from 13 October 2014) you must demonstrate that you are able to identify where service users are at risk of malnutrition/ dehydration and that you are carrying out assessments and taking appropriate actions to ensure service users' nutrition and hydration needs are met.

The interim manager had developed a system whereby residents' weight, Body Mass Index and Malnutrition Universal Screening Tool scores were monitored each month. They used a colour code to be able to easily identify those who were at risk, or who had been, or needed to be, referred to the dietician. Food and fluid monitoring charts were used by staff over a 24 hour period and we could see that these were being appropriately completed. The total amount of fluids that were taken by individual residents was added up at the end of each day. This information was then discussed at each handover from one shift to another. We could see that, in the main, the total amounts of fluids that were being taken were appropriate for that individual. Staff had a good understanding of the need to promote fluids and were aware of how much an individual resident required to take, over a 24 hour period. We could see from records that residents were either maintaining their weight or were gaining

weight, there were less residents who were deemed as being at risk. As a result of this there were less referrals to the dieticians. **This requirement has been fully met.**

By 6 January 2015 (extended from 13 October 2014) you must (a) ensure that all service users have a skin assessment carried out and documented; and (b) where a service user has been assessed as being at risk of pressure ulcers, put in place and implement a care plan to address that risk, which includes the following information:-

- Level of risk and skin integrity status
- Type of mattress in use
- Type of chair cushion in use
- Frequency of skin checks
- Frequency of positional changes/whether turning chart in use
- Any prescribed lotions or creams with details of where, how often applied etc
- Any other relevant individual care interventions
- The frequency of the care plan review
- Where a service user has a wound there should be an effective care plan in place, which is being fully implemented at all times for each wound, with evidence of a wound assessment/treatment chart, record of prescribed wound care products and evidence of on-going evaluation of the wound's progress.

The interim manager had developed a system whereby residents' skin integrity was assessed and recorded each month. This included the calculated risk and what type of mattress was being used. The service was also using the skin pressure cross from the 'Managing Falls and Fractures in Care Homes' pack. This highlighted to staff which residents had a pressure ulcer and whether it was an existing, or a new ulcer. It also highlighted where on the body the ulcer was and what grade of ulcer. Three residents had been identified as having ulcers or skin conditions and they were being cared for and monitored by the Community Nursing Team. They used their own assessments and treatments plans and they were maintained in each resident's bedroom. Staff were using NHS Skin Bundles for those residents who were deemed at risk, which identified the care that was needed and the frequency of positional changes. Positional changes were recorded and we could see that staff were completing these on a regular basis.

By 6 January 2015 (extended from 13 October 2014) you must make proper provision for the administration, dispensing, recording and storage of medication. To include but not limited to ensuring the following:-

a) Where a service user has been assessed as lacking capacity, staff should use an

appropriate pain assessment tool to ensure that medication administered has been effective in managing pain, and

b) Follow specific instructions when administering controlled drug pain relief patches and put in place any specific records which must be maintained

c) Develop specific care plans, which record how and in what circumstances, "as required" (PRN) medications are administered and put in place any specific records which must be maintained.

The service was now using and completing the pain relief patch records.

We also looked at the overall management of medication and could see that this was of a better standard. There was no stockpiling of medicines. The returns book was being used on a regular basis. We checked the Controlled Drugs and could see that these were all correct. All residents now had a photograph in place within the Medication Administration Record (MAR) folder. The service continued to receive the support from the NHS Pharmacy technician and we were informed by them that they felt that the overall management of medication had improved.

By 6 January 2015 (extended from 13 October 2014) you must:-

a) Ensure that, within 28 days of the date on which the service user first received the service, prepare a written personal plan, which sets out how the service user's health, welfare and safety needs are to be met; and

b) Review and revise each service user's written personal plan, where appropriate in consultation with service users and their representatives; and

c) Record and implement all required actions identified as a result of the said review to ensure service users health welfare and safety needs are being met.

We could see that all residents had a care plan folder in place. Formal reviews had been carried out for 25 out of the 28 residents. The remaining three were planned for the near future. Residents and their relatives/representatives had taken part in these reviews.

Minutes from these meetings were available for staff. These showed what had been discussed and there was evidence to support the fact that residents and relatives were being asked for their opinions. They were also supported to request changes and or/additions to the care and support that was offered.

Some residents had "All about Me" information, which gave staff an overview of their past lives, who was important to them and what activities and hobbies they enjoyed.

Some of these contained good information and some had been completed by their relatives.

All residents had an oral health care assessment and care plan in place.

All residents had been seen by an optician to assess their vision.

There was evidence that other healthcare professionals were involved in medical and associated healthcare needs. When residents became ill the staff were carrying out regular observations.

Residents had a risk assessment in place if needed and these were associated to healthcare needs.

Residents had continence care plans in place.

The service employed two activities staff and they covered seven days per week. Residents spoken with said that they enjoyed spending time with the staff and were very enthusiastic about both members of staff. We could see that these staff were very motivated and had a caring attitude. They were also involved in promoting residents with taking drinks and snacks. Where needed, they were recording what residents took on the input charts. We spoke with one of these staff members who had only been working in the service for a few months. Although they had experience in care, this was related to children. We felt that this staff member needed further training in terms of caring for and providing activities for older people. There is a requirement regarding staff training in quality statement 3.3 and the provider was to take account of this staff member when planning staff's training needs.

We observed mealtimes over the two days of the inspection. We could see that this was a more positive experience for residents. There was some good interaction between staff and residents. This improvement was due partly to the supervision and monitoring of staff practice in this area. In addition, tables were appropriately set prior to mealtimes. The staff were also using the quiet lounge for those residents who needed more one to one support and a more quiet environment. Meals that were taken to residents' bedrooms were covered appropriately. There was a menu board, which was situated outside the dining room and this had photographs of the meals that were planned for each day. We spoke with some residents about the provision of food and the response was varied. Please see the areas of development noted below.

Areas for improvement

TISSUE VIABILITY AND SKIN CARE

Whilst there had been some development in relation to this we felt that further improvement was needed. This was in relation to the recording of the settings of airflow mattresses. One mattress we saw was being maintained at its maximum

setting and this was for a resident who was frail and underweight. This could cause further complications in terms of their skin integrity. In addition, staff would not have the information when checking the settings of these mattresses. Although skin checks and positional changes were being recorded, they were not adhering to the instructions highlighted on the skin bundles. In some instances where it was highlighted on the positional charts that this needed to be carried out 4 hourly, they were being carried out 2 hourly and this was over a 24 hour period. The service should review these and take into account residents being routinely disturbed whilst sleeping. The majority of the care plans in relation to skin care did contain sufficient and person centred information. There was no reference to creams or lotions that needed to be used and they did not link with other associated care plans, such as, nutrition or moving and handling. Some of the care plans that we looked at dated back to 2013 and would question the validity of these, especially for those residents who were deemed as at risk. Five care plans that we looked at were blank. The Waterlow monitoring chart had identified 15 residents who were at a high risk or very high risk. Of these, only four had been recently reviewed. Three had no reviews and the remaining eight were reviewed July/September/October 2013. None of the care plans that we looked at had had an evaluation.

This requirement remains in place. We have maintained the Improvement Notice and have extended the timescale to 30 March 2015.

MEDICATION

The service had only addressed one element of this requirement. Care plans had not been further developed and we could see no evidence of staff using a pain management tool.

This requirement remains in place. We have maintained the Improvement Notice and have extended the timescale to 30 March 2015.

CARE PLANS

The service had not sufficiently addressed the requirement. The care plans were still in a state of disarray and difficult to navigate, thereby making it difficult for staff to find relevant information. Some of the folders contained old information, which would be better if it is was archived to avoid confusion. A large majority of care plans did not contain up to date information, with some dating back to 2012/13. None of the care plans that we looked at had been evaluated. However, we could see within the daily notes that some had been evaluated but this had not been transferred to the care plans. The information was only found when we were case tracking specific issues. Some care plans for such areas as pain management were blank. The assessments and care plans for oral health care were not being kept up to date, with some entries dating back to October 2013. We found that the service had either not developed care plans for those residents who lived with dementia, or they were of a poor standard. This would not assist staff with a structured and consistent way of supporting residents. Some residents did not have care plans in place, in relation to their social

and spiritual needs. Although staff took information about past lives and experiences and daily routines, the information from these were not being transferred to the care plans. Overall there was a lack of person centred information within the care plans that we looked at.

We could see that formal reviews had been carried out and that some of the outcomes from these were addressed. However, where changes were requested to personal care such as, the use of different cutlery/changes to consistency of food, or when drinks were to be given, this had not been transferred to the care plans. This would have implications for a consistency of approach from the staff team.

Some of the risk assessments that we saw were either not dated or signed and there was no evidence of a review. There was also no matrix in place, to assist staff to highlight the severity of the risk, which should be used to inform the review timescale.

We discussed the use of a 'Mini Mental Examination', that staff were carrying out with residents on a monthly basis. We could not see how this was being used to develop the care and support and felt that it was unnecessary, as residents would have already undergone an assessment of their mental capacity, prior to moving into the home.

This requirement remains in place. We have maintained the Improvement Notice and have extended the timescale to 30 March 2015.

CONTINENCE

There were still gaps in a person centred approach to the planning of the care for those residents who needed support. There was no reference to specific toilet arrangements. The types and sizes of products were not always highlighted and this included undergarments to be worn with products. There were no links made to other associated care plans such as, nutrition and hydration or mobility. Care plans were not always evaluated and where we found that these had taken place (within the daily notes) these had not been transferred to the care plans. We felt that the requirement that was made as a result of the last inspection of August 2014 had not been addressed. Therefore this requirement remains in place. **See requirement 1.**

MEDICATION - GENERAL MANAGEMENT

Whilst we could see that there had been some improvements in relation to this area, we felt that there were areas that needed to be reviewed and improved upon. Staff signatures were still not in place. There were very little changes noted in the MAR sheets, however, there was a lot of duplications of medicines being printed from one monthly order to the next. This meant that there were several MAR sheets to go through before they found the one that was currently being completed. This proved confusing and difficult. It was discussed with the interim manager during feedback

that they should contact the chemist being used to discuss this. They could also use the NHS Pharmacy technician to review and address this with the pharmacy.

The Controlled Drugs (CD's) were being checked twice daily. We forwarded information from our own pharmacy adviser as to how to best manage the checking of CD's so that staff's time was utilised efficiently.

There was still not a complete audit trail of all medicines being used in the home.

When we checked some of the medication there was an issue when tablets had been halved by the pharmacy.

The service needed to decide on whether they were counting half or whole tablets, as we highlighted a discrepancy with one resident's medicines.

We are making a requirement with regard to the overall management of medication in addition to the continuation of the Improvement Notice (as highlighted above). This is so we can continue to monitor improvements. **See requirement 2.**

NUTRITION AND THE MEALTIME EXPERIENCE

We could see that there had been some improvements in relation to this area. We felt that there were areas that needed to be reviewed and improved upon. The action plan that was returned to us stated that meals and mealtimes would be reviewed with the residents taking part. We could find no evidence of this having happened.

During the observations of mealtimes we could still see that nearly all residents had glasses of milk to drink. We would question this as, when we looked at care plans in relation to food and likes and dislikes information, this was not highlighted.

Supper on the first day of the inspection was not what was on the planned menus. The reason for this was not adequately explained. We looked at the store cupboards and found a good array of meats and vegetables. However these had not been used for supper that day. The meal that was offered was of a bland taste and appearance. This has implications for those residents who may have problems with vision and interpretation as to what was on the plate. We saw one resident mix it all on the plate and not eat it. Other residents when asked for their opinions said "I ate it anyway", "I would like more British food", "If you like mince or chicken then you're alright". On the two days of the inspection, beef and chicken were on the menu for lunch.

The use of the menu board had not been reviewed. It was still placed at a height that not all residents would be able to see. It was not kept up to date on over the two days of the inspection. The photographs that were used were of a poor quality and were laminated, which would have implications for those residents with visual issues. We felt that this recommendation had not been fully met and therefore remains in place.

It was still the case that not all residents had the provision of water/juice jugs in their bedrooms. The provider was to ensure that this was addressed immediately. **See recommendation 1.**

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 1

Requirements

1. It is a requirement that the provider must develop and implement effective care plans following the assessment of service users' continence needs.

   This is in order to comply with:

   Regulations 4(1)(a), 5(1)(2)(a)(b)(i)(ii)(iii) of the Social Care and Social Work Improvement Scotland (Requirements of Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

2. It is a requirement that the provider makes proper provision for the administration, dispensing, recording and storage of medication.

   This is in order to comply with:

   Regulations 4(1)(a), 5(1)(2)(a)(b)(i)(ii)(iii) of the Social Care and Social Work Improvement Scotland (Requirements of Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

Recommendations

1. It is recommended that the provider should carry out a further review of the mealtime experiences for service users. This review was to include the residents and their views, staff's knowledge and understanding of good practice, the environment and the information about menu choice.

   National Care Standards Care homes for older people
   Standard 6 - Support arrangements
   Standard 8 - Making choices
   Standard 13 - Eating well.

Quality Theme 2: Quality of Environment

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the environment within the service.

Service strengths

The strengths that have been identified within statement 1.1 are also relevant here, please refer to that statement for further information.

Areas for improvement

The areas of development that have been identified within statement 1.1 are also relevant here, please refer to that statement for further information.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 2

We make sure that the environment is safe and service users are protected.

Service strengths

At this inspection, we found that the performance of the service was weak for this statement. We concluded this after we looked at maintenance records, risk assessments, accident and incident records, management of infection control and health and safety, management of continence products and carried out observations of the environment.

One requirement was made within the Improvement Notice that was issued to the service on 4 September 2014. This was in relation to accidents/incidents and falls.

By 6 January 2015 (extended from 13 October 2014) you must put in place and implement a system whereby accidents/incidents/falls are reviewed to ensure that residents' safety is addressed and that they are not left at

continued risk, to include but not limited to ensuring the following:-

a) that all accidents and incidents forms are reviewed by the manager following each episode.

b) that where the review of each episode shows that patterns, triggers or other factors are highlighted,
that this is used to assist in the effective management and possible minimisation of such incidents.

c) that once an effective review has taken place of any falls/accidents/ incidents, that where needed, residents' risk assessments and care plans reflect the changes that need to be made to their care and support.

d) that those residents who are deemed at risk of falls have the appropriate assessments/diaries and care plans in place.

e) that the care plans and associated documentation are reviewed on a regular basis or when needs dictate.

f) that there is evidence of discussions with residents and relatives when making decisions about their care and support needs.

g) that you look toward implementing the falls risk management strategy in a meaningful way

h) that when falls risk tools are used that they show evidence of regular review and any action plan is fully addressed.

We could not evidence that any of the areas identified above had been addressed.

Some improvements had been made in relation to the overall management of infection control in the home. Bathrooms were less cluttered and there was no evidence of communal toiletries or creams being used. Liquid soap was being used in all bathrooms and residents' en-suite rooms. The toilet roll dispensers had been placed appropriately so that residents were able to access these independently. Cleaning schedules were in place for the domestic team and we spoke with a staff member and they told us how these were used. The service had good domestic cover and in general, the home looked clean and smelt fresh. All bar one of the empty rooms were locked.

We looked at the overall management of health and safety within the home. The service employed a handyman/maintenance staff member and they were responsible for everyday repairs. Outside contractors were used for larger jobs. There was a maintenance book in place where staff recorded any areas that needed to be

addressed. We could see that these were addressed by the handyman as they signed when the work was completed. Almost all repairs that were needed had been completed.

We could see that domestics did not leave cleaning materials unattended.

Some of the locks to the electrical switch cupboards and boiler rooms had been repaired.

Window restrictors had been reviewed and we could see that the ones that we highlighted as being faulty at the last inspection, had been repaired.

When observing staff during this inspection we could see that inappropriate jewellery was not being worn.

We had made a recommendation regarding the management of continence products. When looking at where these were stored, we could see that all of these were individually named. There was a member of staff who had overall responsibility to ensure that this carried out when orders were received.

We made a recommendation regarding the refurbishment of the home. At this inspection we could see that work had been carried out and there were no longer stained ceilings or walls. New furniture was in place and new beds and mattresses were in use. The interim manager had also reviewed all of the beds and mattresses in the home. They had highlighted what type of mattress was needed for each individual resident. **This recommendation has been met.**

At the last inspection we observed that the provision of bed linen and mattress protectors was of a poor quality. This had been made the subject of a requirement from a previous complaint. At the last inspection we could not comment on this as the timescale for completion had not expired. However, at this inspection this was not an issue and therefore this requirement has been met. We could also see that staff were now making up beds appropriately.

Areas for improvement

ACCIDENTS/INCIDENTS/FALLS

At this inspection we could find no evidence to support that the management had addressed any of the elements of the above requirement.

We found that during the months of November and December four residents had suffered an incident/accident, such as, being found on the floor. No accident forms or subsequent investigations had taken place. As a result of the non completion of accident forms, there was no overview from the management in place. There was no information about the management looking at patterns, triggers or other factors,

which would assist in the minimisation of such occurrences. One incident that had taken place had associated staff statements in place as to how this had occurred but no formal accident form had been completed. Care plans that we looked at were either written in 2013 with no evaluation, or of a poor standard and did not contain sufficient person centred information. There was no evaluation of the current up to date care plans that were in place. The service had not started to use the 'Managing Falls and Fractures in Care Homes' assessments, diaries or care plans.

This requirement remains in place. We have maintained the Improvement Notice and have extended the timescale to 30 March 2015.

INFECTION CONTROL

The provider had not fully addressed the requirement in relation to infection control. The provider had not adhered to the action plan submitted to us, which was to implement this by 19 December 2014. In addition, the provider had only made reference within the action plan to the fact that they had an infection control policy and procedure. They had not highlighted what work needed to be done to address the requirement, and by when.

The service was not adhering to their own policies and procedures in relation to infection control. Although cleaning schedules had been developed for the domestic team, these were not always being completed on a daily basis. In the afternoon of the second day of the inspection, one resident's room was particularly malodorous. This was addressed when it was highlighted to staff. Another room, which had been recently vacated was in a poor state of cleanliness and tidiness.

Cleaning schedules had not been developed for the kitchen; however the interim manager was in the process of completing these at the time of the inspection. The provider was to review their own guidance in relation to the storage of opened foods that were kept in the fridges. This was because we found that opened food was either not covered, or not dated with when it was opened, or when it needed to be used by.

Some residents had their own fridges in their bedrooms where they kept various items. One of these was in a very poor state of cleanliness and the freezer compartment had not been defrosted for some time.

No audit of the overall management of infection control had been developed.

There had been no training carried out for all staff in relation to the management of infection control. (See quality statement 3.3)

We could see that there was a store of new facecloths in the home. We advised that these should be individually named before use.

Therefore, the provider was to address the overall management of infection control within the home in relation to, but not exclusively to, the above findings. They were to ensure that they developed and implemented an audit, in relation to infection control and put in place an action plan to address any shortfalls. The action plan was then to be reviewed, in order that they could then satisfy themselves that the appropriate action had been taken. It would also be good practice to involve staff in this audit and subsequent action plan. **See requirement 1.**

GENERAL HEALTH AND SAFETY

We highlighted at the last inspection that there was a free access from one corridor down to the kitchen and fire exit and that this was via concrete stairs. We felt that this was a risk for those residents who may wander and/or were unsteady when walking. In addition the corridor was not used frequently by staff. This meant that if any resident fell, they would not immediately be found or assisted. We asked the provider to contact their local Fire and Rescue Service to ascertain how this could be best managed in their fire safety regulations. At the feedback following the inspection, the provider indicated that they had done this. We spoke with a fire officer who is working with this service and they told us that the provider had not been in touch. Furthermore, the provider had not generated a risk assessment for these stairs in the interim period. The service is due a fire audit visit on 22 January 2015 and we expect the provider to discuss this issue with them at that visit. We also expect that the provider will inform us via the use of the action plan as to the intended work that needs to be done to make this safe. **See requirement 2.**

In addition to the above some of the locks to the boiler rooms were not operational.

The lighting in some parts of the home was poor with some corridors being dim. This was commented upon by a relative. There was no evidence that the provider had carried out any kind of review, following this being made the subject of a requirement within the last inspection report. There were residents in the home who lived with dementia and/or other visual problems. The poor lighting could have a negative impact and cause difficulties for these residents, in terms of them being able to successfully navigate their way around the home.

We could not evidence that the service had carried out any kind of environmental audit or that environmental risk assessments had been generated, where needed and/or reviewed.

Therefore, the provider was to address the overall management of the environment within the home in relation to, but not exclusively to, the above findings. They were to ensure that they developed and implemented an audit in relation to the environment and put in place an action plan to address any shortfalls. The action plan was then to be reviewed, in order that they could then satisfy themselves that the appropriate action had been taken. It would also be good practice to involve staff in this audit and subsequent action plan. **See requirement 3.**

Although there was a reporting system in place for repair and maintenance, we could see that some areas were not being addressed in a timely manner. For example, the records showed that a set of bed rails had been reported as faulty on 14 December 2014 and were being held in place by a chair. They were reported a further two times and were only repaired on 28 December 2014. This has serious implications for the health and safety of the resident. In addition, whilst the handyman was signing to indicate that repairs had taken place, they were not always identifying the date that the work was completed. Therefore, the provider was to review the current system that was in use to ensure that all repairs were carried out in a timely manner. If this was not possible they were to indicate within the records why this was and the anticipated date of repair. **See requirement 4.**

There was no system in place for the regular checking of bedrails and/or airflow mattresses, which were seen to often have a problem. One mattress that we looked at was at the highest level and had a warning light showing. In some of the daily recording, staff noted that mattresses were turned off in the morning and then switched back on in the evening. There was no reference to any anomalies within the maintenance records. Therefore, the provider was to devise and implement a system whereby all bedrails and airflow mattresses were checked on a regular basis. They were to take account of the instructions of the checking of these within the manufacturer's own guidelines. There is also best practice guidance, which as been issued by the Health and Safety Executive and can be found on www.hse.gov.uk **See requirement 5.**

Whilst carrying out a tour of the building we came across a resident who used an airflow mattress, along with bedrails. There were large gaps between the mattress and the bedrails and these had been padded out with rolled up blankets. We could see from the daily recording that this resident had trapped their legs in between the bedrails previously. There was a bedrail risk assessment in place that was dated July 2014. However, this was not fully completed and did not indicate that the mattress being used was too small for the bed. It had been reviewed twice with no changes noted. Using rolled up blankets to compensate for a poorly fitting airflow mattress is not seen as good practice. We gave the service information from the Health and Safety Executive (www.hse.gov.uk) with regard to the safe use of bedrails and airflow mattresses. The service was to take this into account. The provider was to ensure that the use of airflow mattresses and bedrails for all residents who needed them was reviewed. The service could also contact the NHS Community Nursing team to assist them with this review This was so that residents were using appropriate equipment thereby protecting their health and safety needs. **See requirement 6.**

CONTINENCE

Whilst the service had addressed the storage and naming of continence products in general, we could still see some unnamed packets and loose products such as, pads on trolleys in bathrooms. This is not good practice as it compromises the efficacy. The

urinal bottles that were being used for individual residents had not been named and therefore being used communally. There was a named member of staff who was responsible for continence products. It would be good practice if this member of staff regularly checked that staff were not using unnamed products and that all pads were being used correctly. **See recommendation 1.**

Grade awarded for this statement: 2 - Weak

Number of requirements: 6

Number of recommendations: 1

Requirements

1. It is a requirement that the provider must make proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider having appropriate procedures for the control of infection.

   This is in order to comply with:

   Regulation 4(1)(a)(d) and 10(2)(a)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

2. It is a requirement that the provider makes proper provision for the health, welfare and safety of service users.
   This is specifically in relation to the provision of fire and safety within the home. They were also to develop and implement a risk assessment in relation to the fire escape under question and ensure that all staff were made aware of this.

   This is in order to comply with:

   Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

3. It is a requirement that the provider makes proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider having appropriate procedures for the control of overall health and safety within the service.

   This is in order to comply with:

Regulation 4(1)(a)(d) and 10(2)(a)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement: 30 March 2015.

4. It is a requirement that the provider makes proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider having appropriate procedures for the overall maintenance within the service.

   This is in order to comply with:

   Regulation 4(1)(a)(d) and 10(2)(a)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

5. It is a requirement that the provider makes proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider having appropriate procedures for the maintenance and checking of bedrails and airflow mattresses.

   This is in order to comply with:

   Regulation 4(1)(a)(d) and 10(2)(a)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale requirement: 30 March 2015.

   6. It is a requirement that the provider makes proper provision for the health, welfare and safety of service users. This is specifically in relation to the provider having appropriate procedures for the use and review of airflow mattresses.

   This is in order to comply with:

   Regulation 4(1)(a)(d) and 10(2)(a)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

Recommendations

1. It is a recommendation that the provider ensures that they reviewed the overall management of continence products in the home so that they were allocated to and used by individual residents.

   National Care Standard Care homes for older people
   Standard 5 - Management and staffing
   Standard 6 - Support arrangements
   Standard 8 - Making choices.

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of staffing in the service.

Service Strengths

The strengths that have been identified within statement 1.1 are also relevant here, please refer to that statement for further information.

Areas for improvement

The areas of development that have been identified within statement 1.1 are also relevant here, please refer to that statement for further information.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 2

We are confident that our staff have been recruited, and inducted, in a safe and robust manner to protect service users and staff.

Service strengths

At this inspection, we found that the performance of the service was weak for this statement. We concluded this after we looked at staff recruitment information.

During this inspection we looked at staff recruitment files. We had made a recommendation at the last inspection of August 2014 and this was in relation to the maintenance of staff files.

We requested to view four staff files. Three of these were available, the remaining one was unable to be found.

All of the files we looked at had an application form. Three had two references and the remaining file had only one reference. All had a current PVG certificate.

Areas for improvement

As stated the service was unable to locate one staff member's recruitment information. Therefore, there was no evidence to support that a robust recruitment process had been undertaken, or that a current PVG was in place. The provider was to ensure that this staff member's file was located or put into place new recruitment information and this included a current PVG.

We found that PVG information was not being stored in relation to Disclosure Scotland's best practice guidance. The service had been informed of this, as a result of a recent complaints investigation, and had not addressed the contents of the letter that was sent to them on 27 November 2014.

The other staff files showed that ,in one instance, only one reference had been returned. There was no evidence to support that the service had followed this up. There was no evidence, in any of the staff files, to support the fact that the service was following best practice guidance in the recruitment of staff. For example, there were no interview notes and therefore, no information about how the service was ensuring that the staff member was suitable for the role that they were applying for. There were no letters to confirm that the staff had been successful in their application, their start date or that they were subject to a probationary period. There were no job descriptions in place. There were no staff contracts in any of the files that were looked at. The way that staff recruitment information was stored was haphazard and not well organised. This meant that it was difficult to find the information that was needed.

Therefore, the provider was to ensure that they followed their own policy and procedure in relation to the recruitment of staff. They were also to take account of current best practice in relation to recruitment. The provider was also to ensure that all relevant information regarding the recruitment and selection of staff was stored and maintained appropriately. **See requirement 1.**

Grade awarded for this statement: 2 - Weak

Number of requirements: 1

Number of recommendations: 0

Requirements

1. It is a requirement that the provider must not employ any person in the provision of a care service unless that person is fit to be so employed.

   This is in order to comply with:

Regulation 9(1) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

Timescale for this requirement: March 2015.

Statement 3

We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Service strengths

At this inspection, we found that the performance of the service was weak for this statement. We concluded this after we looked at the training plan, supervision records, induction records, staff meetings and spoke with some staff.

Three requirements were made within the Improvement Notice that was issued to the service on 4 September 2014. These were in regard to having an effective training programme for staff, effective systems for monitoring of staff practice and an effective programme of staff supervision and appraisal. How the service had addressed these requirements are as follows:

1. By 6 January 2015 (extended from 30 November 2014) you must:-

a) put in place and implement an effective programme of training for staff, to include (but not limited to): - Management of Incontinence, Medication, Wound Management/Tissue Viability, Moving and Handling, Dementia Awareness, oral health care, adult support and protection, restraint, dignity and respect, SVQ and Care Planning and Review; and

b) put in place and implement a system for the evaluation of all training to ensure that staff practice improves as a result of the training provided.

A training plan programme had been developed by the manager and this was for the coming year. We could see that 15 staff had attended Moving and Handling training, which was held in December 2014 and January 2015. The interim manager of the home was the trainer in this area of care and support. We could see that four members of staff had completed an evaluation form following the training. Staff indicated the quality of the training provided and the benefits to their practice. We spoke with some staff and they said that they had attended this training and had found it beneficial.

The interim manager indicated to us that they were waiting for dates for further training opportunities for staff.

2. By 6 January 2015 (extended from 13 October 2014) you must put in place and implement effective systems for the monitoring of staff practice in all aspects of their work to include (but not limited to):- Care tasks, medication and dignity and privacy in order to ensure they have the skills necessary for the work they perform in the service and in particular to identify strengths and weaknesses in their practice. Where weaknesses in staff practices are highlighted, these should be followed up through the programme of supervision where further training may be identified and implemented.

We could see at this inspection that the service had commenced practical supervision with four members of staff. The records showed that staff were being monitored in relation to moving and handling and when staff assisted those residents who were unable to eat their meals independently. The documentation contained information about good practice and well as some areas that they needed to improve upon.

3. By 6 January 2015 (extended from 30 November 2014) you must put in place and implement an effective programme of supervision and appraisal to provide all staff with support, the opportunity to raise individual issues and as a means of monitoring staff awareness of working practices, effectiveness of induction and training and to identify any further training needs. If issues are identified as part of supervision and/or appraisals there should be clear written evidence of how these are being addressed and reviewed.

Again we could see that the service had commenced formal supervision with eight members of staff. These were all in relation to nutrition/hydration and the mealtime experience for residents. Staff were directed to good practice "Practical guide to supporting people to eat well". The supervisor was seen to discuss the importance of a positive and fulfilling dining experience. Staff were able to highlight other matters and these were recorded. Staff commented on mealtimes and other care related matters. Some staff highlighted areas that they felt would improve the experience for residents.

There was one requirement and one recommendation made as a result of the last inspection of August 2014 that were not part of the improvement notice. How the service had addressed these are as follows:

Requirement 1 - Staff induction

We looked at the records for three staff members who had commenced working in the service since the last inspection. The activities co-ordinator, who had joined in August, had a completed induction in place; however this had not been signed by their mentor. For the remaining two members of staff there were no induction records present. One of these members of staff had joined in September 2014. The

other staff had just joined the night staff team and we were told that they would have the paperwork with them and that is why it was not maintained in their staff file.

Recommendation 1 - Staff recruitment information
We were told that all staff files for the service were now maintained within the service. However, when checking this we found that one staff member's file could not be found. Please refer to quality statement 3.2 as during this inspection we highlighted some concerns surrounding the overall management of staff recruitment.

Areas for improvement

STAFF TRAINING
The service had not sufficiently addressed the requirement from the Improvement Notice of 4 September 2014. As highlighted above the only training that had taken place was in relation to Moving and Handling. There was no other information regarding any other training that had taken place. When we spoke with three members of staff they confirmed that they had received some fire training. They could not tell us that they had taken part in any of the training needs that were stated within the Improvement Notice.

This requirement remains in place. We have maintained the Improvement Notice and have extended the timescale to 30 March 2015.

MONITORING OF STAFF PRACTICE
The service had not sufficiently addressed the requirement from the Improvement Notice of 4 September 2014. Only four members of staff had had their practice monitored. We could not see any evidence that the remaining staff had taken part. There was no evidence that any weaknesses in staff's performance was being followed up.

This requirement remains in place. We have maintained the Improvement Notice and have extended the timescale to 30 March 2015.

STAFF SUPERVISION
The service had not sufficiently addressed the requirement from the Improvement Notice of 4 September 2014. Not all of the staff team had taken part in supervision. The supervision that had taken place was focused on nutrition and related good practice, rather than it being across all aspects of the care and support of residents. Where staff had highlighted other areas/issues or concerns, we could not see that these had been taken forward or appropriately addressed. There was no information about the supervisors identifying individual training needs. Supervision should provide an opportunity to identify where skills, knowledge and experience need to be gained. Any training needs should then be transferred to the training plan. The documentation did not provide objectives or the monitoring of progress on a regular

basis. Supervision is seen as a vital part of a Manager's responsibility to support staff members. These meetings help the performance, development and motivation of a team, as well as create a relationship based on openness and honesty.

This requirement remains in place. We have maintained the Improvement Notice and have extended the timescale to 30 March 2015.

STAFF INDUCTION

The provider had not adhered to the action plan submitted to us, which was to implement this by 19 December 2014. The induction material that we looked at was a simple ticklist. One of the inductions that we looked at was signed off as being completed on the staff's first day in the service. It indicated that the staff member had taken part in five different training sessions. We would question the validity of this and also how effective this had been in ensuring staff's understanding of the needs and care of the older person. They were to ensure that all staff took part in an appropriate induction relevant to their role within the home. They were to take into consideration what standards their induction paperwork was based on. For example, they could relate to the Common Induction Standards or the National Occupational Standards. These standards also include units that highlight the 'values' required to work in care. The service was also to take account of the codes of conduct as stipulated by the Scottish Social Services Council. By developing their induction it would ensure that staff could then demonstrate their understanding of how to provide high quality care and support. **See requirement 1.**

Grade awarded for this statement: 2 - Weak

Number of requirements: 1

Number of recommendations: 0

Requirements

1. It is a requirement that the provider makes proper provision for staff to take part in an effective and appropriate induction. At the end of the induction, staff's competence and any further training needs were to be addressed.

   This is in order to comply with:

   Regulation 15(a)(b)(i) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service.

Service strengths

The strengths that have been identified within statement 1.1 are also relevant here, please refer to that statement for further information.

Areas for improvement

The areas of development that have been identified within statement 1.1 are also relevant here, please refer to that statement for further information.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Service strengths

At this inspection, we found that the performance of the service was weak for this statement. We concluded this after we spoke with people using the service, spoke with staff, carried out observations in all areas of the home, examined policies and procedures and looked at how the service managed overall quality assurance.

Some audits of the care and support offered to residents had been carried out. This was in relation to nutrition and hydration, tissue viability and skin care. The interim manager maintained an on-going view of all residents in these areas and the findings were shared with staff.

A staff meeting had been held in November 2014 and staff were given information about how the service had progressed.

The staff that we spoke with were all aware of the Improvement Notice and also that they had been given information about this and the most recent inspection report. Staff told us that things were more settled in the home. The qualified staff told us that there had been improvements and that the interim manager was more involved in the overseeing of the care and support. They felt that they were being consulted and that the way the manager had introduced the audits as highlighted above was a more positive way to monitor resident's health and wellbeing needs. All staff felt that the interim manager was approachable and that they were kept up to date with changes to the care and support of the residents. Overall we could see that staff morale had improved since the last inspection.

There had been some work carried out in relation to the requirements and recommendations from the previous report. The service had also satisfactorily addressed one of the requirements within the Improvement Notice which was issued on 4 September 2014.

Since the last inspection it was highlighted by NHS Highland that the management of residents' finances were not being effectively managed. Our Professional Adviser (Finance) visited the home along with the inspectors on 20 October 2014. Following this visit they provided verbal feedback to the provider, which was then followed up with a formal letter. This indicated the steps that needed to be taken to improve the systems of financial management. At this inspection our Professional Adviser accompanied the inspectors. They sampled the following: residents' cash book, cash sheets and a sample of residents' cash envelopes in the safe. They found the following improvements:

- Schedules had been compiled recording transfers of cash from the safe to the residents' bank account by individual resident
- The blue cash book has been replaced by a file of residents' cash sheets. A sample of balances transferred from the blue cash book to the cash sheets was checked and agreed. A sample of residents' balances on the cash sheets was agreed to the cash in the safe. A review of cash sheets sampled indicated that deposits were recorded weekly. The omitted deposits had been credited. Movements were witnessed by two signatures. The issue of personal allowance in cash to one of the three residents, who manage these themselves, was witnessed during the visit and the resident signed for the money
- A receipt book has been set up for monies received at the care home's office for fees from one resident's relative who hands in cash
- A separate deposit sheet has been implemented to record date, purpose and amount of residents' personal allowance deposits from the bank, evidenced by two signatures. The system for noting other deposits is as noted above.

- Per the manager, purchases on behalf of residents shall be made after consultation with relatives and staff (and resident, where their wishes are known) with cash from the resident's account. This was evidenced for some purchases in the period since our last visit.
- Per the provider, staff have been advised that no residents' funds should be used to fund another resident's purchase (as was sometimes practised in the past). No further evidence of this practice was noted in the sample reviewed at this visit.

The residents and relatives/friends that we spoke with during the inspection overall were all happy with the level of care and support that was offered. They told us that the interim manager had made a difference as they were approachable and attended to their suggestions and comments.

Areas for improvement

The provider had not addressed the requirement in relation to the development and implementation of a quality assurance system. The provider had not adhered to the action plan submitted to us, which was to implement this by 19 December 2014. The service was not adhering to their own policies and procedures, in relation to quality assurance or audit and self assessment. There was no evidence to support the fact that the management were proactively or formally managing the overall quality of the service. There was no focus to quality improvement and in some cases, where issues, concerns and decisions had been highlighted, there was no follow-up to ensure that they had been effectively addressed. These are highlighted throughout the report under the quality statements. We have highlighted under other quality statements where we feel that further improvements need to be done. These are in relation to care planning, infection control, health and safety and the environment, staff recruitment and staff training. The provider should initially consider the development of audits in these areas. This would then ensure that staff were working toward quality improvement in a focused manner. In addition, the interim manager had not developed their own action plan, as to how and by when, they were going to address the requirements made within the Improvement Notice, or the last inspection report. Given there were many areas that required attention we felt that this would have been a prudent move. The formulation of an action plan would assist the whole staff team to address these in a focused manner. Therefore, this requirement remains in force and the provider was to ensure that robust measures to ensure the on-going quality of the overall care and management of the home was addressed. S**ee requirement 1.**

As highlighted above, the interim manager was working five days a week in the home. However, at the end of January they were returning to college. This meant that they would then only be available to work three days per week. At one of our monitoring visits of 8 December 201,4 the inspectors noted that there was some

confusion and a lack of clarity as to who was in charge when the interim manager was not on duty (at this time they were only working in the home three days per week). This lack of clarity has implications for the on-going and overall care and support of the residents. We are making a requirement that the provider forward to us an action plan as to how this was to be addressed, when the current interim manager returned to three days per week. They were also to ensure that the staff working in the home were made aware of who was in charge of the home on a day to day basis. **See requirement 2.**

There were still areas within the overall management of the residents' finances that were required to be addressed. These were as follows:

1. A breakdown of the residents' balances held in the residents' bank account and reconciled to the actual balance in the residents' bank account is still required, together with clarification whether the un-presented cheques, made out to two residents from the Mr T.S. Manda t/a Fairfield Care Home account, had been credited to their accounts.

2. Supporting records should be available to evidence that the transfers from the Fairfield business account to the residents' account are the correct amounts.

3. The receipt system would benefit from the use of consecutively numbered receipts (to ensure completeness of recording) within the care home's office and a similar system of recording set up at the nurse's office to record monies and cheques etc., deposited out of office hours. A suitable, secure depository should also be considered to avoid use of the controlled drugs cupboard to hold money.

4. Updating of residents' inventories within the residents' individual files is on-going and requires further work.

5. Residents' cash balances within the safe varied at the time of our visit. A significant amount of residents' money is held within the residents' bank account. A more proactive approach should be taken to ensure that the residents benefit from their funds.

6. Financial risk assessments and authorities and arrangements for supporting each resident have not been detailed in the residents' care plans yet. A copy of any authority held to manage one resident's financial affairs has been requested from their relative, but this information has not been received yet. A resident's money should not be given out without formal authorisation, or the consent of the resident themselves (where they have the capacity to give this)

7. The provider is to ensure that all residents have up to date contracts, specifying which services are included in the fee and which services are additional and need to be purchased by the resident.

8. Inventories of residents' possessions and valuables (if appropriate) held within the home are to be established and maintained, their possessions labelled and periodically reconciled to the inventory.

9. The provider is to establish how many keys there are to the safe and where these are located and formalise procedures and controls to limit access to residents' funds.

The Care Inspectorate expects rigorous and robust financial procedures and controls for the management of service users' funds and belongings in any registered service, where staff are supporting service users to manage these. We expect a clear audit trail for all transactions with withdrawals and expenditure being supported by receipts. **See requirement 3.**

The policies and procedures that were in place were now contained within two folders. However, these were very large folders with a mixture of administration, maintenance and care related policies. They proved difficult to navigate and locate a policy. The management was to look at reviewing how these were managed, so that the staff who were working within the different areas of the home, had easy access to the policies that related to their area of responsibility. **See recommendation 1.**

We were told that staff meetings had been held, however, we could only find evidence of one set of minutes. Only seven staff members had attended this meeting, which was held in November 2014. Whilst it is good practice to highlight to staff what they are doing well, these minutes did not inform staff what needed to be addressed. Therefore, the management were to plan and carry out staff meetings, for all grades of staff on a regular basis. Minutes were to be produced and shared and action plans were to be used, to ensure their focus on quality improvement. The action plans were to state who was responsible for the work that was needed and by when they were to be addressed. The action plans were then to be revisited to ensure that the work had been effectively addressed. **See recommendation 2.**

A requirement was made as a result of the last inspection and this was in relation to the development and implementation of a procedure, which would detect poor practice. The provider had not adhered to the action plan submitted to us, which was to implement this by 19 December 2014. This requirement is allied to requirement that is being maintained within the Improvement Notice of 4 September 2014, which now has an extended timescale of 30 March 2015.

Three complaints had been made to us since the last inspection and all of these were upheld. The service was to provide action plans, within a given timescale, as to how they were going to address the requirements that had been made. We did not receive these within the given time. We are not making a requirement at this time as all of the aspects of the complaints were inspected at this visit. We have made further requirements to ensure that these areas are effectively addressed. However, at the

feedback it was highlighted to the management that it is a requirement that action plans from complaints and/or inspection were to be forwarded to us, within the given timescales.

In addition the provider must ensure that when they completed the actions plans for the Care Inspectorate that they addressed each requirement within the given timescale. They were also to ensure that the actions that they identified as needing to be done were specific, measurable, achievable and realistic.

Grade awarded for this statement: 2 - Weak

Number of requirements: 3

Number of recommendations: 2

Requirements

1. It is a requirement that the provider must ensure that they develop and implement quality assurance systems and processes so that service users and their relatives/ representatives could be assured that the service they were receiving was of a high quality.

   This is in order to comply with:

   Regulations 3 and 4(1)(a) of the Social Work Improvement Scotland (Requirements of Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

2. It is a requirement that the provider must ensure that they provide the Care Inspectorate with a plan of action as to how the future management of the service was to be addressed.

   This is in order to comply with:

   Regulations 15(a) of the Social Work Improvement Scotland (Requirements of Care Services) Regulations 2011 Scottish Statutory Instrument 2011/210.

   Timescale for this requirement: 30 March 2015.

3. SSI 28 of The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011:**Records, notifications and returns**

   4.- (1) On granting registration of a care service under Chapter 3 or 4 of Part 5 of the Act, SCSWIS must, in addition to issuing a certificate of registration, notify the provider of the care service of:-

(a) the records the provider must keep and where they must be kept;

The service, if an 'authorised establishment' or any registered establishment where residents, to a varying extent, need help with their financial affairs must keep records that identify:

- the financial procedures and controls in place to safeguard the property of a person using the service which is managed by the provider
- that the funds of the service and people using the service are separate
- that the funds of each person using the service are distinguishable from each other
- that transactions, source of income and purpose of expenditure, balance and interest on each account is clear at any time

Timescale for this requirement: 30 March 2015.

Recommendations

1. It is a recommendation that the provider should review the overall management of the policies and procedures of the service. This was to enable staff who worked within the different departments of the home being able to locate each policy easily and as required.

   National Care Standards Care homes for older people. Standard 5 - Management and staffing.

2. It is a recommendation that the provider should plan and carry out regular staff meetings for all grades of staff and for those who worked in different parts of the service.

   National Care Standards Care homes for older people. Standard 5 - Management and staffing.

4 Other information

Complaints

Three separate complaints had been made to us since the last inspection of August 2014. These were investigated and all were all upheld. However, the service did not provide us with action plans, in line with the timescales that were indicated within the complaint letters. Please refer to quality statement 4.4 for furher information.

Enforcements

An Improvement Notice was issued under Section 62 Public Services Reform (Scotland) Act 2010 ("the Act") to the Service Provider on 4 September 2014. This included nine requirements. Further information regarding these requirements and how the provider had responded to this enforcement action can be found throughout this report. Two of these requirements have been fully met. It was considered at this visit to the service on 7 and 8 January 2015 that the remaining requirements had not been fully met, as there had been no significant improvements. Further information regarding the Improvement Notice can be found on our website at www.careinspectorate.com

Additional Information

Action Plan

Failure to submit an appropriate action plan within the required timescale, including any agreed extension, where requirements and recommendations have been made, will result in the Care Inspectorate re-grading a Quality Statement within the Quality of Management and Leadership Theme (or for childminders, Quality of Staffing Theme) as unsatisfactory (1). This will result in the Quality Theme being re-graded as unsatisfactory (1).

5 Summary of grades

Quality of Care and Support - 2 - Weak	
Statement 1	3 - Adequate
Statement 3	2 - Weak
Quality of Environment - 2 - Weak	
Statement 1	3 - Adequate
Statement 2	2 - Weak
Quality of Staffing - 2 - Weak	
Statement 1	3 - Adequate
Statement 2	2 - Weak
Statement 3	2 - Weak
Quality of Management and Leadership - 2 - Weak	
Statement 1	3 - Adequate
Statement 4	2 - Weak

6 Inspection and grading history

Date	Type	Gradings	
28 Aug 2014	Unannounced	Care and support Environment Staffing Management and Leadership	1 - Unsatisfactory 2 - Weak 1 - Unsatisfactory 1 - Unsatisfactory
26 Mar 2014	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 3 - Adequate 3 - Adequate 3 - Adequate
26 Jun 2013	Unannounced	Care and support Environment Staffing	3 - Adequate 3 - Adequate 3 - Adequate

		Management and Leadership	3 - Adequate
20 Mar 2013	Unannounced	Care and support Environment Staffing Management and Leadership	2 - Weak 3 - Adequate Not Assessed Not Assessed
17 Jan 2013	Unannounced	Care and support Environment Staffing Management and Leadership	2 - Weak 1 - Unsatisfactory 3 - Adequate 3 - Adequate
7 Sep 2012	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 3 - Adequate 2 - Weak 2 - Weak
9 Mar 2012	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate Not Assessed 4 - Good Not Assessed
5 Aug 2011	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate Not Assessed 4 - Good Not Assessed
15 Feb 2011	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good Not Assessed Not Assessed Not Assessed
17 Aug 2010	Announced	Care and support Environment Staffing Management and Leadership	4 - Good 4 - Good Not Assessed Not Assessed
11 Dec 2009	Announced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 4 - Good Not Assessed

21 Aug 2009	Announced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 4 - Good 4 - Good
15 Dec 2008	Unannounced	Care and support Environment Staffing Management and Leadership	3 - Adequate 4 - Good 3 - Adequate 4 - Good
17 Sep 2008	Announced	Care and support Environment Staffing Management and Leadership	3 - Adequate 3 - Adequate 3 - Adequate 3 - Adequate

All inspections and grades before 1 April 2011 are those reported by the former regulator of care services, the Care Commission.

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ی ہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے۔

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